Progress Report

of the PMHA, its CDMS and the Network

1 July 2011 – 30 June 2013

PMHA | PRIVATE MENTAL HEALTH ALLIANCE

Private Mental Health Consumer Carer Network (Australia)

engage, empower, enable choice in private mental health

PMHA CDMS | THE CENTRALISED DATA MANAGEMENT SERVICE *of the* PRIVATE MENTAL HEALTH ALLIANCE

PMHA | PRIVATE MENTAL HEALTH ALLIANCE

The PMHA gratefully acknowledges the funding and support provided by the following organisations.

AMA

Australian Private Hospitals Association

Private Healthcare Australia

Australian Government Department of Health

Private Mental Health Consumer Carer Network (Australia)

engage, empower, enable choice in private mental health

The Network is please to acknowledge the funding and support of the following organisations.

AMA

Australian Private Hospitals Association

Private Healthcare Australia

Australian Government Department of Health

The Royal Australian & New Zealand College of Psychiatrists

APS Australian Psychological Society

beyondblue

PMHA CDMS | THE CENTRALISED DATA MANAGEMENT SERVICE *of the* PRIVATE MENTAL HEALTH ALLIANCE

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FOREWORD

The Australian Medical Association (AMA), Private Healthcare Australia (PHA) representing private health insurers, the Australian Private Hospitals Association (APHA), representing private hospitals with psychiatric beds (Hospitals), and the Australian Government are strongly committed to supporting a Private Mental Health Alliance (PMHA or Alliance) for the private mental health sector. Established by the AMA in 1996, the PMHA is an unusual organisation in the Australian health environment that brings together providers, payers and consumers and carers on a regular and structured basis to work on difficult and complex issues related to funding, classification, quality of care, outcome measurement, and consumer and carer participation.

The level of trust and cooperation that has developed over time between the stakeholders has enabled the Alliance to establish a unique national PMHA Centralised Data Management Service (CDMS) to improve the quality of information and enable benchmarking within the private hospital sector. Established in 2001, the PMHA's CDMS works with private hospitals and health insurers to put in place efficient systems for the routine collection of outcomes data that enables the quality and efficiency of mental health service delivery to be evaluated and reported on every quarter.

To improve consumer and carer participation, the Alliance and beyondblue supported the formation of a Private Mental Health Consumer Carer Network (PMHCCN or Network) for Australia in 2002. As a peak private sector advocacy organisation, the Network exists to advance the interests of both the mental health consumers who receive their treatment and care in the private sector, and their carers.

Over the course of the financial years 2011-13, the PMHA, its CDMS, and the Network were supported by a funding agreement between the AMA, the then Australian Government Department of Health and Ageing (DoHA), APHA, PHA and Beyondblue. Parties to that AMA Agreement made funding contributions for the provision of the services required to support the operation of all three entities. For PMHA, all stakeholders, except beyondblue, made equal contributions. The PHA, APHA and DoHA made equal contributions to support the CDMS, and all stakeholders contributed to support the Network. Chartered accountants RSM Bird Cameron have conducted an audit of the revenue and expenditure for the PMHA, its CDMS and the Network and their letter of acquittal appears at Attachment 1 to this Report. Statements of income and expenditure for PMHA, its CDMS and the Network are dealt with under each respective subsection of this Report.

This Progress Report covers the activities of the PMHA, its CDMS and the Network for the period 1 July 2011 to 30 June 2013. The Report has been unanimously endorsed by the PMHA.

I trust you will find the Report informative and useful.

Philip Plummer
PMHA Independent Chair

PRIVATE SECTOR MENTAL HEALTH SERVICES

In Australia, a mix of public and private service agencies and providers are responsible for the delivery of mental health services for people with a mental illness. While State and Territory Governments manage specialised public mental health services, the majority[1] of Australians with a mental illness receive their treatment and care in the private sector from a range of providers including private psychiatric facilities, general practitioners (GPs), psychiatrists, psychologists, mental health nurses, social workers, and occupational therapists. Mental health services are also provided by private health insurers through chronic disease management programs, and by some government and Non–Government Organisations. This system operates to prevent unnecessary admissions and readmissions to hospital and helps to keep the pressure off the public mental health sector.

1. THE PMHA

The PMHA was established in 1996 under the auspices of the Federal AMA to address issues related to funding, classification, quality of care, outcome measurement, consumer and carer participation and related topics as they affected the private mental health sector. The Alliance provides a forum for its members – Providers, Payers, Consumers and Carers, and the Australian Government to meet on a regular and structured basis with the aim of furthering their shared objectives. The Alliance enables its members to achieve a better understanding of each other's different perspectives and provides a vehicle for those members to work together on key issues. The level of trust that has developed over the past seventeen years has enabled the Alliance's members to deal with very difficult and complex issues in a collaborative and highly functional manner. The PMHA continues to demonstrate the extent, scope, contribution and importance of mental health services in the private sector.

The Alliance works closely with the Australia Government to improve the interface and understanding between the private and public mental health sectors. Through the PMHA the private sector has been fully engaged at the national level in key reform and evaluation activities. Until July 2012, the PMHA was linked to the Australian Health Ministers Advisory Council (AHMAC) through its position on AHMAC's Mental Health Standing Committee (MHSC). In 2012, however, a review of AHMAC's committee and governance structures resulted in the work of the MHSC being subsumed under the auspice of the new Mental Health/Drug and Alcohol Principal Committee (MHDAPC) of AHMAC. The PMHA is not a member of MHDAPC, so the PMHA linkage is now through the positions it holds on MHDAPC's Safety and Quality Partnership Standing Committee (SQPSC) and the Mental Health Information Strategy Standing Committee (MHISSC) and its subcommittees.

In 2008–09, the PMHA expanded its structure to include a Collaborative Care Models Working Group (CCMWG) to accommodate the major stakeholder groups that now

1 Refer to the review of available data sources presented in the Fact Sheet, of the PMHA Newsletter, 8th Edition, May 2011.

comprise the private mental health sector. In addition to the existing groups represented by the PMHA (consumers and carers, psychiatrists, private hospitals, private health insurers, and the Australian Government), this structure has enabled the PMHA to involve general practitioners (GPs), psychologists, mental health nurses, and allied health professionals in our Alliance.

The PMHA seeks to develop sound policy that provides guidance on issues around the provision of mental health services and funding models. Members work together to formulate collaborative solutions on agreed key issues that affect mental health services in the private sector. The collaborative process operates to better inform the policy base of all participating organisations and has ensured that the private sector is properly engaged with a range of national policy issues.

The final major area of PMHA activity involves informing and effecting practice within the sector. For example, the PMHA is responsible for the review and ongoing development of the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care*. The 2012 Edition includes advice that is applicable, in some instances, to both the hospital–based and office–based settings. The Guidelines cannot be prescriptive and, at present, are primarily intended to provide guidance for hospitals and health insurers in determining health insurance benefits for private patient hospital–based mental health care. This includes same–day, half–day, overnight and approved outreach services as well as community and outpatient services, where applicable. The Guidelines may also be of assistance to State and Territory health authorities and their public hospitals in the treatment of Medicare and privately insured patients and to office–based practitioners. The 2012 Edition includes advice for services that substitute for traditional admitted hospital-based care in a new section titled, *Alternatives to In Hospital Treatment.*

1.1 PMHA Representatives

During the two Financial Years (FYs) of 2011–13, the PMHA was chaired independently by *Mr Philip Plummer.*

The Australian Medical Association was represented by *Dr Choong–Siew Yong* and *Dr Bill Pring.*

Representation for all private health insurers that pay benefits for psychiatric care was provided by the Chair of the PHA Mental Health Committee, *Ms Andrea Selleck* and *Ms Helen Eriksson.*

Ms Moira Munro and *Ms Carol Turnbull* continued to represent private hospitals with psychiatric beds. Moira is the Chief Executive Officer (CEO) of the Perth Clinic in Western Australia and Deputy Chair of the PMHA. Carol is the CEO of Ramsay Healthcare in South Australia. Both Moira and Carol are members of the Australian Private Hospitals Association Psychiatric Sub–committee.

Ms Janne McMahon OAM represented private sector consumers. Janne is also the Chair of the Private Mental Health Consumer Carer Network (Australia).

Carers were represented by *Mr Patrick Hardwick.* Patrick also represented the PMHA on the Network and has co–chaired the National Mental Health Consumer and Carer Forum.

The Australian Government Department of Health and Ageing (DoHA) representation included *Ms Robyn Milthorpe, Ms Helen Marx, Mr Bradley Schultz, Mr Peter Callanan* and *Ms Isobel Leal. Ms Kym Connolly, Ms Christine Reed* and *Mr Matthew Jackson* represented the Department of Veterans' Affairs (DVA).

1.2 PMHA Meetings

Over the term of the AMA Agreement, the PMHA conducted six face–to–face meetings, which are set out in Table 1 together with the record of attendance.

Table 1: PMHA Meetings FYs 2011–13

PMHA REPRESENTATIVE(S)			PMHA MEETINGS						
			14th	15th	16th	17th	18th	19th	20th
			22/07/11	21/10/11	30/3/12	15/6/12	9/11/12	8/3/13	5/7/13
			Adelaide	Adelaide	Adelaide	Adelaide	Adelaide	Canberra	Adelaide
PMHA Chair		Mr Philip Plummer	✓	✓	✓	✓	✓	✓	✓
Consumers		Ms Janne McMahon	✓	✓	✓	✓	✓	✓	✓
Carers		Mr Patrick Hardwick	✓	✓	✓	✓	✓	✓	✓
AMA		Dr Choong–Siew Yong	Apology	Apology	✓	Apology	Apology	Apology	✓
		Dr Bill Pring	✓	✓	✓	✓	✓	✓	✓
APHA		Ms Moira Munro	✓	✓	✓	✓	✓	✓	✓
		Ms Carole Turnbull	✓	✓	✓	Apology	✓	✓	✓
PHA		Ms Helen Eriksson	✓	✓	✓	✓	✓	✓	✓
		Ms Andrea Selleck	✓	✓	✓	✓	✓	✓	✓
Australian Government	DoHA	Ms Robyn Milthorpe			✓	✓	✓	✓	
		Ms Helen Marx						✓	✓
		Mr Bradley Schulz	✓	✓					
		Ms Isobel Leal	✓	Apology	Apology				
	DVA	Ms Kym Connolly				Apology			
		Ms Christine Reed	✓		Apology				
		Ms Karen Campbell		✓					
		Ms Emma Parker					✓		
		Mr Matthew Jackson						✓	Apology
		Mr Jonathon Wauer							✓
CDMS Director		Mr Allen Morris-Yates	✓	✓	✓	✓	✓	✓	✓
PMHA Director		Mr Phillip Taylor	✓	✓	✓	✓	✓	✓	✓

In 2012, PMHA representatives met with the Chair of the National Mental Health Commission, Professor Allan Fels AM, and its CEO, Ms Robyn Kruk AM, in Sydney and also with the Hon. Mark Butler MP, former Minister for Mental Health and Ageing, Minister for Social Inclusion, and Minister Assisting the Prime Minister on Mental Health Reform, in Adelaide.

The purpose of these meetings was to discuss the essential role the private sector plays in the overall provision of mental health services in Australia. At these meetings, the PMHA's CDMS was highlighted as the cornerstone for the provision of high quality mental health care in the private hospital sector. The CDMS Director, Allen Morris–Yates, described how CDMS works with private hospitals and private health insurers to put in place efficient systems for the routine collection of outcomes data that enables the quality and efficiency of mental health service delivery to be evaluated and reported on every quarter. Mr Morris–Yates also provided information for the Commission during the development of the first National Report Card on Mental Health and Suicide Prevention on how the private sector is successfully addressing continuous quality improvement through the PMHA's CDMS.

1.3 PMHA Collaborative Care Models Working Group

The Collaborative Care Models Working Group, or CCMWG, is comprised of representatives from the following organisations.

- Australian Medical Association (AMA)
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- The Royal Australian College of General Practitioners (RACGP)
- Australian Psychological Society (APS)
- Australian College of Mental Health Nurses (ACMHN)
- Australian Private Hospitals Association (APHA)
- Australian Association of Social Workers (AASW)
- Occupational Therapy Australia (OTA)
- Private Mental Health Consumer Carer Network (Australia) (Network)
- Private Healthcare Australia (PHA)
- Australian Government Department of Health and Ageing (DoHA)
- Australian Government Department of Veterans' Affairs (DVA)

Between FYs 2011–13, CCMWG met on seven occasions (see Table 2) and undertook the following tasks at the request of the PMHA.

1. Development of industry agreed national guidelines for the provision of services that are able to substitute traditional acute in–patient treatment in the private sector. Such services have the potential to reduce hospital admissions, re–admissions, length–of–stay, and possibly even the severity of illness over time.

   These new guidelines were incorporated into the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care 2012* Edition. They are intended to assist providers, payers, consumers and carers, better understand the level of expectation such services should meet, particularly in relation to such issues as level of integration, continuity of care, and risk management.

Copies of the Guidelines are available from the PMHA Website at: http://www.pmha.com.au/PublicationsResources/Guidelines.aspx

2. The development of ***Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers*** (Principles). The aim of the Principles is to ensure that mental health professionals dealing with the care of people with a mental illness are able to refer, collaborate and communicate effectively, and where necessary, share care. To date, the Principles have been fully endorsed by the following organisations.

   - The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
   - Australian Psychological Society (APS)
   - Australian College of Mental Health Nurses (ACMHN)
   - Australian Association of Social Workers (AASW)
   - Occupational Therapy Australia (OTA)

   RANZCP, ACMHN, AASW, and OTA are also willing to have their organizational insignia included on the cover of the final Principles document.

   The Royal Australian College of General Practitioners (RACGP) is very supportive of the Principles document and would like to see it produced with an indication that the RACGP participated in its development. The RACGP views this document as a positive contribution to aid better communication and collaboration between mental health professionals and they would be glad to promote this document as an accepted clinical resource to RACGP members.

   All of the above organisations are supportive of the proposed implementation strategy, which has been agreed as follows.

   1. Request the Mental Health Professionals Network (MHPN or Network), to disseminate the Principles via webinars and through the MHPN for discussion at local Network meetings.
   2. Dissemination of the Principles by the respective mental health professional training organisations through their normal communications channels, for example via email and inclusion in Newsletters.
   3. Inclusion of the Principles as a resource for use in vocational training programs of mental health professionals.
   4. Inclusion of the Principles as a resource for mental health professionals Continuing Professional Development (CPD) programs and events, particularly those that relate to establishing and working in private practice.

   The dissemination and implementation of the Principles will be incorporated into the CCMWG Work Plan for the next two financial years from 1 July 2013 to 30 June 2015.

All these tasks required stakeholders to come together and determine how best to move forward on many complex and difficult issues. This highly collaborative process has now been operating successfully since 2009.

Table 2: Meetings of the CCMWG FYs 2011–13

REPRESENTATIVES		CCMWG Meetings						
		10th	11th	12th	13th	14th	15th	16th
		15/7/11	14/10/11	17/2/12	18/5/12	10/8/12	2/11/12	12/4/12
Chair & Secretary	Mr Phillip Taylor	✓	✓	✓	✓	✓	✓	✓
Consumers	Ms Janne McMahon	✓	Apology	✓	✓	Apology	✓	✓
Carers	Mr Patrick Hardwick	✓	✓	✓	✓	✓	✓	✓
AMA	Dr Bill Pring	Apology	✓	✓	✓	✓	✓	✓
RANZCP	Dr Richard Astill	✓	Apology	✓	✓	Apology	✓	✓
	Dr Gary Galambos			Guest				
RACGP	Dr Caroline Johnson				✓	✓	✓	✓
APHA	Ms Carole Turnbull	✓	✓	✓	✓	✓	✓	✓
ACMHN	Ms Kym Ryan	✓	Apology	Apology				
	Ms Anne Buck				✓	✓	✓	
AASW	Ms Liz Sommerville	✓	Apology	✓	✓	✓		
	Mr Stephen Brand						✓	✓
APS	Dr John Brown	✓						
	Ms Anne Goyne		✓					
	Dr Pam Connor			✓	✓	Apology	Apology	✓
OTA	Mr Chris Kennedy	✓	Apology					
	Ms Joy Pennock			✓	Apology	✓	Apology	✓
PHA	Ms Helen Eriksson	✓	✓	Apology	✓	✓	✓	Apology
DoHA	Ms Isabel Leal	✓	Apology	Apology				
	Ms Robyn Milthorpe		✓		✓		Apology	
	Ms Helen Marx							✓
	Mr Bradley Shultz	✓		✓				
	Ms Melissa Carters					✓		
	Ms Lisa Bai					Observer		
DVA	Ms Kym Connolly	✓	Apology			✓	✓	Apology
	Ms Christine Reed			Apology				
	Ms Karen Campbell	✓			✓			
	Mr Tim Adams							✓

1.4 PMHA Quality Improvement Project

In 2009, an anonymous offer of financial support of $250,000 was made available to the AMA to manage, on behalf of the PMHA, for a Quality Improvement Project (QIP) directed at improving outcomes for consumers within the context of the mental health services that are provided by private hospitals with psychiatric beds (Hospitals) and psychiatrists in private practice. The purpose being to make better use of the mechanism of the PMHA and its Centralised Data Management Service (CDMS). QIP contained a suite of four complementary activities.

1. Implementation of Consumer Perceptions of Care (CPoC) Measure. This first activity involved the development and implementation of a standardised measure of CPoC in all private hospital–based psychiatric services across Australia.

2. Outcomes in Private Psychiatry Practice. Work on this second activity established a Private Psychiatrist Research Network (PPRN) and the conduct of a Psychiatrists' Workload Study.

3. Internet Access to the PMHA's CDMS. This third activity involved a scoping exercise to determine the requirements for a model Agreement that would enable appropriate and secure internet–based access for participating stakeholders to the data currently held by the PMHA's CDMS.

4. Borderline Personality Disorder (BPD). This activity involves preliminary work to scope what models of care are currently being used for people with a diagnosis of BPD.

In 2010, the PMHA established a QIP Steering Committee to act as a reference group and to assist with managing the Project over the course of 2011-13. The Steering Committee was comprised of the following representatives.

Ms Andrea Selleck (Chair)	Private Healthcare Australia
Ms Moira Munro	Australian Private Hospital Association
Dr Bill Pring	Australian Medical Association
Ms Robyn Milthorpe	DoHA Mental Health Reform Branch
Ms Janne McMahon	Consumer Representative
Mr Patrick Hardwick	Carer Representative
Professor Andrew Page	Expert Adviser
Mr Allen Morris–Yates	QIP Project Manager
Mr Phillip Taylor	PMHA Director (Secretary)

In 2010, the Steering Committee held several meetings in order to develop the Project Brief, advertise for a Senior Research Officer (SRO), and conduct interviews. Ms Ellie Rosenfeld was subsequently appointed for the Project, and commenced duties on 31 January 2011 located at the PMHA Research Office, at Kahlyn Day Centre, in Adelaide. The Director of the PMHA's CDMS, Mr Allen Morris–Yates, was appointed as the QIP Project Manager. At the beginning of QIP, the Commonwealth Department of Health and Ageing provided $230,081 in additional funding, which strengthened the following aspects of the QIP Work Programs.

- Ms Rosenfeld and and Dr Bill Pring were able to undertake visits to Western Australia, South Australia, Queensland, New South Wales and Victoria to facilitate the establishment of a PPRN and to enlist the

support of participating Hospitals, their Medical Advisory Committees (MACs) and psychiatrists in private practice for the Psychiatrists' Workload Study.

- The PMHA website was completely re-developed to a point whereby the old website was replaced with the architecture necessary to eventually enable secure access for Hospitals and private health insurers to CDMS Training Resources and Standard Quarterly Reports.
- The Expert Adviser to the QIP Steering Committee, Associate Professor Andrew Page, was able to attend meetings of the Steering Committee. Professor Page's advice and guidance proved invaluable and timely for the Steering Committee throughout the course of QIP, and for Ms Rosenfeld and Mr Morris-Yates.

Toward the end of QIP, the small surplus evident in the QIP Budget was utilised to enable Ms Rosenfeld's employment to continue until 30 April 2013 to assist with bringing QIP to its proper conclusion. This surplus also enabled Professor Andrew Page to attend a final meeting of the QIP Steering Committee on 7 March 2013 in Canberra.

Over the course of 2011-13, the Steering Committee held face–to–face meetings back–to–back with meetings of the PMHA to enable proper reporting arrangements for the SRO and to manage and support QIP.

Table 3: Meetings of the PMHA-QIP Steering Committee 2011–13

REPRESENTATIVE(S)		PMHA-QIP Steering Committee Meetings						
		1st	2ND	3RD	4TH	5TH	6TH	7TH - Final)
		17/03/11	21/07/11	20/10/11	29/03/12	14/06/12	8/11/12	7/03/13
		Adelaide	Adelaide	Adelaide	Adelaide	Adelaide	Adelaide	Canberra
Chair (PHA)	Ms Andrea Selleck	✓	✓	✓	✓	✓	✓	✓
APHA	Ms Moira Munro	✓	✓	✓	✓	✓	✓	✓
AMA	Dr Bill Pring	✓	✓	✓	✓	✓	✓	✓
Consumers	Ms Janne McMahon	✓	Apology	✓	✓	✓	✓	✓
Carers	Mr Patrick Hardwick	✓	✓	✓	✓	✓	✓	✓
DoHA	Ms Robyn Milthorpe	✓			✓	Apology	✓	✓
	Mr Bradley Schultz	✓	✓	✓				
QIP Expert Adviser	Professor Andrew Page	✓	Apology	✓	✓	Apology	✓	✓
QIP SRO	Ms Ellie Rosenfeld	✓	✓	✓	✓	✓	✓	✓
QIP Manager	Mr Allen Morris-Yates	✓	✓	✓	✓	✓	✓	✓
Secretary	Mr Philip Taylor	✓	✓	✓	✓	✓	✓	✓

The QIP Steering Committee held its last meeting on 7 March 2013 and agreed that the tasks detailed in the work plan for the QIP had been largely completed with aspects of work remaining incorporated successfully into the normal program of work the PMHA's CDMS for financial years 2013-15. The small surplus evident in the QIP Budget was used, as agreed by the QIP Steering Committee, to bring the four work programs to completion. This included the extension of employment of the PMHA Senior Research Officer, Ms Ellie Rosenfeld, to 30 April 2013. There is also likely to be some costs involved later in 2013 to ensure user access to the secure areas of the PMHA's CDMS portal operate correctly.

Set out below is the substantial and detailed final report on each of the four QIP Work Programs.

1.4.1 Implementation of Consumer Perceptions of Care (CPoC) Measure

The goal of the CPoC Work Program was to develop a measure of consumers' perceptions and experience of the care they receive in both the overnight inpatient and the ambulatory care service settings.

The CPoC Work Program originally involved the development of a *National Model for the routine collection, analysis and reporting of Consumer Perceptions of Care (National Model for CPoC)* in both the overnight inpatient and the ambulatory care (day programme) service settings. The first draft of the National Model for CPoC was based on revised versions of the survey instruments piloted by private hospitals in 2006.[2] In September 2011, that draft of the National Model was put to the APHA Psychiatric Committee (APHA–PC) for their review and received a resounding endorsement by all State representatives.

Unfortunately, in late 2011 it was discovered that approximately a third of the survey items were no longer in the public domain. Both the APHA–PC and QIPSC agreed that a return to the drawing board was warranted and fortuitous, given the two other significant pieces of development work in this field, one for public mental health services and the other for all public and private general hospital inpatient services, had reached the point where their development teams had delivered final draft versions of their proposed survey instruments. By drawing on all these strands of work, including that done by QIP to date, it was possible to develop an excellent survey instrument comprised of the smallest effective set of items that:

1. covered the issues identified in *National Standards for Mental Health Services* and the *Australian Charter of Healthcare Rights* as being fundamental to a patient–centred and recovery–oriented approach to care;
2. best met the needs of Hospitals; and
3. most easily allowed relevant comparisons with the public sector.

This work required the development of a 100 page document that provided the results of a highly detailed and cross referenced analysis of the content of surveys of patients'[3] perceptions, or experiences of care. The document titled, *Items reference for PMHA Patient Experiences of Care survey consultations*, presented a first draft of a single set of items suitable for examination

2 Morris–Yates (2009) A pilot study of the Routine Collection and Reporting of Consumer Perceptions of Care in Private Hospital–based Psychiatric Services. Canberra; Private Mental Health Alliance

3 We used patients' rather than consumers' perceptions or experiences because first, the survey is intended for use in private hospital–based psychiatric services, and second, the agreed collection protocol specifies that the survey be offered to consumers whilst they are at the hospital, either in the day or so preceding discharge, or at review, not at some time following their discharge from the hospital's care. That is, this will be a survey of currently admitted patients who are asked to reflect on their current and recent experiences of care, not of consumers who are being asked, perhaps several weeks or even months after their discharge, to reflect on their most recently completed episode of care.

in a validation study. In developing this document the agreed objective was to bring together the following three surveys that were under development.

1. *PMHA's Consumer Perceptions of Care Survey* (PMHA–CPoC), which was based on the MHSIP Adult Consumer and the NRI Inpatient Consumer Surveys used in the pilot study of the routine collection and reporting of consumers' perceptions of care in eight private hospitals, completed in 2006.

2. The new *Consumer Experiences of Care Survey* developed for use in public sector inpatient and community based mental health services (PMHS–EoC), developed by a project team within Victoria's Department of Human Services for the AHMAC National Mental Health Working Group's Mental Health Information Strategy Subcommittee.

3. The brief *Patient Experiences of Care Survey* being developed by the Australian Commission on Safety and Quality in Healthcare (ACSQHC–PEx).

In conducting the analysis of the above three surveys, we also reviewed and made reference to the item content of three other surveys, two specifically designed for use in mental health service settings and the other designed for use in the general hospital setting. The first was New South Wale Health's *Mental Health Consumer Perceptions and Experiences of Services* survey (MH–CoPES),[4] which was being used by public sector mental health services in that state.[5] The second was the originally published long version of the Verona Service Satisfaction Scales (VSSS–54).[6] Unfortunately, we were not able to work off the most recently published translation of that survey, the VSSS-EU, developed for use in the Epsilon 7 study and now widely used across the European Union, but instead have relied on an English translation of the original version obtained from the survey's authors in 1995.[7] The third is the 2008 version of the UK National Health Service's *Inpatient Questionnaire* (NHS–2008).[8] The content of that survey and an analysis of it reported in a discussion paper published in 2009,[9] formed the starting point for the PEx development work now being undertaken by the ACSQHC.

Working in close collaboration with the Private Mental Health Consumer Care Network (PMHCCN) National Committee (PMHCCN–NC) and the APHA–PC the *Items reference for PMHA Patient Experiences of Care* survey consultations document was reviewed and a final set of survey items developed. The Items were evaluated in the *PMHA's Patient Experiences of Care (PMHA–PEx) Validation Study*, which was conducted between July and September 2012. All private hospitals with psychiatric beds (Hospitals) were invited to participate in the PMHA–PEx Validation Study (Study). The following Hospitals volunteered.

4 NSW Department of Health (2006) *A statewide approach to measuring and responding to consumer perceptions and experiences of adult mental health services.* A report on stage one of the development of the MH–CoPES framework and questionnaires. Sydney, NSW Health.

5 Oakley, Malins and Doyle (2011) *The MH–CoPES Framework and Questionnaires ready for statewide implementation. Final Report of the MH–CoPES Stage 2 Project.* Sydney, NSW Consumer Advisory Group– Mental Health Inc.

6 Ruggeri and Daii'Agnola (1993) The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community–based psychiatric services in patients, relatives and professionals. Psychological Medicine, 23, S11–523.

7 Ruggeri, et al (2000) Development, internal consistency and reliability of the Verona Service Satisfaction Scale– European Version EPSILON Study 7. British Journal of Psychiatry, 177, s41–s48.

8 Garratt (2009) The key findings report for the 2008 inpatient survey. Oxford, Co–ordination Centre for the NHS Patient Survey Programme, Picker Institute Europe. Obtained from http://www.nhssurveys.org/ in April 2012.

9 Sizmur and Redding (2009) Core domains for measuring inpatients' experience of care. Oxford, Picker Institute Europe.

1. Mayo Private Hospital, New South Wales (NSW)
2. The Hills Clinic Kellyville, NSW
3. The Melbourne Clinic, Victoria (VIC)
4. Pinelodge Clinic, VIC
5. Albert Road Clinic, VIC
6. Belmont Private Hospital, Queensland (QLD)
7. Toowong Private Hospital, QLD
8. Currumbin Clinic, QLD
9. Perth Clinic, Western Australia (WA)
10. Sentiens Clinic, WA
11. The Hobart Clinic, Tasmania (TAS)

After all the data from the Validation Study had been collected a final set of items was developed in consultation with the QIP Steering Committee. After that process, the final survey instrument, together with PMHA–PEx related local analysis and reporting functionality was built into the CDMS Hospital Standardised Measures Database (HSMdb) software. Implementation by Hospitals then coincided with the release of the next version of the HSMdb in the second half of 2013.

1.4.2 Outcomes in Private Psychiatry

The objectives of the Outcomes in Private Psychiatry Practice work program was to establish a Private Psychiatrist Research Network (PPRN) and conduct a survey of psychiatrists of the full spectrum of the population currently served by them (Psychiatrists Workload Study).

A total of 19 psychiatrists joined the PPRN, including all the members of the AMA Psychiatrists Group (AMAPG).

After formal endorsement by the AMA and the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Psychiatrists Workload Study (WLS) was pilot tested in November 2011 with members of PPRN and AMAPG. The results of the Pilot informed the wider Study, which was conducted online from 1 March to 31 March 2012. In November 2012 the QIP Steering Committee endorsed the ***PMHA Psychiatrists' Workload Survey 2012*** – Final Report (Final Report) for public release and inclusion on the PMHA website at:

http://www.pmha.com.au/PublicationsResources/QIPPsychiatristWorkloadStudy.aspx

Appropriate articles with a link to the report on the PMHA website were included in the following.

- PMHA Newsletter December 2012 Edition
- AMA Psychiatrists Newsletter December 2012 Edition
- RANZCP Psych–E Bulletin

Electronic copies of the Final Report were also circulated to the following, under cover of appropriate conjoint correspondence from the Chairs of the PMHA and the QIPSC.

- The Hon. Tanya Plibersek MP, Minister for Health
- The Hon. Mark Butler MP, Minister for Mental Health and Ageing
- The Chair of the National Mental Health Commission
- Relevant Australian Government Departments
- The President of the AMA
- The President of the RANZCP
- The CEO of Health Workforce Australia

While this substantive and rigorous report should be read in its entirety, some of the findings have been set out below.

- Respondents were representative of other Australian psychiatrists in age and gender distribution. The average age was 54 years; just under two thirds of the survey participants were men (65%) and just over a third were women (35%).
- Respondents were representative of the usual state and territory distribution of Australian psychiatrists, with a somewhat higher representation from Queensland and lower representation from Victoria.
- The mean number of years since psychiatry qualification was 19, with the 75th percentile being 26 years.
- The mean number of years since beginning psychiatric practice in Australia was 18 years. Given the 75th percentile was 25 years since beginning practice, these psychiatrists had lengthy experience of psychiatry practice.
- Respondents worked on average 46 hours per week.
- The majority of respondents nominated private psychiatrists' rooms as the setting they worked in most often during their last usual month, spending over two thirds of their working time in private rooms.
- Direct patient care consumed the greatest proportion (62%) of the working time of most participants.
- Psychiatrists used mostly an eclectic or integrative therapeutic approach, with a broad range of different therapeutic approaches tailored to the individual needs of patients.
- Two thirds of respondents felt the administrative tasks associated with their practice had increased in the past five years.
- A substantial proportion of respondents, 40%, felt themselves to be positioned more in a consulting role than an ongoing care role compared to five years previously.
- Psychiatrists saw an overall average of 37 patients a week, 32 of whom were in private rooms. Of these patients, 47% were men and 53% were women; 1% of patients were Aboriginal or Torres Strait Island people; 9% spoke English with difficulty or as a second language; and most patients were aged 25-44 years.
- Almost half the patients had some form of employment and most patients were securely housed.
- Patients treated in private rooms experienced the full range of mental disorders, including schizophrenia and schizo-affective disorder, though they were predominantly people with Major Depression, Anxiety Disorders, Bipolar Disorder, Borderline Personality Disorder, and Post Traumatic Stress Disorder (PTSD).
- A substantial number of patients had co-morbid medical conditions such as arthritis, diabetes, cardiovascular disease, renal disease, and respiratory disease.
- General practitioners (GPs) and psychologists were the other professionals seen most frequently by patients in the previous year.
- Half the respondents felt there had been no change in the severity or complexity of the clinical presentation of patients at first referral compared to five years ago, however 34% felt their patients' condition on clinical presentation was more severe.

The QIP Steering Committee and the PMHA congratulated Ms Ellie Rosenfeld, and Mr Allen Morris–Yates, on the conduct of the WLS and the quality of their thorough analysis of the survey results.

1.4.3 Internet Access to the PMHA's CDMS

Originally, the *Internet access to the PMHA's CDMS Work Program* was intended to only involve a scoping exercise to determine the requirements for a Model Agreement that would enable appropriate and secure internet–based access for participating stakeholders to the data currently held by the PMHA's CDMS. The scoping exercise was to specify the requirements for the following.

1. Privacy and confidentiality guidelines consistent with the National Model's information access guidelines.
2. Protocols for the protection of intellectual property, in particular, for private psychiatric facilities contributing data.
3. Protocols for the publication of information derived from CDMS data.
4. Reliable and cost effective systems for granting and revoking authenticated user access.
5. A Model Agreement for internet–based access for each organisation to sign whose staff will be granted access.

The tasks specified under this Work Program were just one part of the work needed to give participating private hospitals and private health insurers secure access to CDMS Training Resources, Standard Quarterly Reports. Ultimately, they will have access to a web–based system for ad–hoc analysis that works within the constraints of the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures', Guidelines for access to aggregate statistical information*. That full work program actually involved two complex tasks.

- First, in order to enable web–based access to Standard Quarterly Reports, the requirements and protocols for secure access to that data by authenticated users must be developed. The tasks and funding originally included under the QIP Work Program were designed to enable completion of that work.
- Second, the PMHA's website would need to be redeveloped so that it could provide a secure and more robust platform for the future development of the secure web–based access systems. The funding originally included under the QIP Work Program did not extend to the completion of that work.

The additional funding from the Commonwealth enabled the full redevelopment of the PMHA website to be progressed to a point whereby the old website was replaced with the architecture necessary to eventually enable secure access for private hospitals and private health insurers to CDMS Training Resources and Standard Quarterly Reports. The launch of the new website took place in September 2011.

After implementation of the website, the task remaining was the development of a Model Agreement between the AMA and authenticated responsible officers of participating Hospitals and private health insurers (Security Officials) that are to be given secure access to the CDMS. The Agreement will enable these Security Officials to be given secure access to their organisation's Standard Quarterly Reports (SQRs). They will not have access to any other organisation's SQRs.

The PMHA Director and CDMS Director (PMHA Officers) will be responsible for the authentication of identification of the person signing the Agreement for their organisation and for the registration of their organisation's designated Security Official. On completion of the registration process, an email providing the Login ID will be generated and temporary password will be sent to the Security Official. Security Officials will then be able to login into the website and change their password. Security Officials will then be responsible for authenticating any of their staff they wish to provide access for. The steps to be followed by Security Officials in providing access for their staff have been set out in User Guide for Security Officials, which will form part of the Agreement with the AMA.

At 30 June 2013 an *AMA Agreement for Internet Access to the Secure Areas of the Private Mental Health Alliance Centralised Data Management Service Website* had been drafted. It is anticipated that finalisation of the Agreement and testing of internet-based access for private hospitals and private health insurers will be completed before the end of this year, as part of the CDMS work program for Financial Years 2013–15.

1.4.4 Borderline Personality Disorder (BPD)

The objective of the Borderline Personality Disorder (BPD) project was to conduct a survey about the provision of psychological services to people with diagnoses of BPD who are admitted to private hospitals.

The draft survey instrument was developed in 2012 and endorsed by the APHA–PC. Several strategies were used to recruit as many Hospital Managers of private psychiatric hospitals, and Unit Heads of co–located psychiatry units in private hospitals as possible. The survey was then conducted online during October 2012.

The response rate was excellent at 84%.

The results were analysed and the *PMHA Provision of Psychological Services for Borderline Personality Disorder in Private Hospital Settings – Final Report 2013* was endorsed and released in April 2013.

Some of the Findings are set out below.

Hospital Characteristics

Of the 49 respondents, most (73.3%) were Managers of stand–alone private psychiatric hospitals and over a quarter (26.7%) were Managers of co–located psychiatric units within private general hospitals. Given stand–alone hospitals constitute approximately 53% of CDMS data contributors, and co–located units 47%, this sample was more representative of the BPD services of stand–alone hospitals than of co–located units. As could be expected with such a high response rate, all Australian states and territories were well represented, though NSW, the ACT, and Queensland hospitals were somewhat under–represented, and the remaining states and territories were somewhat over–represented in the sample.

Treatment Programmes

Most hospitals (86.5%) provided group treatment programmes for in–patients or day–based patients. The principal **group–based treatment** approach for **overnight inpatients** was Cognitive Behaviour Therapy (CBT) with 37% of respondents nominating this group–based treatment approach, followed by Dialectical Behaviour Therapy (DBT) 22% and Mindfulness (15%). The principal group–based treatment approach for **day patients** was predictably and overwhelmingly DBT for most hospitals (78%); followed by CBT (7%); Acceptance and Commitment Therapy (ACT) (4%); Mindfulness (4%); Supportive Therapy (4%) and Art Therapy (4%).

The principal **individual psychological treatment approach** for **overnight inpatient**s was CBT (48%), with DBT the second most prevalent (22%) followed by Insight–oriented Therapies (9%). The principal individual psychological treatment approach for **day patients** was also DBT (43%), with CBT the second most prevalent (22%), followed by ACT and Psychoeducation at 9%.

Staff Training

A major theme was the availability of staff training for BPD. It was difficult to access in Australia generally, particularly difficult for hospitals far from major centres and there was a limited number of possible trainers. In addition BPD training was expensive; management did not always support the need for training, and sending staff to courses required back filling, which was not easy to roster.

Involvement of other Agencies and Professionals

There was a difference of opinion about the therapeutic value of the involvement of people with BPD diagnoses in a range of services; there was consensus regarding the critically important need for coordination and case management; and the view that private sector patients with BPD diagnoses did not receive adequate public sector services.

The PMHA QIP Steering Committee extended its sincere thanks to the APHA Director of Policy and Research, to the APHA–PC and to Moira Munro and Carol Turnbull for their efforts in promoting this survey with Hospital Managers.

1.4.5 PMHA QIP Income and Expenditure

Table 4 sets out the Income and Expenditure for the PMHA QIP.

The Table has been prepared on a cash basis.

At the end of 30 June 2013, there was a surplus of $18,835 remaining in the PMHA QIP Budget, which is being utilised to complete the ongoing work that emerged during the QIP.

Table 4: PMHA QIP Income and Expenditure

PMHA QIP INCOME AND EXPENDITURE			
PMHA QIP BEQUEST	**INCOME**		
Bequest	250,000		
Total	250,000		
PMHA QIP BEQUEST EXPENDITURE	**Budget**	**Actual**	**Balance**
1 Staffing	163,792	163,636	-844
2 Infrastructure	34,000	29,256	4,744
3 Teleconferences	14,000	1,480	12,520
4 Other Costs	13,500	14,734	-1,234
Total before AMA Administration charge	224,292	209,106	15,186
AMA Administration Charge of 10%	22,429	22,429	0
Total	**246,721**	**231,535**	**15,186**
Total PMHA QIP Bequest Funds Remaining	18,465		
PMHA QIP DOHA GRANT INCOME	**INCOME**		
Commonwealth Department of Health and Ageing (ex GST)	45,341		
Commonwealth Department of Health and Ageing (ex GST)	82,801		
Commonwealth Department of Health and Ageing (ex GST)	30,000		
Commonwealth Department of Health and Ageing (ex GST)	51,023		
Total	209,165		
PMHA QIP DOHA GRANT EXPENDITURE	**Budget**	**Actual**	**Balance**
5 Travel Support	46,044	14,165	31,879
6 Redevelopment of PMHA Website	140,800	152,636	-11,836
7 Audit of Financial Statements	3,637	497	3,631
8 Final costs to bring project to completion	0	23,183	-23,183
Total before AMA Administration Charge	190,481	190,481	0
AMA Administration Charge of 10%	18,684	18,684	0
Total	**209,165**	**209,165**	**0**
Total PMHA QIP DOHA Grant Funds Remaining	0		
TOTAL QIP PROJECT INCOME	**INCOME**		
Bequest and DOHA Grant	**459,165**		
TOTAL PMHA QIP PROJECT EXPENDITURE	**Budget**	**Actual**	**Balance**
Total PMHA QIP Project Expenditure	**455,886**	**440,700**	**15,678**
Total PMHA QIP Project Funds Remaining	18,465		

1.5 Australian Health Minister's Advisory Council (AHMAC) Health Policy Priorities Principal Committee (HPPPC), Mental Health Standing Committee (MHSC)

Up until 1 July 2012, the MHSC had reported to the Australian Health Ministers' Conference (AHMC) through the Australian Health Ministers' Advisory Council (AHMAC) and the Health Policy Priorities Principal Committee (HPPPC). In 2012, however, AHMAC accepted the final report and recommendations of the Review of the AHMAC Principal Committee and governance structures. The new Principal Committee structure is comprised as follows.

1. Australian Health Protection Principle Committee (AHPPC)
2. Community Care and Population Health Principal Committee (CCPHPC)
3. Health Workforce Principal Committee (HWPC)
4. Hospitals Principal Committee (HPC)
5. **Mental Health/Drug and Alcohol Principal Committee (MHDAPC)**
6. National Health Information and Performance Principal Committee (NHIPPC)

The Health Policy Priorities Principal Committee (HPPPC) was subsequently disbanded and its work transferred to other Principal Committees, primarily the CCPHPC.

The new MHDAPC listed above now undertakes the following.

- Work previously undertaken via the MHSC.
- Work undertaken through the Fourth National Mental Health Plan Cross Sectoral Working Group.
- The responsibilities of the Intergovernmental Committee on Drugs which, as one of its responsibilities, has the ongoing work of the National Drug Strategy 2010–15.

After discontinuation of MHSC in late 2012 and establishment of the MHDAPC, the PMHA continued its presence in the AAMAC sub-committee structures through MHISSC and SQPSC.

The two sub committees of the MHSC, the Mental Health Information Strategy Sub–Committee (MHISS) and the Safety and Quality Partnership Sub–committee (SQPS), have become Standing Committees of the new MHDAPC. The PMHA has retained its position on both of these Standing Committees. The Business Rules and Terms of Reference for both Mental Health Information Strategy Standing Committee (*now MHISSC*) and the SQPSC Safety and Quality Partnership Standing Committee (*now SQPSC*) have been amended to reflect these changes. Work plans for both standing committees have been examined by the MHDAPC in the context of mental health reform objectives and will be adjusted to reflect emerging priorities.

The attendance of agreed PMHA representatives at meetings of the MHSC, MHISS and SQPS are set out in Table 5.

Table 5: Meetings of the MHSC sub–groups thereof FYs 2011–13

MHSC, SQPS AND MHISS MEETINGS			PMHA REPRESENTATIVES		
DATE	MEETING	Location	Mr Philip Plummer	Ms Moira Munro	Dr Bill Pring
1 July 2011	SQPS	Melbourne			✓
16 September 2011	MHSC	Melbourne	✓	✓	
3/4 November 2011	MHISS	Sydney		✓	
18 November 2011	SQPS	Melbourne			✓
24 November 2012	MHSC	Melbourne	Apology	✓	
17 February 2012	MHSC	Brisbane	Apology	✓	
9 March 2012	SQPS	Sydney			✓
15/16 March 2012	MHISS	Melbourne		✓	
11 May 2012	MHSC	Sydney	✓	Apology	
7/8 June 2012	MHISS	Darwin		✓	
13 July 2012	SQPS	Melbourne			✓
18/19 October 2012	MHISS	Hobart		✓	
26 October 2012	MHSC (Final)	Brisbane	✓	✓	
16 November 2012	SQPSC	Melbourne			✓
15 March 2013	SQPSC	Sydney			✓
21/22 March 2013	MHISSC	Adelaide		✓	
6/7 June2013	MHISSC	Perth		✓	

1.6 MHISSC

MHISSC now provides expert technical advice and, where required, recommends policy for consideration by MHDAPC in accordance with the following terms of reference.

Mental Health Information Advice

1. Provide advice and recommendations for the development and implementation of mental health information development priorities outlined under the current National Mental Health Plan and National Mental Health Information Development Priorities document or other relevant national policies.
2. Provide expert technical advice on mental health data and information to relevant health data and information groups as directed by MHDAPC.

National Monitoring and Reporting

3. Lead the development of national key performance indicators and benchmarking in mental health services.
4. Provide expert advice on the development of national mental health publications, such as the National Mental Health Report, Mental Health Services in Australia and the mental health management chapter in the Report on Government Services

Development and Management of National data collections

7. Provide advice on maintenance of current national mental health data collections, and - ensure appropriate ongoing maintenance and support of those NMDSs and associated meta-data.

8. Provide advice and lead work on the further development of the mental health data collections, including new Mental Health National Minimum Data Sets and the National Outcomes and Casemix Collection.

Communication and Collaboration

6. Establish and maintain linkages between mental health information and national health information processes through NHIPPC and relevant subcommittees e.g. NHISSC and SPCR.

7. Establish a functional collaborative relationship with the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the SQPSC to ensure mental health information development and safety and quality information development are informed by each other.

8. Establish and maintain linkages with relevant government, private sector and non-government agencies and organisations and provide expert advice on mental health information development and reporting across these sectors.

9. Maintain a watching brief on relevant national information initiatives and identify opportunities for collaboration.

10. Provide MHDAPC with regular progress reports on the MHISSC work plan.

Decisions requiring policy change or resource commitment by jurisdictions require endorsement by MHDAPC.

MHISSC consists of representatives with responsibility for mental health information management and data collection systems, members with technical expertise in mental health data collection and reporting, and members who represent key stakeholder input.

In 2011–13, PMHA was represented on MHISSC by ***Ms Moira Munro***.

MHISSC will now meet over two days three times a year in order to progress a daunting volume of complex work. Just a few of the issues progressed over the course of the last two years have included the following.

- National project – Measuring Consumers' Experiences of Care
- Development of a carer experiences of care (family inclusiveness) measure
- National project – Development of a consumer self–report measure that focuses on the social inclusion aspects of recovery
- National project – Mental Health Non–Government Organisation National Minimum Data Set Project
- Mental Health National Outcomes and Casemix Collection (NOCC) Review
- COAG National Action Plan on Mental Health 2006–2011 Progress Reports
- National project – Mental Health Intervention Classification (MHIC) 09 Pilot Study
- AIHW publication *Mental health services in Australia 2012*
- Activity Based Funding and Mental Health

1.7 SQPSC

A key role of the SQPSC is the provision of expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality in mental health taking into consideration the National Mental Health Strategy, national mental health plan(s), and mainstream health initiatives. The SQPSC has a watching brief in relation to safety and quality in mental health and may respond, through the provision of advice to the MHDAPC, on emerging issues of concern and related quality and safety initiatives. The SQPSC may also provide advice in relation to monitoring and implementation of the National Standards for Mental Health Services.

The Terms of Reference for the SQPSC are set out below.

1. Provide expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality in mental health consistent with the *National Mental Health Strategy*, national mental health plans, and mainstream health initiatives;
2. Provide advice to MHDAPC on the implementation of the national safety priorities identified in the *National safety priorities in mental health: a national plan for reducing harm;*
3. Provide advice and recommendations to the MHDAPC on implementation of the *National Standards for Mental Health Services* (NSMHS); and options for the ongoing review of services against these Standards;
4. Develop an annual work plan for endorsement by the MHDAPC, which prioritises activities and initiatives in the safety and quality agenda.
5. Provide MHDAPC with regular progress reports on the implementation of identified Safety and Quality priority initiatives agreed in the work plan.;
6. Develop recommendations for the MHDAPC on safety and quality initiatives coordinating national policies and activity through jurisdictional frameworks;
7. Establish a functional collaborative relationship with MHDAPC Mental Health Information Strategy Standing Committee (MHISSC) to ensure that data and information system development, and safety and quality system development are informed by each other;
8. Liaise and develop linkages with the Australian Commission for Safety and Quality in Health Care to ensure that Mental Health Services form an integral part of any national developments in safety and quality;
9. Develop appropriate linkages with other activity and groups pertinent to safety and quality; and
10. Establish functional collaborative relationships with the professional colleges, accreditation agencies, and other key stakeholders which will assist in the dissemination, uptake, review and evaluation of the principles of evidence based practice and integration of the National Standards for Mental Health Services.

The PMHA was represented on the SQPSC by ***Dr Bill Pring***. The work undertaken by SQPSC during FYs 2011–13 was essentially focussed on progressing the Fourth National Mental Health Plan (4th NMHP) Actions, and other safety and quality activities. These included the following.

- 4th NMHP Action 4 – National Recovery Forum
- 4th NMHP Action 4 – National Recovery Framework
- 4th NMHP Action 23 – Review of the Statements of Rights and Responsibilities
- Accreditation Workbook for Mental Health Services following the 2010 release of the National Standards for Mental health Services Recognition and response to clinical deterioration.
- Seclusion and Restraint Reduction Initiatives and annual National Seclusion and Restraint Forums
- Safe Transport of People Experiencing Mental Health Problems – supplementary principles applicable to air and general transport
- Electro Convulsive Therapy (ECT) – Jurisdictional stocktake on ECT
- In February 2013 SQPSC was allocated oversight of some projects from the former Mental Health Workforce Advisory Committee (MHWAC), including Mental Health Professional Online Development (MHPOD) and the review of the National Practice Standards for Mental Health Workforce.

1.8 Mental Health Workforce Advisory Committee

The Mental Health Workforce Advisory Committee (MHWAC) provides advice to the Health Workforce Principal Committee and the Mental Health Standing Committee (MHSC) on mental health workforce related issues.

Ms Carol Turnbull represents the PMHA on MHWAC.

The Terms of Reference for MHWAC are set out below.

1. To provide advice to the Health Workforce Principle Committee (HWPC) and MHSC on workforce related issues that may be appropriate for cross–jurisdictional or national action.
2. To provide advice to the HWPC and MHSC regarding the implications of broader health and other workforce issues/ initiatives for mental health.
3. To coordinate the workforce related activities of the MHSC.
4. To facilitate information sharing on workforce related initiatives between the jurisdictions.
5. To facilitate communication between MHSC, training bodies and professional associations, and other mental health workforce stakeholders.
6. To review the collection of national mental health workforce data and make recommendations to the HWPC, the MHSC and other relevant bodies on strategies to improve data collection.
7. To analyse and report on that data with a view to assisting mental health workforce planning.
8. To encourage the development of consumer led services in jurisdictions.
9. To undertake specific workforce related tasks as directed by the HWPC.

Some of the issues on the MHWAC agenda include the following.

- Contained Review of the National Practice Standards and Development of Mental Health Competencies.
- Mental Health Professional Online Development MHPOD, which is a learning resource being developed for people working in mental health.
- Development of an implementation plane for the National Mental Health Workforce Strategy and Plan (NMHWS&P).
- Mental Health in Tertiary Curricula (Social Workers and Occupational Therapists)
- Mental Health Teaching and Learning Clearinghouse, which was established at www.mhtlc.gov.au in the second half of 2011.

1.9 PMHA Newsletter

In FYs 2011–13 the PMHA produced five newsletters, which included the following articles.

- Editorial from the PMHA Independent Chair
- Regular updates on the PMHA Quality Improvement Project
- PMHA's Collaborative Care Models Working Group
- Psychiatrists Workload Study
- Australian Commission on Safety and Quality in Health Care
- National Mental Health Commission
- Ten Year Road Map for Mental Health Reform
- Independent Pricing Authority and Activity Based Funding
- Safety and Quality Partnership
- Collaboration, Communication and Co–operation
- AHMAC Committee Structure Review

Every Edition also included a *Stakeholder Round–up* section to provide a brief snapshot on some of our stakeholder activities, and a Fact Sheet to showcase the information and statistics publically available from the PMHA's CDMS.

1.10 PMHA Income and Expenditure

PMHA Income and Expenditure for the Financial Years 1 July 2011 to 30 June 2012 and 1 July 2012 to 30 June 2013 is set out in Table 6. The Table has been prepared on a cash basis. The PMHA has confirmed that all expenditure has been made in accordance with the terms and conditions of the *AMA Agreement for Services 2011–13*. At 30 June 2013, there was a surplus of $23,781 remaining in the PMHA Budget. The Parties contributing to the PMHA have agreed that the surplus be carried forward into the Financial Year 2013-14 PMHA income stream.

Table 6: PMHA Income and Expenditure Financial Years 2011–13

PMHA FINANCIAL YEAR 1 JULY 2011 TO 30 JUNE 2012			
PMHA INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Medical Association	56,649		
2. Australian Private Hospitals Association	56,649		
3. Australian Health Insurance Association	56,649		
4. Australian Government Department of Health and Ageing	64,649		
Transfer of PMHA Balance from 1 July 2010 to 30 June 2011	28,146		
P10GJ10 Recovery PMHA MYates LSL	-3,005		
AMA Interest stakeholder funds held in AMA bank account	2,683		
Total	**262,420**		
PMHA EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	167,679	156,874	10,805
Infrastructure	4,633	7,601	-2,968
Recurrent and other expenses	21,988	17,729	4,259
PMHA Meetings	9,273	10,154	-881
PMHA Subgroup Meetings	3,182	17,471	-14,289
PMHA Representatives attending Other Meetings	7,680	6,620	1,060
Total before AMA Administration Charge	214,435	216,450	-2,014
AMA Administration Charge	21,444	21,444	0
Total	**235,879**	**237,893**	**-2,014**
Total PMHA Funds Remaining	***24,527***		

PMHA FINANCIAL YEAR 1 JULY 2012 TO 30 JUNE 2013			
PMHA INCOME (Stakeholder Contributions)	**Contribution**		
5. Australian Medical Association	57,492		
6. Australian Private Hospitals Association	57,492		
7. Australian Health Insurance Association	57,492		
8. Australian Government Department of Health and Ageing	65,492		
Transfer of PMHA balance from 1 July 2011 to 30 June 2012	24,527		
AMA Interest stakeholder funds held in AMA bank account	1,415		
Total	**263,909**		
PMHA EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	174,152	161,642	12,510
Infrastructure	0	4,182	-4,182
Recurrent and other expenses	21,445	21,529	-84
PMHA Meetings	9,551	9,576	-25
PMHA Subgroup Meetings	3,277	12,073	-8,796
PMHA Representatives attending Other Meetings	7,910	10,279	-2,369
Total before AMA Administration Charge	216,335	219,281	-2,946
AMA Administration Charge	21,634	21,634	0
Total	**237,970**	**240,915**	**-2,945**
Total PMHA Funds Remaining	***22,995***		

2. PMHA's Centralised Data Management Service

The PMHA provides a Centralised Data Management Service, or CDMS for private hospital–based psychiatric services. The CDMS was established in 2001 to support the ongoing implementation of a *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital–based Psychiatric Services* (National Model).

2.1 Facilities Participating in PMHA's CDMS

All private hospitals across Australia with psychiatric beds have implemented the National Model and participate in the service provided by the CDMS. The list of participating facilities, as at 30 June 2013, is set out below.

Queensland

1. Belmont Private Hospital
2. Brisbane Private Hospital
3. The Cairns Clinic
4. Greenslopes Private Hospital
5. Hillcrest Rockhampton Private Hospital
6. New Farm Clinic
7. The Palm Beach Currumbin Clinic
8. Pine Rivers Private Hospital
9. St Andrews Private Hospital Toowoomba
10. The Sunshine Coast Private Hospital
11. Toowong Private Hospital

New South Wales

12. Albury Wodonga Private Hospital
13. Brisbane Waters Private Hospital
14. Baringa Private Hospital
15. Campbelltown Private Hospital
16. Dudley Private Hospital
17. Lingard Private Hospital
18. Mayo Private Hospital
19. Mosman Private Hospital
20. The Hills Private Hospital
21. The Northside Clinic
22. Northside Cremorne Clinic
23. Northside West Clinic
24. St John of God Hospital Burwood
25. St John of God Hospital Richmond
26. South Pacific Private
27. St Vincent's Private Hospital
28. The Sydney Clinic
29. Sydney South West Private Hospital
30. Warners Bay Private Hospital
31. Wesley Private Hospital Ashfield
32. Wesley Private Hospital Kogarah

Australian Capital Territory

33. Calvary Private Hospital

Victoria

34. The Albert Road Clinic
35. Beleura Private Hospital
36. Delmont Private Hospital
37. Essendon Private Hospital
38. The Geelong Clinic
39. The Melbourne Clinic
40. Malvern Private Hospital
41. Mitcham Private Hospital
42. Northpark Private Hospital
43. St John of God Hospital Warrnambool
44. St John of God Pinelodge Clinic
45. The Victoria Clinic

South Australia

46. The Adelaide Clinic
47. Fullarton Private Hospital
48. Kahlyn Day Centre

Western Australia

49. Abbotsford Private Hospital
50. Hollywood Private Hospital
51. Joondalup Health Campus
52. The Marian Centre
53. Perth Clinic
54. Sentiens Clinic

Tasmania

55. The Hobart Clinic
56. St Helens Private Hospital
57. North West Private

Under the PMHA's National Model these participating private hospitals collect two measures of patients' clinical status at key occasions during the provision of care including:

- at Admission to and Discharge from episodes of Overnight inpatient care;
- at Admission to and Discharge from episodes of Ambulatory care, for example Day Programs and Hospital–In–The–Home type care; and
- where episodes of care are extended over longer periods, at Review every three months.

The two measures of clinical status are the Health of the Nation Outcome Scale, or the *HoNOS*, and a fourteen item patient–completed questionnaire, which for convenience is known as the *MHQ–14*.

This clinical data is recorded and then linked with data collected under the *Hospital Casemix Protocol* (HCP) using the CDMS's Hospitals Standardised Measures database. This database application, commonly known as HSMdb, is provided to participating Hospitals by the CDMS. The two sets of linked data are then submitted, in a de–identified format, to the CDMS by participating Hospitals. The data submitted by all Hospitals forms the basis for the *Standard Quarterly Reports* that are prepared and distributed to Hospitals and private health insurers by the CDMS. As well as providing participating Hospitals with a database application, the CDMS provides detailed training materials and considerable active support in the implementation of the data collection process.

In operating under the umbrella of the PMHA, consumers and carers, their treating psychiatrists, participating private hospitals and payers, are provided with assurance that the highly sensitive information managed by the CDMS is protected by an appropriate governance structure.

2.2 Preparation and Publication of the Annual (financial year) Statistical Reports.

The CDMS also produces an Annual Statistical Report (ASR) on Private Hospital–based Psychiatric Services based on data submitted by private hospitals listed above. These Reports are produced each year, as part of the PMHA's ongoing commitment toward improving the quality, reliability, and use of information on private sector mental health services. Our ASRs set out useful summary statistics that include the following.

- Number of patients admitted to private hospitals for psychiatric care.
- Demographic and diagnostic profiles of those patients.
- Comparison of patients reported mental health, social and role functioning at Admission and on Discharge against that of the general population.
- Comparisons of the demographic and diagnostic profiles to indicate that generally different groups of people are receiving mental health care in each sector.

A copy of the most recent ASR is available from the PMHA Website at www.pmha.com.au

2.3 PMHA Quality Improvement Project 2011-13

The Director of the PMHA's CDMS, Mr Allen Morris–Yates, was appointed as the Project Manager for the PMHA's QIP, which is described in detail under 1.4 above. This substantive role required some of the tasks detailed in the original CDMS Work Plan for 2011-13 to be carried forward into the CDMS Work Plan for 2013-15. The QIP was successfully completed by 30 June 2013 and the following tasks have now been included in the CDMS work plan for FYs 2013-15.

- Re–development of the four components of the CDMS Data Warehouse, including:

  (1) entity management;

  (2) data submission and processing;

  (3) analysis and reporting; and

  (4) documentation of process for alternate administrators.

- Incorporation of the PMHA PEx Measure into the CDMS SQRs.

- Routine preparation of SQRs and other reports including Annual Statistical Reports (ASRs), COAG Indicator Reports and requests for ad–hoc Reports approved by the PMHA.

- Administration and maintenance of the CDMS infrastructure and PMHA website, including the equipment maintained at the CDMS Dale Road office and in the Adelaide CBD.

- Revision and update of the HSMdb software for Hospitals. The final version of the Access 97 HSMdb software will be provided to Hospitals next year. It will have the Patient Experiences of Care survey built into the software. In the second half of 2013, the new fully revised version of the HSMdb software will be released to Hospitals.

- Ongoing support for Hospitals with the local processing and submission of data to the CDMS.

Future work of the CDMS will focus on maintaining and enhancing the services and products currently provided; assisting providers and payers in making effective use of the information provided; and meeting the private sector's increasingly sophisticated requirements for statistical information to use in benchmarking and continuous quality improvement.

2.4 PMHA–CDMS Income and Expenditure

PMHA–CDMS Income and Expenditure for the period 1 July 2011 to 30 June 2012 and 1 July 2012 to 30 June 2013 is set out in Table 7.

The Table has been prepared on a cash basis.

The PMHA has confirmed that all expenditure has been made in accordance with the *AMA Agreement for Services 2011–13* terms and conditions.

At 30 June 2013, there was a surplus of $28,198 remaining in the CDMS Budget. The Parties contributing to the PMHA–CDMS have agreed that the surplus be carried forward into the FY 2013–15 PMHA–CDMS income stream.

Table 7: PMHA–CDMS Income and Expenditure Financial Years 2011–13

PMHA-CDMS 1 JULY 2011 TO 30 JUNE 2012			
PMHA–CDMS INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Private Hospitals Association (APHA)	102,608		
2. Australian Health Insurance Association (AHIA)	102,608		
3. Australian Government Department of Health and Ageing (DoHA)	102,608		
Transfer of CDMS Balance From 1 July 2010 to 30 June 2011	17,984		
P10GJ10 Recovery CDMS MYates LSL	-10,682		
Australian Private Hospitals Association (APHA)	14,000		
AMA Interest stakeholder funds held in AMA bank account	3,772		
Total	**332,897**		
PMHA–CDMS EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	195,695	188,960	6,735
Infrastructure	41,750	43,556	-1,806
Recurrent and Other Expenses	38,796	38,159	637
PMHA-CDMS Director attending Other Meetings	3,600	3,154	446
Workshops	0	7,206	-7,206
Total before AMA Administration Charge	279,841	281,035	-1,194
AMA Administration Charge	27,984	27,984	0
Total	**307,825**	**309,019**	**-1,194**
Total CDMS Funds Remaining	***23,878***		

PMHA-CDMS 1 JULY 2012 TO 30 JUNE 2013			
PMHA–CDMS INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Private Hospitals Association (APHA)	98,496		
2. Australian Health Insurance Association (AHIA)	98,496		
3. Australian Government Department of Health and Ageing (DoHA)	98,496		
Total before AMA Administration Charge	23,878		
AMA Administration Charge	1,212		
Total	**320,578**		
PMHA–CDMS EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	203,697	189,778	13,919
Infrastructure	19,855	37,010	-17,155
Recurrent and Other Expenses	41,366	33,352	8,014
PMHA-CDMS Director attending Other Meetings	3,708	4,823	-1,115
Workshops	0	1,340	-1,340
Total before AMA Administration Charge	268,626	266,304	2,322
AMA Administration Charge	26,863	26,863	0
Total	**295,489**	**293,166**	**3,108**
Total CDMS Funds Remaining	***27,412***		

3. The Network

The Private Mental Health Consumer Carer Network (Australia), or Network as it is most commonly known, was established in 2002 to promote the interests of members of the community who receive treatment and care from private mental health services, and their carers. The Network promotes effective consumer and carer participation as the driving force for change in mental health services delivered in the private sector.

Since its inception, the Network has become an integral part of key policy and decision–making processes affecting many Australians, and provides a strong authoritative voice for private sector mental health consumers and their carers. The Network facilitates the sharing of the *lived experience* of mental health problems, addresses common issues, and encourages people to seek help. The Network is recognised within Australia as the peak organisation representing, and comprising of, both private sector mental health consumers and their carers.

The activities of the Network are largely facilitated through its Chair and Executive, the Network's National Committee, and it's State Coordinators for Queensland, New South Wales, Victoria, South Australia, Western Australia, Tasmania, and the Australian Capital Territory.

As a peak private sector organisation, the Network strives to provide systemic advocacy for mental health consumers and their carers. The Network participates in a wide range of events and has representatives on over 40 organisations, as listed under 3.5 below.

3.1 Network National Committee

The Network's National Committee is comprised of the Network's Executive Officers and its State Coordinators, who are either a consumer or carer representative from each Australian State and the Australian Capital Territory. At the end of Financial Year 2013, the Networks National Committee was comprised as follows.

Network Independent Chair	Ms Janne McMahon OAM
Network Deputy Co Chair	Ms Kim Werner
Network Deputy Co Chair	Mr Patrick Hardwick
Network Coordinator QLD	Mr Norm Wotherspoon
Network Coordinator NSW	Vacant
Network Coordinator ACT	Ms Werner
Network Coordinator VIC	Mr Evan Bichara
Network Coordinator SA	Associate Professor Sharon Lawn
Network Coordinator WA	Mr Hardwick
Network Coordinator TAS	Ms Lucy Henry

Over the course of FYs 2011-13, the Network's National Committee held four two day face–to–face meetings, which are set out in Table 8, together with the record of attendance.

Table 8: Network National Committee attendance 2011–13

REPRESENTATIVES		NETWORK MEETINGS			
		24th	25th	26th	27th
		15-16/08/2011	27-28/02/2012	6-7/10/2012	25-26/02/2013
		Melbourne	Melbourne	Adelaide	Melbourne
Independent Chair	Ms Janne McMahon	✓	✓	✓	✓
QLD	Mr Norman Wotherspoon	✓	✓	✓	✓
NSW	Mr Lee Hill	Apology	Vacant	Vacant	Vacant
ACT	Ms Kim Werner	✓	✓	✓	✓
VIC	Mr Evan Bichara	✓	✓	✓	✓
SA	Mr John Kincaid	✓	✓	6/10	Vacant
WA	Mr Patrick Hardwick	✓	✓	✓	✓
TAS	Ms Lucy Henry	✓	✓	Apology	✓
Bluevoices	Mr Michael O'Hanlon	Apology	Apology	Apology	✓
Secretary	Mr Phillip Taylor	✓	✓	✓	✓

Invited guests that attended meetings of the Network included the following.

28 February 2012 Ms Tracey Higlett, Managing Consultant
Healthcare Management Advisors (HMA)

3.2 Network State Activity

Each of the Network's State Coordinators conduct Network related activities in their jurisdiction geared toward the following.

- identifying issues relevant to consumers and carers in the private sector.
- fostering linkages with consumer and carer committees/consumer consultants in private hospitals;
- encourage and facilitate exchange of information on issues and initiatives relevant to consumers and carers;
- reviewing issues of national significance with consumers and carers in their jurisdiction;
- identify issues of significance for referral to the Network's National Committee; and
- acting as a convenor and chair for any state-based Network committee activity.

Table 9 sets out the state–based Network activity that took place during course of the last two financial years.

Table 9: State Activity 2011–13

JURISIDICTION	DATE	ACTIVITY	LOCATION	CONVENOR
QLD	21/6/2011	Network QLD Committee Meeting	Belmont Private Hospital	Mr Norm Wotherspoon
	11/10/2011	Network QLD Committee Meeting	Pine Rivers Private Hospital	Mr Norm Wotherspoon
	27/3/2012	Network QLD Committee Meeting	Greenslopes Private Hospital	Mr Norm Wotherspoon
	4/12/12	Network QLD Committee Meeting	Belmont Private Hospital	Mr Norm Wotherspoon
	24/3/13	Network QLD Advisory Forum	Belmont Private Hospital	Mr Norm Wotherspoon
VIC	17/6/2011	Network VIC Committee Meeting	Albert Road Clinic	Mr Evan Bichara
	30/9/2011	Network VIC Committee Meeting	Albert Road Clinic	Mr Evan Bichara
	16/3/2012	Network VIC Committee Meeting	Pinelodge Clinic	Mr Evan Bichara
	24/3/2013	Network VIC Advisory Forum	Delmont Private Hospital	Mr Evan Bichara
SA	26/5/2011	Network SA Committee Meeting	The Adelaide Clinic	Mr John Kincaid
	2/2/2012	Network SA Committee Meeting	The Adelaide Clinic	Mr John Kincaid
	28/6/2013	Network SA Committee Meeting	The Adelaide Clinic	Mr John Kincaid
	18/4/2013	Network SA Advisory Forum	The Adelaide Clinic	Ms Janne McMahon
	20/6/2013	Network SA Advisory Forum	The Adelaide Clinic	Ms Janne McMahon
WA	7/2/2012	Network Activity Briefing	Abbottsford Hospital	Mr Patrick Hardwick
	20/3/2012	Network Activity Briefing	Perth Clinic	Mr Patrick Hardwick
	21/11/2012	Accreditation Briefing	Perth Clinic	Mr Patrick Hardwick
	5/12/2012	Consumer / Supporter Meeting	Perth Clinic	Mr Patrick Hardwick
	13/3/2013	Consumer / Supporter Meeting	Perth Clinic	Mr Patrick Hardwick
	19/6/2013	Consumer / Supporter Meeting	Perth Clinic	Mr Patrick Hardwick

3.3 Network Representation at Other Meetings and Events 2011-13

Network Members participated in a range of other meetings and events over the course of FYs 2011-13 to advance the interests of both the mental health consumers who receive their treatment and care in the private sector, and their carers. These meetings and events included Network representatives attending the following.

1. Action on Disability within Ethnic Communities (ADEC)
2. APHA Psychiatry Task Force
3. APHA Psychiatry Committee
4. Belmont Private Hospital Consumer and Carer Committee
5. Carers SA Mental Health Carers Task Group
6. e-Mental Health Initiative –Expert Advisory Committee
7. Flourish (Tasmanian Consumer Organisation)
8. Flourish Southern Regional Advisory Group
9. FOCUS on Health Reference Group, Maroochydore, Qld
10. Mental Health Council of Tasmania
11. Media conference, Tasmania 'restraint and seclusion' from the AIHW report
12. Mental Health Nurses Incentive Program Expert Reference Group
13. Mental Illness Fellowship of Victoria Directions Committee
14. Mental Illness Fellowship of Victoria CALD Oversight Committee
15. MHCA Members Policy Forum
16. MHCA National Register
17. Minister's Disability Advisory Committee, Tasmania
18. National Carer Strategy Implementation Reference Group
19. National Consumer and Carer Peer Work Qualification Reference Group
20. ACSQHC National Scoping Study on the Implementation of National Standards in Mental Health Services Reference Group
21. Nevil Management Training (North Eastern Victoria region)
22. National Mental Health Consumer Carer Consumer Forum
23. Pharmaceutical Guild of Australia, Mental Health Project, Reference Group
24. PMHA
25. PMHA Collaborative Models Working Group
26. Private Hospitals' Association (Queensland) Psychiatric Committee
27. RANZCP Community Collaboration Committee
28. RANZCP Members Advisory Committee
29. RANZCP Post Traumatic Stress Disorder Clinical Practice Guidelines Evaluation Committee.
30. RANZCP Committee of Continuing Professional Education
31. RANZCP Committee of Professional Practice
32. RANZCP Practice and Partnerships Committee
33. South Australian Health Practitioners Tribunal
34. South Australian Statewide Mental Health Clinical Network
35. Social worker masters student training, Mental Health Council of Tasmania on 'Communication with Consumers',
36. St Vincent's Hospital Victoria Consumer Reference Group
37. Sunshine Coast Private Hospital Consumer and Carer Committee
38. Sunshine Coast Private Hospital Mental Health Services Oversight Board
39. The Victorian CALD Consumer Reference Group.
40. Victorian Mental Health Carers Network
41. The Victorian Spectrum of Cultures Mental Health Consumer Group.
42. Victorian Mental Illness Awareness Council (VMIAC) - Vic Consumer Peak Body

Network Expert Advisory Panel

The Network's Expert Advisory Panel was established in 2002 and is currently constituted as follows.

Dr Bill Pring	Psychiatrist
Dr Jo Lammersma	Psychiatrist
Ms Moira Munro	Hospitals
Mr David Stokes	Psychologist
Dr Chris McAuliffe	General Practitioner
Dr Margaret Leggatt	Prominent Carer representative

3.4 Network Work Plan 2011-13

The activities of the Network were guided by its work plan for 2011–13. In Financial Years 2011–13, the Network activity was focussed on the following activities.

3.4.1 Governance

Working in close consultation with the PMHA and the AMA, the Network Executive completed a substantive review of the Network's governance arrangements during FY 2011-13. That review included the revision and further development of the following.

1. Position Description Network Chair
2. Position Description Network Deputy Chairs
3. Position Description and Nomination Process Network State Coordinators
4. Information for Consumer and Carer State Advisory Forum Participants
5. Network Code of Behaviour
6. Network Operating Guidelines 2013–15

In addition, the Network Executive supported the PMHA Independent Chair becoming a PMHA representative on the NC to formalise the relationship between the Network and the PMHA and to provide an additional level of expertise for the NC. The PMHA Director will continue to act as Secretary to these biannual meetings.

The new arrangements were implemented under the auspice of the next AMA Agreement for Services 2013-15 from 1 July 2013 to 30 June 2015.

3.4.2 Structure

After its inception in 2002, the Network progressively established State-based Committees for the Network in most Australian states, comprised of consumers and carers who use private hospital with psychiatric beds and other private psychiatric services.

In February 2013, the Network determined that the structure and title of the Network's "State Committees" be changed to "Network State Advisory Forums" to enable the membership to be more in–formal, less structured and open to greater attendance by Network Members. Network State Advisory Forums are intended to provide systemic rather than individual advocacy. The Forums objectives are as follows.

1. Identify issues of potential national significance for consumers and carers in the various private sector settings.
2. Provide feedback as requested to State Coordinators on current Network activities and priorities.
3. Foster links with established consumer and carer groups in private hospitals.
4. Promote the interest and involvement of the State Advisory Forum.

At each face–to–face meeting of the Network National Committee, State Coordinators report on their meetings to date and discuss any issues arising from those meetings.

3.4.3 Borderline Personality Disorder (BPD)

There is increasing national and international interest in the treatment of people with diagnoses of BPD, and there is growing evidence of a range of effective psychological therapies for the treatment of BPD, evidence which contradicts the previous perception of BPD as an untreatable condition. Yet, despite Australia having one of the most comprehensive health care systems in the world, it is relatively difficult for people with diagnoses of BPD to access effective psychological treatments. The Network previously identified that the private mental health sector has an important role to play in the provision of psychological therapies to people with diagnoses of BPD, and undertook the following activities during the course of FY 2011-13.

BPD Expert Reference Group

In 2010, Ms McMahon, (Chair of the Network), was appointed to the Commonwealth Government's Ministerially appointed BPD Expert Reference Group (BPDERG) established by the Federal Minister for Mental Health the Hon. Mark Butler MP. BPDERG first met on the 9 December, 2010. The last meeting of the BPDERG was held on 9 March, 2012.

BPDERG gathered information from public and private sector on policies and treatment options for people with BPD and their carers. As part of that work, the BPDERG asked Ms McMahon to gather information from consumers and carers via a survey to help inform their discussions. The surveys were conducted online in 2011 under the auspice of the Network. After the two surveys were completed, two Primary Reports and a Summary Report were drafted, reviewed and subsequently approved for release in August 2012 via the Network's website. Copies were provided to the BPDERG, the National Mental Health Commission (NMHC or Commission). The Reports, as listed below, are available from the Network website at http://www.pmhccn.com.au.

BPD Survey – Primary Reports

1) Foundations for Change PART 1 Experiences of Consumers with the diagnosis of BPD

2) Foundations for Change PART 2 Experiences of Carers supporting someone with the Diagnosis of BPD

BPD Survey – Summary Report

3) Foundations for Change Borderline Personality Disorder – Consumers' and Carers' Experiences of Care Summary Report

BPD Clinical Practice Guidelines

In 2010, Ms McMahon was also appointed to National Health and Medical Research Council (NHMRC) multidisciplinary BPD Guideline Development Committee responsible for development of a *Clinical Practice Guideline for the management of Borderline Personality Disorder (BPD)*. This Guideline was developed in accordance with NHMRC standards and involve the review of existing evidence and international guidelines, in particular the United Kingdom's National Institute for Health and Clinical Excellence (NICE) *Guideline on the Treatment and Management of Borderline Personality Disorder (2009)*. The Australian Guideline was completed and released in March 2013 and is available from the NHMRC website at:

http://www.nhmrc.gov.au/guidelines/publications/mh25

BPD Conference

In 2011, 5 October was declared National BPD Awareness Day. In 2012, the Network hosted the National BPD Awareness Day Conference in Adelaide on Friday, 5 October 2012 with funding from the Australian Government's Department of Health and Ageing through the Mental Health Council of Australia grant program, SA Health, MIND Australia and headspace. The Conference brought together consumers, carers and health professionals to create a greater awareness of BPD including the challenges for people, their families and carers, health professionals and the mental health system. There were presentations on a range of different topics including treatment models, legacy of trauma, the need for awareness from a consumer and carer perspective, and whether recovery is possible. The Conference was informative, stimulating and proved a great success. Dr Bill Pring brought the private sector psychiatrists' views to the Conference as an invited Keynote Speaker.

3.4.4 Submissions

During Financial Year 2011 to 2013 the Network's made the following submissions.

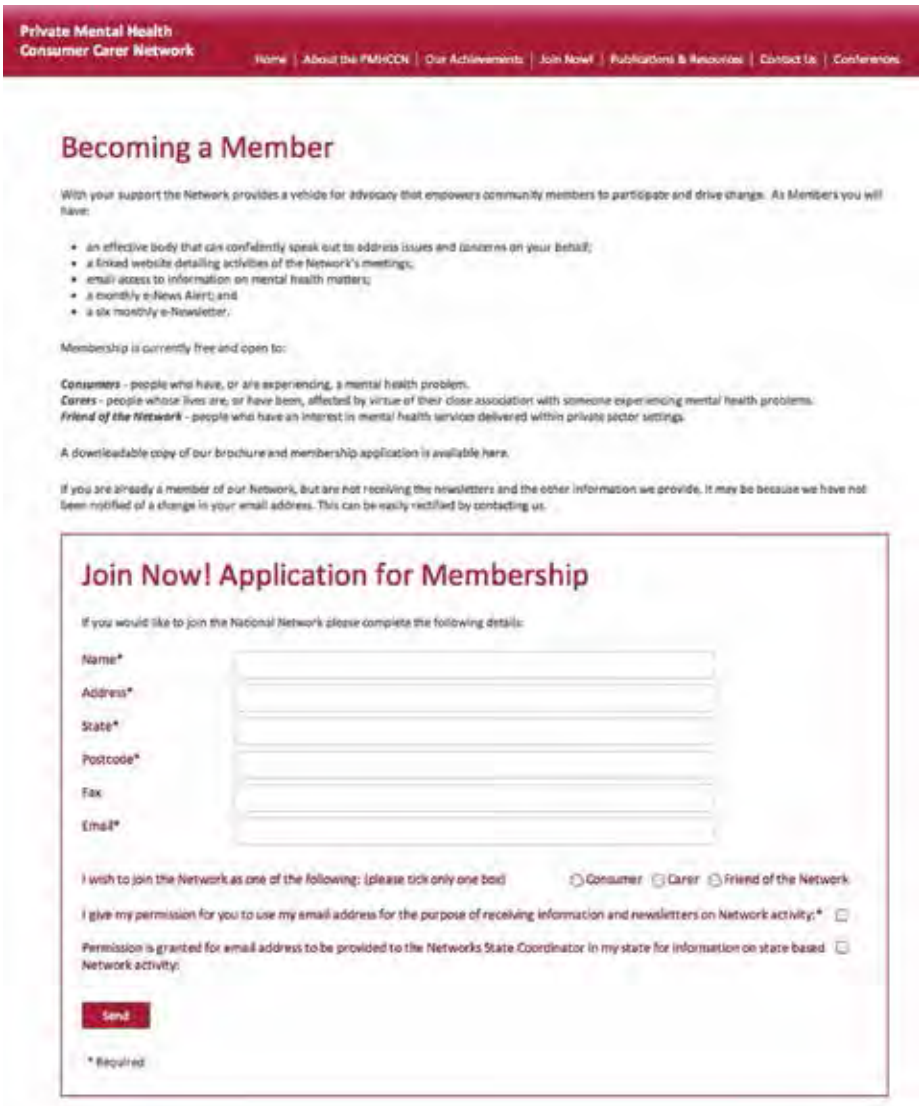
- Senate Community Affairs Committee Finance and Public Administration Reference Committee the Government's administration of the Pharmaceutical Benefits Scheme (PBS) (11 July 2011).
- Senate Community Affairs Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services (27 July 2011)
- The Establishment of the Royal Commission into Institutional Responses to Child Sexual Abuse, (22 November 2012)
- Rural Mental Health Services Consultation inquiry into Improving mental health services in country Australia (19 December 2012).
- Senate Community Affairs Committee Inquiry into the National Disability Insurance Scheme Bill 2012 (25 January 2013).
- Senate Community Affairs Committee Inquiry into the care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD) (29 April, 2013)

3.4.5 Online Registration

During the course of Financial Year 2012-13 the Network website was revised to include online registration. Prospective Members are now able to complete a registration form on the website. The request is forwarded directly to the Network Chair and the PMHA Director via email. At the same time the applicant is automatically advised that their request for membership has been sent and that they will receive an email response as soon as their details have been registered on the PMHCCN database. The applicant details are registered on the PMHCCN database, which is securely held at the offices of the Federal AMA in Canberra. An email confirming registration is then sent to the new Network Member, with a copy to the PMHCCN Chair and Network Coordinator for their state, if applicable.

Network membership has been steadily increasing since the implementation of the online registration system.

A screenshot of the online registration page appears on page 38.


Private Mental Health Consumer Carer Network

Home | About the PMHCCN | Our Achievements | Join Now! | Publications & Resources | Contact Us | Conferences

Becoming a Member

With your support the Network provides a vehicle for advocacy that empowers community members to participate and drive change. As Members you will have:

- an effective body that can confidently speak out to address issues and concerns on your behalf;
- a linked website detailing activities of the Network's meetings;
- email access to information on mental health matters;
- a monthly e-News Alert; and
- a six monthly e-Newsletter.

Membership is currently free and open to:

Consumers - people who have, or are experiencing, a mental health problem.
Carers - people whose lives are, or have been, affected by virtue of their close association with someone experiencing mental health problems.
Friend of the Network - people who have an interest in mental health services delivered within private sector settings.

A downloadable copy of our brochure and membership application is available here.

If you are already a member of our Network, but are not receiving the newsletters and the other information we provide, it may be because we have not been notified of a change in your email address. This can be easily rectified by contacting us.

Join Now! Application for Membership

If you would like to join the National Network please complete the following details:

Name*
Address*
State*
Postcode*
Fax
Email*

I wish to join the Network as one of the following: (please tick only one box) ◯ Consumer ◯ Carer ◯ Friend of the Network

I give my permission for you to use my email address for the purpose of receiving information and newsletters on Network activity:* ☐

Permission is granted for email address to be provided to the Networks State Coordinator in my state for information on state based Network activity: ☐

Send

* Required

3.4.6 Network Income and Expenditure

Network CDMS Income and Expenditure for the periods 1 July 2011 to 30 June 2012 and 1 July 2012 to 30 June 2013 are set out in the Table 10 below. The Tables have been prepared on a cash basis. The PMHA has confirmed that all expenditure has been made in accordance with the AMA Agreement for Services 2011–13 terms and conditions. At 30 June 2013, there was a surplus of $53,626 remaining in the Network Budget for Financial Year 2012–13. Part of this surplus includes the interest for funds held on behalf of the Network, donations received from the Australian Psychological Society and donations received to date, to be used by the National Committee members for additional activities within their states, professional development and Conference attendance. Additionally, the Network's National Committee determined during 2012 and 2013 to attempt to put aside via a number of measures a significant amount to allow all 7 members of the National Committee to attend the World Hearing Voices Conference, to be held on 20-22 November, 2013 in Melbourne. The Parties contributing to the Network have agreed that the surplus be carried forward into the Financial Year 2013–14 Network income stream.

Table 10: Network Income and Expenditure Financial Years 2011–13

NETWORK 1 JULY 2011 TO 30 JUNE 2012			
NETWORK INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Medical Association (AMA)	12,424		
2. Australian Private Hospitals Association	12,424		
3. Australian Health Insurance Association	12,424		
4. Beyondblue	18,509		
5. Australian Government Department of Health and Ageing	107,154		
Transfer of NN Balance from 1 July 2010 to 30 June 2011	12,592		
Royal Australian & NZ College of Psychiatry (RANZCP)	15,424		
Donations Other	1,702		
Donations received from prior years	16,809		
Australian Psychological Society Donation 2011/2012	5,000		
AMA Interest stakeholder funds held in AMA bank account	3,240		
Total	**217,702**		
NETWORK EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	108,863	109,670	-807
Infrastructure and Other Costs	1,971	14,615	-12,644
Network and Other Meetings	40,995	38,196	2,799
Other Meetings	9,043	10,857	-1,814
Total before AMA Administration Charge	160,872	173,338	-12,466
AMA Administration Charge	16,087	16,087	0
Total	**176,959**	**189,425**	
Total Network Funds Remaining	***28,277***		

NETWORK 1 JULY 2012 TO 30 JUNE 2013			
NETWORK INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Medical Association (AMA)	12,797		
2. Australian Private Hospitals Association	12,797		
3. Australian Health Insurance Association	12,797		
4. Australian Government Department of Health and Ageing	110,369		
5. Beyondblue	19,497		
Royal Australian and New Zealand College of Psychiatry Donation	16,248		
Australian Psychological Society Donation	5,000		
Donations received from prior years	18,511		
Donations received in the current year	1,364		
Transfer of balance from 1 July 2011 to 30 June 2012	9,766		
AMA Interest stakeholder funds held in AMA bank account	2,310		
Total	**221,456**		
NETWORK EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	113,216	113,775	-559
Infrastructure and Other Costs	2,030	6,820	-4,790
Network and Other Meetings	42,225	27,246	14,979
Other Meetings	9,314	4,097	5,217
Total before AMA Administration Charge	166,785	151,938	14,847
AMA Administration Charge	16,679	16,679	0
Total	**183,464**	**168,616**	**14,847**
Total Network Funds Remaining	***52,840***		

D13/536

RSM Bird Cameron

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INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF

AUSTRALIAN MEDICAL ASSOCIATION LIMITED

In accordance with the Agreement between the Australian Medical Association limited (AMA), the Australian Private Hospitals Association Limited (APHA), the Private Healthcare Australia (formerly the Australian Health Insurance Association (AHIA)), the Commonwealth of Australia, as represented by the Department of Health and Ageing (Commonwealth) and Beyond Blue Limited (Beyond Blue); we have audited the Statements of Income and Expenditure (the Statements) for the period 1 July 2011 to 30 June 2013 for the following activities:

- Private Mental Health Alliance (PMHA);
- PMHA Centralised Data Management Services (CDMS);
- Private Mental Health Consumer Career Network Australia (The Network);
- PMHA Quality Improvement Project (QIP)

Directors' Responsibility for the Statements

The directors of the AMA are responsible for the preparation of the Statements, and have determined that the basis of preparation is appropriate to meet the requirements of the Agreement. This responsibility also includes establishing and maintaining such internal control as the directors determine is necessary to enable the preparation of the Statements that is free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on the Statements based on our audit. We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the Statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the Statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Directors, as well as evaluating the overall presentation of the Statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

RSM Bird Cameron

Independence

In conducting our audit, we have complied with the independence requirements of the Australian professional accounting bodies.

Opinion

In our opinion the Statements for

- Private Mental Health Alliance (PMHA);
- PMHA Centralised Data Management Services (CDMS);
- Private Mental Health Consumer Career Network Australia (The Network);
- PMHA Quality Improvement Project (QIP).

a) present fairly the transactions of the Agreement for 1 July 2011 to 30 June 2013; and

b) are based on the Financial Records maintained by the Australian Medical Association Limited.

RSM Bird Cameron

RODNEY MILLER
Director

Canberra, Australian Capital Territory
Dated: 13th September 2013

PMHA | PRIVATE MENTAL HEALTH ALLIANCE

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