Progress Report

of the PMHA, its CDMS and the Network

1 July 2013 – 30 June 2015

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

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

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

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FOREWORD

by **Philip Plummer,** PMHA Independent Chair

The private sector plays an essential role in the overall provision of mental health services in Australia. Private sector mental health services are delivered by psychiatrists and GPs in private practice, private hospitals with psychiatric beds (Hospitals) and other allied health professionals. These services account for over 70% of all people seen by the Australian specialist mental health sector. This system operates to prevent unnecessary admissions and readmissions and helps to keep the pressure of the public mental health sector. The private sector employs at least 9% of the national mental health workforce and provides 22% of total psychiatric beds. Over 90% of people with a mental illness seeking hospital–based mental health services in the private sector are privately insured.

Since 1996, the AMA, Private Healthcare Australia (PHA) representing private health insurers, the Australian Private Hospitals Association (APHA), representing private hospitals with psychiatric beds (Hospitals), and the Commonwealth of Australia have been strongly committed to supporting a Private Mental Health Alliance (PMHA) for the private mental health sector. The PMHA is a fairly rare organisation in the Australian health environment that exists to bring 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 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 under the auspice of the Federal AMA 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. Essentially, the CDMS is helping the private hospital sector to answer the fundamental questions that can be asked of any health system – who receives what services, at what cost, and with what effect. 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 a governance structure.

To improve Consumer and Carer participation, PMHA supported the formation of a Private Mental Health Consumer Carer Network (Network) in 2002.

Currently, all 63 or so private psychiatric facilities and most private health insurers across Australia are subscribed to the PMHA, its CDMS and the Network.

Since 2001, the PMHA, its CDMS, and the Network have been supported by a funding agreement between the AMA, APHA, PHA and the Commonwealth. Parties to that agreement make 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 Department of Health made equal contributions to support the CDMS, and all stakeholders contributed to support the Network.

FOREWORD

Under the Agreement, the Federal AMA provides infrastructure support and coordination for the activities of the PMHA, its CDMS and the Network. The current support arrangements are as follows.

- An Independent Chair for the PMHA, currently Mr Philip Plummer located in Adelaide.
- A Director for the PMHA, currently Mr Phillip Taylor, who is located in Canberra. Mr Taylor is responsible for supporting all the activities of the PMHA and provides oversight of the activities of the PMHA's CDMS and the Network.
- A Director for the PMHA's CDMS, currently Mr Allen Morris–Yates, who is located in Adelaide.
- A Chair for the Network, currently Ms Janne McMahon OAM, who is located in Adelaide.

This Progress Report covers the activities of the PMHA, its CDMS and the Network for the period 1 July 2013 to 30 June 2015. The Report has been unanimously endorsed by the PMHA and I trust you will find it informative and useful. 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.

Going forward, the substantive work involved in negotiating, drafting and executing our new funding contract (AMA Agreement for Services 2015-16) was completed in July 2015. This new agreement is intended to provide continuity for the activities of the PMHA, its CDMS and the Network until 30 June 2016. Work Plans for the PMHA, its CDMS and the Network have been developed to guide activity going forward.

Under the PMHA work plan, we will continue to work on issues related to funding, classification, quality of care, outcome measurement, and consumer and carer participation, as they affect the private mental health sector. A working group will be established to explore how to facilitate research using the CDMS data, with a particular focus on the important contribution the private sector is making in mental health.

We will also be facilitating and encouraging the uptake of internet–based access for all our participating Hospitals and Payers to the secure areas of the PMHA website so they can obtain their Standard Quarterly Reports (SQRs) produced by the PMHA's CDMS in a more efficient and timely manner. The AMA contract to facilitate that access is in place.

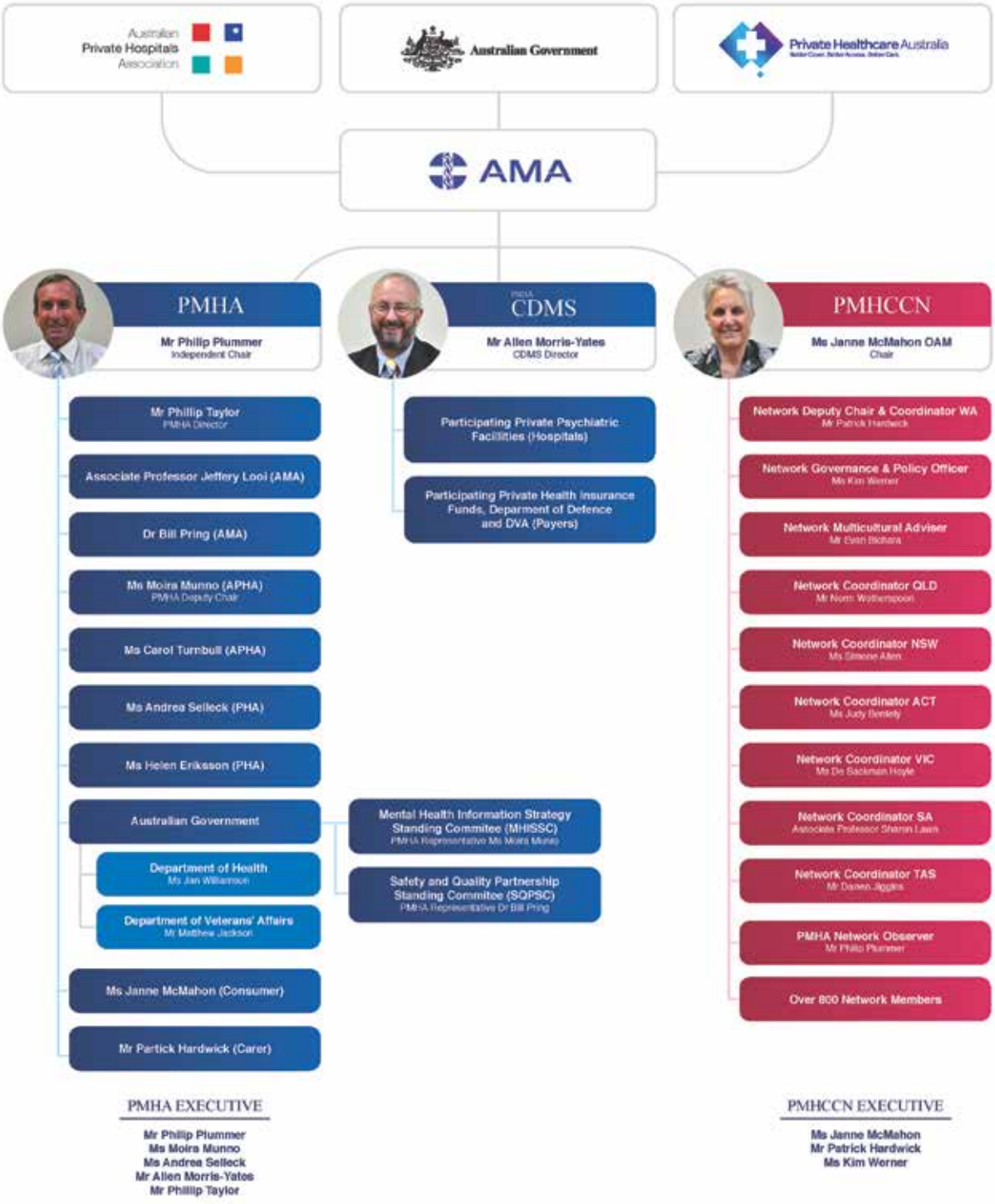
The PMHA's CDMS will continue the preparation and provision of SQRs for our participating Hospitals and Payers and the production of Annual Statistical Reports (ASRs) for the private mental health sector. Beyond that, and quite a few other routine tasks, the CDMS work plan includes the development of criteria and indicators to enable the identification of effective clinical programs.

The work plan for the Network carries a busy schedule and includes an exciting National Carer Project. The project will help to consolidate the Network's commitment toward mental health carers.

To aid in understanding the relationships between our core funders, the PMHA, its CDMS and the Network, an organisational chart has been developed that maps out how this unique package of services for the private sector is structured.

ORGANISATIONAL CHART

Through a funding agreement between the Australian Medical Association (AMA), the Australian Private Hospitals Association (APHA), Private Healthcare Australia (PHA) & the Australian Government, the Federal AMA auspices the activities of the Private Mental Health Alliance (PMHA), its Centralised Data Management Service (CDMS) & the Private Mental Health Consumer Carer Network (Australia) (PMHCCN or "The Network"). The interrelationships between the stakeholders and these activities are set out below.



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 affect 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 eighteen 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.

1.1 PMHA Representatives

During the two Financial Years (FYs) of 2013–15, the PMHA was chaired independently by *Mr Philip Plummer.*

The AMA was represented by *Dr Choong–Siew Yong, Dr Bill Pring* and *Associate Professor Jeffrey Looi. Mr Howard Pickrell*, Director, AMA Corporate Services and *Ms Cherie Roe*, AMA Financial Controller, also attended some meetings as AMA Observers.

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 continued to represent private sector consumers. Janne is also the Chair of the Private Mental Health Consumer Carer Network (Australia) [the Network]. Ms Kim Werner, the Network's Governance and Policy Officer and a member of its Executive, also attended meetings of the PMHA as an Observer. Carers were represented by *Mr Patrick Hardwick*. Patrick is also the Deputy Chair of the Network.

The Australian Government Department of Health representation included *Ms Helen Marx, Ms Kirsty Cheyne–Macpherson* and *Ms Jan Williamson. Mr Jonathon Wauer, Ms Joanna Devereux* and *Mr Matthew Jackson* represented the Department of Veterans' Affairs (DVA).

1.2 PMHA Executive

The PMHA Executive is comprised as follows

1. Mr Philip Plummer PMHA Independent Chai
2. Ms Moira Munro PMHA Deputy Chair
3. Ms Andrea Selleck Chair PHA Mental health Committee
4. Mr Allen Morris–Yates PMHA–CDMS Director
5. Mr Phillip Taylor PMHA Director.

The role of the Executive is to progress matters between meetings of the PMHA.

1.3 PMHA Meetings

Over FYs 2013–15 the PMHA conducted six face–to–face meetings, which are set out in Table 1.1 together with a record of attendance.

Table 1: PMHA Meetings FYs 2013–15

PMHA REPRESENTATIVE(S)		PMHA MEETINGS						
		20th	21st	22nd	23rd	24th	25th	26th
		5/7/2013	1/11/2013	7/3/2014	13/6/2014	7/11/2014	27/3/2015	12/6/2015
		Adelaide	Canberra	Canberra	Canberra	Canberra	Canberra	Canberra
PMHA Chair	Mr Philip Plummer	✓	✓	✓	✓	✓	Apology	✓
Consumers	Ms Janne McMahon	✓	✓	Apology	✓	✓	✓	✓
Carers	Mr Patrick Hardwick	✓	✓	✓	✓	✓	✓	✓
Network Observer	Ms Kim Werner		Apology	✓	Apology	Apology	✓	✓
AMA	Dr Choong–Siew Yong	✓	✓	Apology				
	Dr Bill Pring	✓	✓	✓	✓	✓	✓	✓
	A/P Jeffrey Looi			✓	Apology	✓	✓	Apology
AMA Observer	Mr Howard Pickrell					✓	✓	✓
AMA Observer	Ms Cherie Roe					✓	✓	✓
APHA	Ms Moira Munro	✓	✓	✓	✓	✓	✓	Apology
	Ms Carole Turnbull	✓	✓	✓	✓	Apology	✓	✓
PHA	Ms Helen Eriksson	✓	✓	✓	✓	✓	Apology	✓
	Ms Andrea Selleck	✓	✓	✓	✓	✓	✓	✓
Australian Government – DoHA	Ms Helen Marx	✓	✓					
	Ms Kirsty Cheyne–Macpherson			Apology	Apology			
	Mr Jan Williamson					Apology	✓	Apology
	Mr Paul Linden							✓
Australian Government – DVA	Mr Jonathon Wauer	✓						
	Ms Joanna Devereux		✓					
	Mr Matthew Jackson	Apology	Apology	✓	✓	✓	✓	✓
CDMS Director	Mr Allen Morris-Yates	✓	✓	Apology	✓	✓	✓	✓
PMHA Director	Mr Phillip Taylor	✓	✓	✓	✓	✓	✓	✓

1.4 PMHA Work Plan for FYs 2013-15

The PMHA Work Plan for FYs 2013–15 was developed to broadly guide the activities of the PMHA under the auspice of the *AMA Agreement for Services 2013–15* for the two FYs 1 July 2013 to 30 June 2015. During that time, the Work Plan was evaluated at each meeting of the PMHA and modified when necessary. The PMHA's program of work included the core business of governing and reviewing the PMHA's CDMS to ensure ongoing improvement in the quality of CDMS data collection, analysis and reporting. There was wide dissemination of information from the CDMS to highlight its achievements and work undertaken by the sector. Available CDMS data was used to promote a sector wide perspective on what the CDMS does. Beyond that, the PMHA Work Plan also included the following activities. 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.

1.5 Enabling internet–based access to the PMHA's CDMS Resources and SQRs

In 2014, the PMHA worked with the AMA and Minter Ellison Lawyers to develop an *AMA Private Mental Health Alliance Website Access Agreement*. The purpose of this Agreement is to provide terms regarding internet–based access to the confidential subscriber only resources that may be held on the website of the PMHA and its CDMS. These resources may include both the Training Resources and the Standard Quarterly Reports (SQRs) prepared by the CDMS for participating Hospitals, Health Insurers and other Payers, including DVA and the Australian Government Department of Defence. Ms Debra Tippett from Minter Ellison Lawyers was commissioned to prepare a contract acceptable to the AMA, Hospitals and Payers. Debra is a specialist IT contracts lawyer with many years' experience working with clients to develop bespoke and template contracts for major projects, including the SourceIT suite of template ICT contracts used across the Australian Government. The AMA Access Agreement will facilitate uptake of internet–based access by participating Hospitals and Payers over the course of FY 2015-16.

1.6 PMHA Collaborative Care Models Working Group

The role of the PMHA's Collaborative Care Models Working Group, or CCMWG, is to facilitate collaboration between diverse stakeholders so they can work together on key issues in a highly functional and productive manner. Over the course of FYs 2013–15 the CCMWG was comprised as follows.

1.	AMA	*Dr Bill Pring*
2.	Royal Australian and New Zealand College of Psychiatrists (RANZCP)	*Dr Richard Astill*
3.	Royal Australian College of General Practitioners (RACGP)	*Dr Caroline Johnson*
4.	Australian Psychological Society (APS)	*Mr Harry Lovelock*
5.	Australian College of Mental Health Nurses (ACMHN)	*Ms Anne Buck*

6.	Australian Private Hospitals Association (APHA)	*Ms Carol Turnbull*
7.	Australian Association of Social Workers (AASW)	*Mr Stephen Brand*
8.	Occupational Therapy Australia (OTA)	*Ms Joy Pennock*
9.	The Network	*Ms Janne McMahon (consumers)*
10.	The Network	*Mr Patrick Hardwick (Carers)*
11.	Private Healthcare Australia (PHA)	*Ms Helen Eriksson*
12.	Australian Government Department of Health	*Ms Helen Marx*
13.	Australian Government Department of Veterans' Affairs (DVA)	*Ms Kym Connolly*
14.	PMHA	*Mr Phillip Taylor (Chair and Secretary)*

1.6.1 CCMWG Meetings

Over the course of FYs 2013–15, the CCMWG conducted five face–to–face meetings, which are set out in Table 1.2 below, together with the record of attendance.

Table 2: Meetings of the CCMWG FYs 2013–15

REPRESENTATIVES		CCMWG Meetings				
		17th	18th	19th	20th	21st
		19/7/2013	8/11/2013	28/2/2014	27/6/2014	19/9/2014
Chair & Secretary	Mr Phillip Taylor	✓	✓	✓	✓	✓
Consumers	Ms Janne McMahon	✓	✓	Apology	Apology	Apology
Carers	Mr Patrick Hardwick	✓	✓	✓	✓	✓
AMA	Dr Bill Pring	✓	✓	✓	✓	✓
RANZCP	Dr Richard Astill	✓	✓	✓	✓	✓
RACGP	Dr Caroline Johnson	✓	✓	✓	✓	✓
APHA	Ms Carole Turnbull	✓	✓	✓	✓	✓
ACMHN	Ms Anne Buck	✓	✓	Apology	✓	Apology
	Ms Kim Ryan					✓
AASW	Mr Stephen Brand	Apology	Apology	✓	✓	✓
APS	Dr Pam Connor	Apology				
	Mr Harry Lovelock	✓	✓	✓	✓	✓
OTA	Ms Joy Pennock	Apology	Apology	✓	✓	✓
PHA	Ms Helen Eriksson	✓	Apology	✓	✓	✓
	Ms Andrea Selleck		✓			
Department of Health	Ms Helen Marx	Apology	✓			
	Ms Kirsty Cheyne–Macpherson			Apology	Apology	
	Ms Jan Williamson					Apology
DVA	Ms Kym Connolly	Apology	Apology	✓	Apology	Apology
	Mr Tim Adams		✓			✓

The purpose of these meetings was to develop industry agreed *Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers* and to undertake a major review the 2012 edition of the *PMHA Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care.*

1.6.2 Development of Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers

The aim of developing national industry agreed *Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers* (Principles), was based on the CCMWG's vision for a mental health system that addresses the need for consumers and carers to have a robust referral pathway and process that promotes better communication between providers of mental health services in the private sector.

The Principles ensure that mental health professionals can refer, collaborate and communicate effectively, and where necessary, share care. Implementation of the Principles will help to improve outcomes for people with a mental illness and their carers.

The Principles were developed through the CCMWG's highly collaborative process and have been recognised as an *Accepted Clinical Resource* by the RACGP. They carry the full endorsement of AMA, RANZCP, APS, ACMHN, AASW, OTA, APHA, PHA, Network, Mental Health Professionals Network, and the General Practice Mental Health Standards Collaboration.

The Principles are an important resource for mental health professionals Continuing Professional Development (CPD) programs and CPD events, particularly those that might relate to establishing and working in private practice.

Education and training providers including universities may find the Principles particularly useful for developing and delivering their mental health curricula.

To assist with promotion, the Mental Health Professionals Network (MHPN) dedicated its thirtieth webinar to the Principles. Held at on 25 March 2014, the webinar ran for 75 minutes and had an interdisciplinary focus on collaborating to optimise the support provided to a young woman (Cassie) as she utilised a range of mental health services. The webinar highlighted ways practitioners from different mental health disciplines can work effectively together to deliver an improved service.

Panelists included:

1. Ms Janne McMahon (South Australian based consumer advocate)
2. Dr Caroline Johnson (Victorian based GP)
3. Dr Louisa Hoey (Victorian based clinical psychologist)
4. Dr Bill Pring (Victorian based psychiatrist)
5. Dr Mary Emeleus (Queensland based GP) will facilitated the panel discussion.

MHPN received 1,138 registrations and 433 of those logged in over the course of the live webinar. In March, there were a further 90 plays of the recording and another 80 in April bringing the tally to 603. The webinar is now part of the MHPN Webinar Library and can be viewed at: http://www.mhpn.org.au/webinars.

The Principles are available from the PMHA website www.pmha.com.au

1.6.3 Review of the Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care

In 2014, the CCMWG also undertook a substantive review of the 2012 edition of the *PMHA Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care* (Guidelines). The multidisciplinary nature of the CCMWG enabled a much more robust edition of the Guidelines to emerge because of the wide range of disciplines and stakeholders involved in their development. The process involved private sector providers of clinical care (psychiatrists, GPs, psychologists, mental health nurses, occupational therapists, social workers and private psychiatric facilities) working with consumers, carers and payers (private health

insurers and the Commonwealth). While the Guidelines primarily provide guidance for private hospitals and private health insurers in determining health insurance benefits for private patient hospital–based mental health care, they 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.

For private hospitals with psychiatric beds the Guidelines cover a range of activity including:

- *Care delivery;*
- *Choice of setting;*
- *Patient Acuity, Level of Distress and Disability;*
- *Treatment and care options;*
- *Quality standards;*
- *Staffing; and*
- *Facilities*

The 2015 edition includes advice for services that substitute for traditional admitted hospital–based care based on two distinct models of service provision.

(1) Traditional overnight and day only admitted patient treatment that is conducted to achieve a continuum of care for the patient *within* the hospital setting.

(2) Substitution of traditional admitted patient treatment with an alternative service model able to achieve a continuum of care for the patient *outside* the hospital setting.

For the alternative to in hospital treatment the Guidelines provide advice on the following.

- *Legislation*
- *Hospital Treatment*
- *General Treatment*
- *Funding*
- *Approaches to service delivery*
- *Quality and Standards*
- *Entry and Duty of care*
- *Care Plan*
- *Review*
- *Discharge*
- *Governance*
- *Staffing*

The Guidelines were endorsed by the PMHA and promulgated by the Commonwealth in early 2015. The Guidelines are available from the Department of Health website at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health–phicirculars2015–22

1.7 Recognising and Responding to Deterioration in Mental State: A Scoping Review

In late 2013, the Australian Commission on Safety and Quality in Health Care (ACSQHC) engaged Craze Lateral Solutions to prepare a review of policy and practice relating to recognising and responding to deterioration in mental state.

Craze Lateral Solutions worked with St Vincent's Hospital's Alcohol, Drug and Mental Health Program (Sydney), represented by Dr Peter McGeorge, Steve Bernardi and Douglas Holmes; Homeless Health Services; O'Brien Centre for Urban Health; St Vincent's and Mater Health Services; Carers NSW represented by Ms Eileen McDonald and the PMHA represented by PMHA Director, Phillip Taylor and the PMHA's CDMS Director, Allen Morris–Yates.

The Project's purpose was to inform the Commission about what is known about this topic, gaps that could be addressed by the Commission, and whether and how the Commission's existing framework for recognising and responding to physiological deterioration could be applied to deterioration in a person's mental condition. The Project's scope, while recognising that a significant proportion of care for people mental illness is delivered in the community, focused on people whilst they were being treated in an acute setting, including public and private general and specialist mental health hospitals.

The review included patients treated in the emergency department, those admitted voluntarily, and involuntary admissions. All patients, not only those with a mental health admission or in a mental health inpatient facility, but also those whose mental state deteriorates whilst they are in a medical or surgical setting in a general hospital were in scope.

The Project focussed on key adverse outcomes associated with deterioration in a patient's mental state including those of:

- Suicide
- Self–harm
- Aggression to other patients, visitors and staff
- Self–discharge from acute facilities
- The need for involuntary admission and/or readmission, seclusion and restraint.

With respect to patients who are being treated in an acute setting, including public and private general and specialist mental health hospitals, the Commission wanted to know.

- *How is deterioration in a patient's mental state currently defined and assessed?*
- *What are the factors, either individual or systemic, that lead to adverse outcomes associated with this deterioration?*
- *How often are there adverse outcomes associated with deterioration in a patient's mental state? Where are these outcomes currently reported? Are they publicly reported?*
- *What kind of strategies, tools, frameworks, guidelines and approaches are in place to support early recognition of deterioration in mental state for patients in acute care facilities?*
- *What kind of strategies, tools, frameworks, guidelines and approaches are in place to manage the potential for adverse outcomes associated with deterioration in a patient's mental state?*
- *How are these strategies evaluated? How successful have these strategies been?*
- *What are the gaps that need to be addressed to reduce the risk of adverse outcomes associated with deterioration in a patient's mental state?*
- *To what extent can the framework developed by the Commission regarding recognising and responding to physiological deterioration be applied to deterioration in a patient's mental state?*
- *What actions may be needed for the Commission to contribute to improvements in this area?*

The project involved an online literature review and survey, and interviews with people working in the field to elicit what is actually happening on the ground.

In the private psychiatric hospital sector, Phillip Taylor and Allen Morris–Yates played a key role conducting telephone interviews with a sample of six private psychiatric facilities and the members of the AMA's Psychiatrists' Group. A summary of those interviews was provided to the project team. The Principle Investigator, Leanne Craze worked with Douglas Holmes and Eileen McDonald on the other interviews, including those with mental health consumers and carers in the public sector. In the private sector, Leanne worked with Janne McMahon and the members of the Private Mental Health Consumer Carer Network and its National Committee. The project was a highly collaborative effort and copies of the scoping review are available from the Commission's website at: www.safetyandquality.gov.au

Since the review, the Commission has expanded its existing Recognising and Responding to Clinical Deterioration Program to encompass deterioration in mental state, and the findings of this review will inform the development of this work to improve the safety and quality of care for consumers with a mental health condition.

1.8 PMHA Newsletter

In FYs 2013–15 the PMHA produced five electronic newsletters, which included editorials from the PMHA Independent Chair and regular updates and articles on PMHA and other activities, including the following.

- Activity Based Funding and Mental Health
- PMHA's CDMS implementation of the PMHA Patient Experiences of Care Measure
- Recognising and responding to deterioration in mental state
- PMHA Collaborative Care Models Working Group
- National Report Card on Mental Health 2013
- Mental Health Professionals Network
- Mental Health Australia
- Improving Performance Indicator #17: Treatment rates for mental illness
- Transcranial Magnetic Stimulation
- National Mental Health Commission Review – CDMS Data provided for the review
- Veteran Mental Health Consultation Companion
- *PMHA Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers*
- 2015 edition of the *PMHA Guidelines for Determining Benefits for Health Insurance Purposes for Private Mental Health Care*
- PMHA and CDMS Work Plans for FYs 2015–18
- Activity Based Funding and the Mental Health Costing Study
- National Carer Project
- Neurocognitive markers of affective and psychotic disorders

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 publically showcase the information and statistics available from the PMHA's CDMS. The PMHA e–Newsletter is circulated via email to over 430 recipients throughout the private and public sectors, including all 63 participating private psychiatric facilities, 40 or so private health insurance funds, and the respective directors of public mental health services in each Australian State and Territory.

1.9 Meeting with the Commonwealth Minister for Health Canberra

On March 26 2015, the following members of the PMHA Executive met with the Commonwealth Minister for Health, The Hon. Susan Ley MP and her Senior Adviser Mr James McAdam.

1. Mr Philip Plummer	PMHA Independent Chair
2. Ms Moira Munro	PMHA Deputy Chair
3. Ms Helen Eriksson	Proxy for Ms Andrea Selleck
4. Mr Allen Morris–Yates	PMHA–CDMS Director
5. Mr Phillip Taylor	PMHA Director

The following members of the PMHA Executive met on 12 February with senior officials of the Commonwealth Department of Health.

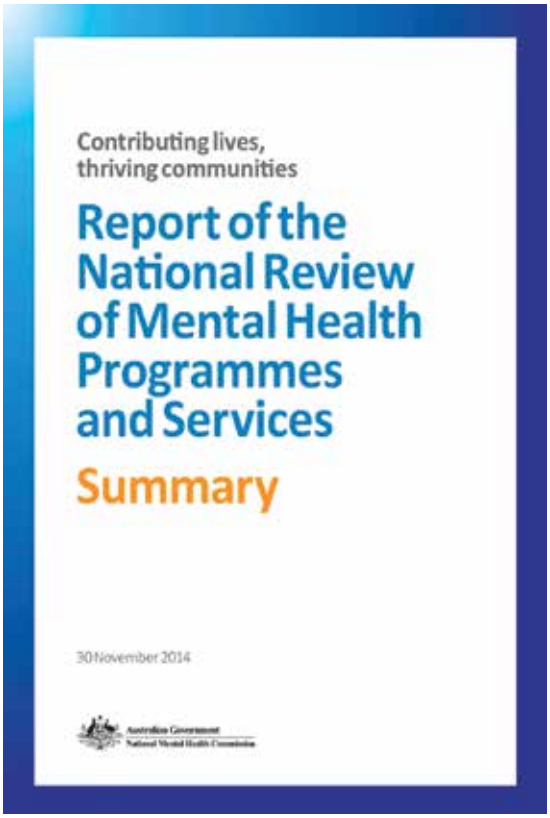
1. Mr Philip Plummer	PMHA Independent Chair
2. Ms Moira Munro	PMHA Deputy Chair
3. Ms Andrea Selleck	Chair PHA Mental Health Committee
4. Mr Allen Morris–Yates	PMHA–CDMS Director
5. Mr Phillip Taylor	PMHA Director

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 Executive described how its 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. The Executive also provided information on how the private sector is successfully addressing continuous quality improvement through the PMHA. At both meetings the Executive was well received and the importance of our work and its continuity was formally acknowledged by Minister Ley.

1.10 Mental Health Reform

In 2014, the National Mental Health Commission (NMHC) conducted a national Review of Mental Health Services and Programmes for the Australian Government. The review examined existing mental health services and programmes across the government, private and non–government sectors. The focus of the review was to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community. In May 2014, the PMHA Executive met with the NMHC Chief Executive, Mr David Butt, to discuss the Review. After that meeting the Commission subsequently made a formal request for the CDMS to provide statistics for the Review. The statistics provided to the Commission are discussed under section 2 The CDMS of this Progress Report.

The NMHC report was publically released in April 2015 and will be used to help inform the Government's future decisions on mental health. After release of this report, the Government announced the revival of a national approach to improving mental health outcomes and access to support



services long–term. The Government developed a considered and unified strategy to ensure the right steps were taken to deliver a genuine national approach. This has involved the revival of a dedicated COAG Working Group on Mental Health Reform and Expert Reference Group to coordinate the reform the process. The PMHA, wrote to the Commonwealth Minister for Health, The Hon. Susan Ley MP to congratulate her on these developments.

1.11 Mental Health Drug and Alcohol Principle Committee

The Australian Health Ministers Advisory Council (AHMAC) Mental Health/Drug and Alcohol Principal Committee (MHDAPC) is comprised of Senior Government Officials. The role of the MHDAPC is to advise AHMAC on national mental health, alcohol, tobacco, and other drug issues. The PMHA is linked to the work of MHDAPC through the positions it holds on MHDAPC's Mental Health Information Strategy Standing Committee (MHISSC) and its Safety and Quality Partnership Standing Committee (SQPSC).

1.11.1 MHISSC

MHISSC provides expert technical advice and, where required, recommends policy for consideration by MHDAPC in relation to mental health information advice, national monitoring and reporting, development and management of national data collections and communication and collaboration. 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. The list of representatives at the end of 2014 is set out below.

1. Dr Grant Sara
   Chair
2. Ms Ruth Fjeldsoe
   Queensland
3. Ms Sharon Jones
   New South Wales
4. Mr Paul Mayers
   Australian Capital Territory
5. Ms Leanne Beagley
   Victoria
6. Mr Marc Currie
   South Australia
7. Mr Michael Moltoni
   Western Australia
8. Mr Darren Turner
   Tasmania

9. Ms Veronica Snook
   Northern Territory
10. Ms Colleen Krestensen
    Commonwealth Department of Health
11. Ms Karen Pickering
    Commonwealth Department of Social Services
12. Mr Gary Hanson
    Australian Institute of Health and Welfare (AIHW)
13. Ms Anna O'Mahony
    AIHW
14. Ms Michelle Ducat
    Australian Bureau of Statistics (ABS)
15. Ms Catherine Katz
    ACSQHC
16. Mr James Downie
    Independent Hospital Pricing Authority
17. Ms Kathryn Apeness
    Productivity Commission
18. Mr Lei Ning
    Mental Health Consumer Representative
19. Ms Jackie Crowe
    Mental Health Carer Representative
20. Mr Geoff Harris
    Community Mental Health Australia
21. Ms Moira Munro
    PMHA
22. Mr Josh Fear
    Mental Health Australia
23. Kara Tew
    MHISSC Secretariat

MHISSC meets over two days three times each in order to progress a daunting volume of complex work, which has included the following.

- National project – Mental Health Non–Government Organisation (NGO) National Minimum Data Set Project
- Development of a carer experiences of care (family inclusiveness) measure
- National project – Measuring Consumers' Experiences of Care
- National project – Development of a consumer self–report measure that focuses on the social inclusion aspects of recovery
- Australian Bureau of Statistics (ABS) Private Hospitals Establishments Collection

During FYs 2013–15, the PMHA was represented on MHISSC by the PMHA Deputy Chair, Ms Moira Munro. Ms Munro provides a comprehensive a report on PMHA activity for each MHISSC meeting, which includes copies of the following reports prepared by the PMHA's CDMS.

- *Annual Statistical Report from the PMHA's CCDMS regarding the services provided by participating Private Hospitals with Psychiatric Beds and Private Psychiatric Day Hospitals.*
- *Report from the PMHA's Centralised Data Management Service regarding participating Hospitals implementation of the PMHA's National Models with historical statistics.*

In addition, the CDMS Director, Mr Allen Morris–Yates was invited to attend the 16/17 October 2014 MHISSC meeting to provide a presentation on the development and implementation of the PMHA's Patient Experience of Care Measure for private psychiatric facilities.

Through working with MHISSC, the constant problem of the under reporting of Ambulatory Care in the private sector in the AIHW's Mental Health Services in Australia Report (MHSA) has been addressed. After meetings with the Australian Bureau of Statistics, the AIHW, and the Commonwealth Department of Health, MHISSC agreed to incorporate statistics from the PMHA's CDMS into MHSA in a chapter devoted to Private hospital–based ambulatory psychiatric services. The introduction to the Chapter and its associated downloads appears on the AIHW MHSA website at: http://mhsa.aihw.gov.au/services/pmha/

1.11.2 SQPSC

The SQPSC provides 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 list of SQPSC representatives at the end of 2014 is set out below.

1. Associate Professor John Allan
   Chair
2. Dr Ed Heffernan
   Queensland
3. Dr Murray Wright
   New South Wales
4. Dr Peter Norrie
   Australian Capital Territory
5. Dr Mark Oakley Browne
   Victoria
6. Dr Aaron Groves
   South Australia
7. Dr Nathan Gibson
   Western Australia
8. Associate Professor Len Lambeth
   Tasmania
9. Associate Professor Rob Parker
   Northern Territory
10. Dr John Crawshaw
    New Zealand
11. Ms Jenna Bateman
    Mental Health Community Coalition/CMHA
12. Mr Lei Ning
    Consumer Representative
13. Ms Eileen McDonald
    Carer Representative
14. Ms Kathryn Sequoia
    Mental Health Australia
15. Dr Suellen Allen
    ACSQHC
16. Dr Bill Pring
    PMHA
17. Ms Colleen Krestensen
    Commonwealth Department of Health
18. Ms Geraldine Carling
    SQPSC Secretariat (ACT Health)

SQPSC meets three times a year and over the course of FYs 2013–15 their agenda included work in the following areas.

- Reducing Adverse Medication Events in Mental Health Services
- Physical Health and Wellbeing of People with Mental Health Issues
- National Community Managed Organisations (CMO) Outcomes Measures
- Recovery Oriented Care
- Seclusion and Restraint
- Reducing Suicide and Deliberate Self Harm in Mental Health Services
- Involuntary Treatment Orders – data benchmarking
- General Safety in Inpatient Settings

During FYs 2013–15, the PMHA was represented on SQPSC by *Dr Bill Pring*.

Dr Pring routinely provides a comprehensive a report on PMHA activity for each SQPSC meeting. The report includes updates on the work of the PMHA's CDMS related to the reporting of the quality and efficiency of mental health service delivery in the private hospital sector. SQPSC is also provided with access to the *Annual Statistical Report from the PMHA's CDMS regarding the services provided by participating Private Hospitals with Psychiatric Beds and Private Psychiatric Day Hospitals*. PMHA representatives also participate in the activities of the SQPSC, which includes an annual Seclusion and Restraint Forum.

1.11.3 MHISSC and SQPSC Meetings FYs 2013–15

Over FYs 2013–15 MHISSC held six two day face–to–face meetings and SQPSC met on six occasions for one day.

Table 1.3: Meetings of the MHISSC and SQPC FYs 2013–15

MHISSC and SQPSC MEETINGS			PMHA REPRESENTATIVES		
DATE	MEETING	Location	Ms Moira Munro	Mr Allen Morris–Yates	Dr Bill Pring
12 July 2013	SQPSC	Melbourne	✓		✓
17/18 October 2013	MHISSC	Canberra	✓		✓
15 November 2013	SQPSC	Sydney	✓		✓
13/14 March 2014	MHISSC	Brisbane	✓		✓
21 March 2014	SQPSC	Sydney	✓		✓
5/6 June 20124	MHISSC	Sydney	✓		✓
11 July 20124	SQPSC	Melbourne	✓		✓
16/17 October 2014	MHISSC	Melbourne	✓	Presentation for MHISSC	✓
14 November 2014	SQPSC	Sydney	✓		✓
13 March 2015	SQPSC	Sydney	✓		✓
19/20 March 2015	MHISSC	Sydney	✓		✓
25/26 June2015	MHISSC	Melbourne	Apology	✓	✓

At the 19/20 March and the 25/26 June 2015 meetings of MHISSC a new meeting structure was trialled consisting of a half day workshop followed by a full day meeting. MHISSC has agreed that the workshop structure worked well for items that required in–depth and technical discussions.

1.12 Mental Health Australia

The Chief Executive Officer of Mental Health Australia (formerly the Mental Health Council of Australia), Mr Frank Quinlan attended the 5 July 2013 meeting of the PMHA in Adelaide. At that meeting, private sector representation on the MHA was discussed and Mr Quinlan suggested that the PMHA should apply for full membership of the MHCA. The benefits of full membership include.

- Nomination of a delegate to the MHCA who has voting rights at the MHCA Annual General Meeting .
- Delegates may nominate for a position on the MH Board.
- Up to two representatives may attend the Members Policy Forum held twice a year. Members may attend the annual State Consultation Workshops.
- Media Monitoring and weekly updates. Daily media stories and updates on Federal and state Government mental health initiatives collated and emailed to members . Weekly updates on the work of the MHA and wider mental health sector from the MHA CEO.
- MHCA Newsletter. News and updates on the work of the MHA and other relevant mental health news produced and emailed bi monthly.
- MHCA Working Groups. From time–to–time the MHA Board will establish a working group in order to progress an issue the MHA membership identifies as a priority. The working groups usually run for 6–12 months and develop a report on the priority issue.

The PMHA's subsequent application to become a full member organisation of MHA was successful. The PMHA Chair is the voting Delegate, with the PMHA Deputy Chair, or PMHA Director, act as proxies in the absence of the Chair. PMHA agreed that the second PMHA representative to attend MHA Meetings with the Chair will be rotated through the other PMHA Members at the discretion of the PMHA Chair.

The PMHA Chair and the Deputy Chair attended the MHA Members Policy Forum (MPF) on 9 April and the MHA Council of Non Government Organisations (CONGO) held on 10 April 2013 in Canberra. The PMHA Director attended the MHA Annual General Meeting on 9 October 2014 and the MPF held the following day.

1.13 AMA Agreement for Services 2015-16

One of the substantive tasks undertaken by the PMHA in FY 2014-15, was the coordination and development of the next AMA Agreement for Services, its supporting budgets and work plans to provide certainty for the activities of the PMHA, its CDMS and the Network beyond 30 June 2015, when the AMA Agreement for Services for FYs 2013-15 expired. Negotiations for the next Agreement commenced in November 2014 and were completed before the end of July 2015. This work involved the substantive task of drafting and negotiating the following documents until they were agreed and endorsed by the PMHA and the Parties to next Agreement (AMA, APHA, PHA and the Commonwealth).

- AMA Agreement for Services 2015–16
- Forward Estimates for PMHA, CDMS and the Network for 2015–16
- PMHA Work Plan 2015–16
- CDMS Work Plan 2015–16
- Network Work Plan 2015–16

Under the agreed PMHA Work Plan 2015-16, we will continue to work on issues related to funding, classification, quality of care, outcome measurement, and consumer and carer participation, as they affect the private mental health sector. A working group will be established to explore how to facilitate research using the PMHA's CDMS data, with a particular focus on the important contribution the private sector is making in mental health. We will also be facilitating and encouraging the uptake of internet–based access for all our participating Hospitals and Payers to the secure areas of the PMHA website so they can obtain their Standard Quarterly Reports (SQRs) produced by the PMHA's CDMS in a more efficient and timely manner. An AMA contract is in place to facilitate that access.

1.14 PMHA Income and Expenditure

PMHA Income and Expenditure for the Financial Years 1 July 2013 to 30 June 2015 is set out in Table 1.4 and Table 1.5. The Tables have been prepared on a cash basis. Table 1.5 reflects a new format for FYs 2014–15 prepared by the AMA at the request of stakeholders. The new format holds stakeholder contributions constant and includes additional budget lines to show how additional income and any aggregated surpluses are being expended. The PMHA has confirmed that all expenditure has been made in accordance with the terms and conditions of the AMA Agreement for Services 2013–15.

Table 1.4: PMHA Income and Expenditure 2013–15

PMHA FINANCIAL YEAR 1 JULY 2013 TO 30 JUNE 2014			
PMHA INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Medical Association	69,758		
2. Australian Private Hospitals Association	69,758		
3. Private Healthcare Australia	69,758		
4. Australian Government Department of Health	69,758		
TTransfer of PMHA Balance from 1 July 2012 to 30 June 2013	22,995		
Transfer of ACSGHC surplus–PMHA 0.6 share	7,876		
AMA Interest stakeholder funds held in AMA bank account	2,804		
Total	**312,707**		
EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	180,881	178,900	1,981
Infrastructure	0	5,626	–5,626
Recurrent and other expenses	21,471	23,649	–2,178
PMHA Meetings	17,849	19,057	–1,208
PMHA Subgroup Meetings	19,120	13,536	5,585
PMHA Representatives attending Other Meetings	21,618	20,354	1,265
Total before AMA Administration Charge	260,939	216,450	–183
AMA Administration Charge	26,094	26,094	0
Total after AMA Administration Charge	**287,033**	**287,216**	
Total Unexpended Funds	**25,491**		

Table 1.5: PMHA Income and Expenditure 2014–15

PMHA FINANCIAL YEAR 1 JULY 2014 TO 30 JUNE 2015			
INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Medical Association (AMA)	73,817		
2. Australian Private Hospitals Association	73,817		
3. Australian Health Insurance Association	73,817		
4. Australian Government Department of Health	73,817		
Total	**295,268**		
EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	177,067	179,211	-2,144
Staffing - Annual Leave	0	-478	478
Staffing - Long Service Leave	3,109	3,136	-27
Infrastructure	5,063	4,673	390
Recurrent and other expenses	22,115	23,035	-920
PMHA Meetings	18,384	21,917	-3,533
PMHA Subgroup Meetings	19,693	5,517	14,176
PMHA Representatives attending Other Meetings	22,267	10,082	12,185
Total before AMA Administration Charge	267,698	247,093	20,605
AMA Administration Charge	27,570	27,570	0
Total after AMA Administration Charge	**295,268**	**274,663**	**20,605**
Total Unexpended Funds	**0**	**20,605**	
PRIOR YEAR SURPLUS	**Budget**	**Actual**	**Variance**
Prior year surplus carried forward		25,491	
Bank Account Interest		4,671	
Infrastructure/other expenses		-20,066	
PMHA Online Subscriptions		-2,432	
PMHA Chair Allowance		-773	
Net Prior Year Surplus		**6,891**	

2. PMHA's CENTRALISED DATA MANAGEMENT SERVICE

2.1 Introduction

During FYs 2013–15, the PMHA continued to provide a ***Centralised Data Management Service***, or CDMS for private hospital–based psychiatric services. The CDMS was established by the AMA in 2001 to support the ongoing implementation of the PMHA's *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital–based Psychiatric Services* (National Model).

Under the PMHA's National Model participating private hospitals with psychiatric beds (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 (HSMdb). 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.

In addition, during the 2011–13 PMHA Quality Improvement Project (QIP), a *PMHA Patient Experiences of Care Measure* (PMHA–PEx) for both overnight inpatient care and ambulatory care was developed. Implementation by participating private psychiatric hospitals commenced in the fourth quarter 2013. At the start of QIP, it was not known how the additional burden of an experience of care measure would be received when participating hospitals were already collecting two clinical outcomes measures (the HoNOS and MHQ14). However, in the very first quarter of data submitted (Oct–Dec 2013) 15 hospitals collected the PMHA–PEx survey. In addition, in just that first quarter of implementation, these hospitals managed to collect 1,798 Surveys, which was an outstanding result.

The data submitted by all Hospitals forms the basis for the *Standard Quarterly Reports*, or SQRs, that are prepared and distributed by the CDMS every quarter to Hospitals and Payers (including private health insurers, the Australian Government's Department of Defence and Department of Veterans' Affairs). At present, hospitals that submit PEx data are provided with an additional separate PEx SQR. As well as providing participating Hospitals with the HSMdb database application, the CDMS provides detailed training materials and considerable active support in the implementation of the data collection process.

The Principal products and services provided by the PMHA's CDMS are set out below in Figure 2.1.

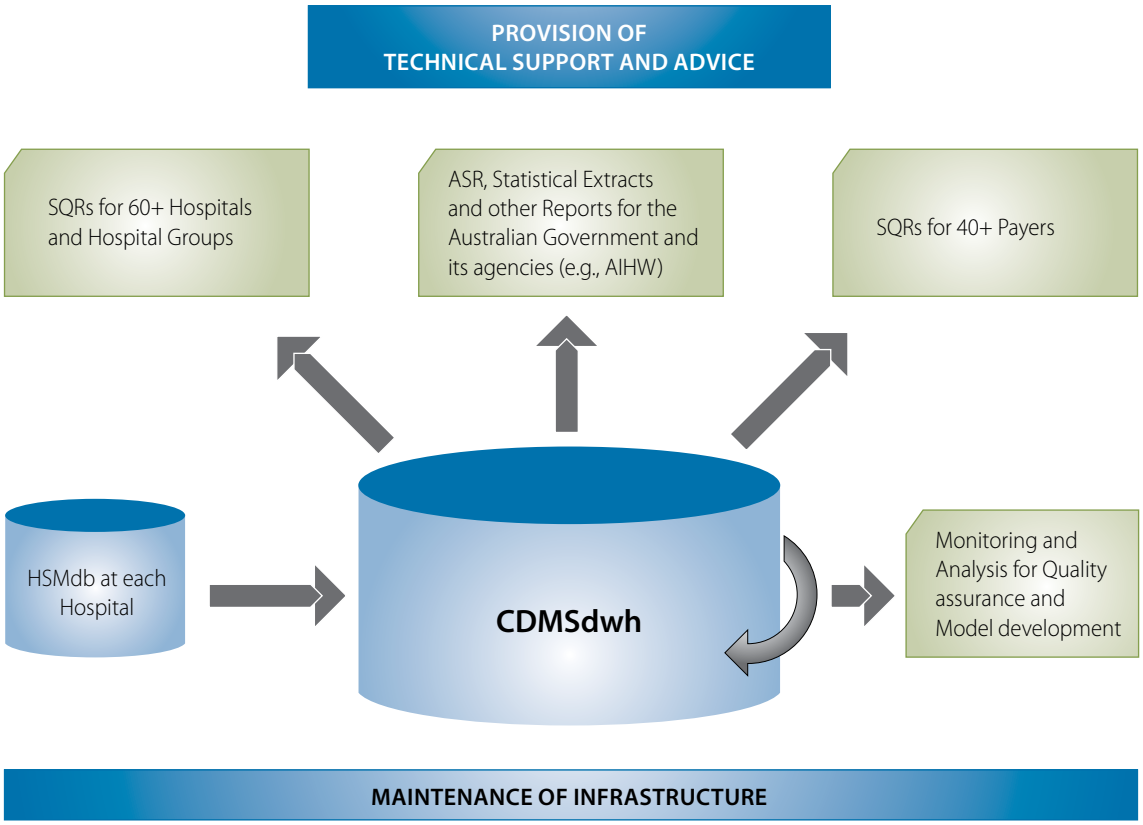


Figure 2.1: Principal products and services provided by the PMHA's CDMS.

2.2 CDMS work plan for the period from 1 July 2013 to 30 June 2015

Over the course of FYs 2013–15 the program of work for the CDMS included the following.

- Ongoing core tasks including preparation of SQRs and support for Hospitals
- Implementation of the PMHA–PEx measure and reporting process
- Independent Hospitals Pricing Authority Mental Health Costing Study
- Enabling internet–based access to CDMS Resources and SQRs
- Upgrade the Hospitals Standardised Measures database application (HSMdb)
- Enhancements to all SQRs

2.3 Australian private hospitals with psychiatric beds and private psychiatric day hospitals participating in the PMHA's CDMS

2.3.1 Hospitals enrolled in the PMHA and its CDMS as 30 June 2015

Within Australia all private hospitals with psychiatric beds have implemented the National Model and participate in the benchmarking service provided by the CDMS. The list of participating facilities as at 30 June 2015 is set out in the following table.

Table 2.1: Currently participating Hospitals as at 30 June 2015

Hospital	Type of facility	Location	First submission date
1. Calvary Private Hospital	General Hospital with Psychiatric Unit	Bruce, ACT	1/01/2002
2. Albury Wodonga Private Hospital	General Hospital with Psychiatric Unit	West Albury, NSW	1/01/2003
3. Baringa Private Hospital	General Hospital with Psychiatric Unit	Coffs Harbour, NSW	1/07/2012
4. Brisbane Waters Private Hospital	General Hospital with Psychiatric Unit	Woy Woy, NSW	1/04/2009
1. Dudley Private Hospital	General Hospital with Psychiatric Unit	Orange, NSW	1/04/2007
2. The Hills Private Hospital	General Hospital with Psychiatric Unit	Baulkham Hills, NSW	1/10/2009
3. The Hills Clinic Kellyville	Stand-alone Psychiatric Hospital	Kellyville, NSW	1/01/2012
4. Maitland Private Hospital	General Hospital with Psychiatric Unit	East Maitland, NSW	1/01/2014
5. Mayo Private Hospital	General Hospital with Psychiatric Unit	Taree, NSW	1/07/2007
6. Mosman Private Hospital	General Hospital with Psychiatric Unit	Mosman, NSW	1/04/2006
7. Northside Cremorne Clinic	Stand-alone Psychiatric Hospital	Cremorne, NSW	1/01/2002
8. The Northside Clinic	Stand-alone Psychiatric Hospital	Greenwich, NSW	1/01/2002
9. Northside Macarthur Clinic	Stand-alone Psychiatric Hospital	Campbelltown, NSW	1/01/2014
10. Northside West Clinic	Stand-alone Psychiatric Hospital	Wentworthville, NSW	1/07/2001
11. St John of God Hospital Burwood	Stand-alone Psychiatric Hospital	Burwood, NSW	1/01/2002
12. St John of God Hospital Richmond	Stand-alone Psychiatric Hospital	North Richmond, NSW	1/01/2002
13. South Coast Private	Stand-alone Psychiatric Hospital	Wollongong, NSW	1/04/2013
14. South Pacific Private	Stand-alone Psychiatric Hospital	Curl Curl, NSW	1/01/2002
15. St Vincent's Private	General Hospital with Psychiatric Unit	Darlinghurst, NSW	1/07/2012
16. The Sydney Clinic	Stand-alone Psychiatric Hospital	Bronte, NSW	1/01/2002
17. Sydney Southwest Private Hospital	General Hospital with Psychiatric Unit	Liverpool, NSW	1/01/2005
18. Toronto Private Hospital	General Hospital with Psychiatric Unit	Toronto, NSW	1/10/2013
19. Warners Bay Private Hospital	General Hospital with Psychiatric Unit	Warners Bay, NSW	1/10/2007
20. Wesley Hospital Ashfield	Stand-alone Psychiatric Hospital	Ashfield, NSW	1/01/2002

Hospital	Type of facility	Location	First submission date
21. Wesley Hospital Kogarah	Stand-alone Psychiatric Hospital	Kogarah, NSW	1/01/2002
22. The Albert Road Clinic	Stand-alone Psychiatric Hospital	South Melbourne, Vic	1/01/2002
23. Beleura Private Hospital	General Hospital with Psychiatric Unit	Mornington, Vic	1/01/2002
24. Delmont Private Hospital	Stand-alone Psychiatric Hospital	Glen Iris, Vic	1/01/2002
25. Epworth Rehabilitation Camberwell	General Hospital with Psychiatric Unit	Camberwell, Vic	1/10/2013
26. Essendon Private Hospital	General Hospital with Psychiatric Unit	Essendon West, Vic	1/01/2009
27. The Geelong Clinic	Stand-alone Psychiatric Hospital	St Albans Park, Vic	1/01/2002
28. Malvern Private Hospital	Stand-alone Psychiatric Hospital	Malvern East, Vic	1/01/2010
29. The Melbourne Clinic	Stand-alone Psychiatric Hospital	Richmond, Vic	1/01/2002
30. Mitcham Private Hospital	General Hospital with Psychiatric Unit	Mitcham, Vic	1/10/2009
31. Northpark Private Hospital	General Hospital with Psychiatric Unit	Bundoora, Vic	1/01/2002
32. St John of God Pinelodge Clinic	Stand-alone Psychiatric Hospital	Dandenong, Vic	1/01/2002
33. St John of God Warrnambool Hospital	General Hospital with Psychiatric Unit	Warrnambool, Vic	1/10/2008
34. The Victoria Clinic	Stand-alone Psychiatric Hospital	Prahan, Vic	1/07/2004
35. Wyndham Clinic	Psychiatric Hospital with Medical Services	Werribee, Vic	1/10/2013
36. Belmont Private Hospital	Stand-alone Psychiatric Hospital	Carina, Qld	1/01/2002
37. Brisbane Private Hospital	General Hospital with Psychiatric Unit	Brisbane, Qld	1/07/2005
38. The Cairns Clinic	Stand-alone Psychiatric Hospital	Cairns, Qld	1/01/2011
39. Caloundra Private Clinic	Psychiatric Hospital with Medical Services	Caloundra, Qld	1/10/2013
40. Currumbin Clinic	Stand-alone Psychiatric Hospital	Currumbin, Qld	1/01/2002
41. Greenslopes Private Hospital	General Hospital with Psychiatric Unit	Greenslopes, Qld	1/10/2003
42. Hillcrest Rockhampton Private Hospital	General Hospital with Psychiatric Unit	Rockhampton, Qld	1/07/2012
43. New Farm Clinic	Stand-alone Psychiatric Hospital	New Farm, Qld	1/01/2002
44. Pine Rivers Private Hospital	Stand-alone Psychiatric Hospital	Strathpine, Qld	1/10/2003
45. St Andrews Private Hospital Toowoomba	General Hospital with Psychiatric Unit	Toowoomba, Qld	1/01/2002
46. The Sunshine Coast Private Hospital	General Hospital with Psychiatric Unit	Buderim, Qld	1/01/2002
47. Toowong Private Hospital	Stand-alone Psychiatric Hospital	Toowong, Qld	1/01/2002
48. The Adelaide Clinic	Stand-alone Psychiatric Hospital	Gilberton, SA	1/01/2002
49. Fullarton Private Hospital	Stand-alone Psychiatric Hospital	Parkside, SA	1/01/2002
50. Kahlyn Day Centre	Psychiatric Day Hospital	Magill, SA	1/01/2002
51. Abbotsford Private Hospital	Stand-alone Psychiatric Hospital	West Leederville, WA	1/01/2002
52. Blackwood River Clinic	Psychiatric Day Hospital	Nannup, WA	1/04/2015
53. Hollywood Private Hospital	General Hospital with Psychiatric Unit	Nedlands, WA	1/01/2002

Hospital	Type of facility	Location	First submission date
54. The Marian Centre	Stand-alone Psychiatric Hospital	Wembley, WA	1/07/2008
55. Perth Clinic	Stand-alone Psychiatric Hospital	West Perth, WA	1/01/2002
56. Calvary Healthcare Launceston	General Hospital with Psychiatric Unit	Launceston, Tas	1/01/2014
57. The Hobart Clinic	Stand-alone Psychiatric Hospital	Rokeby, Tas	1/01/2002
58. North West Private Hospital	General Hospital with Psychiatric Unit	Burnie, Tas	1/07/2010
59. St Helens Private Hospital	General Hospital with Psychiatric Unit	Hobart, Tas	1/01/2002

2.3.2 Changes in hospital enrolments during the period

During the course of 2013-2015, eight new hospitals enrolled in the services provided by the CDMS. The hospitals were Calvary Healthcare Launceston in Tasmania, Blackwood River Clinic in Western Australia, Maitland Private Hospital in New South Wales, Caloundra Private Clinic in Queensland, Wyndham Clinic in Victoria, Epworth Rehabilitation Camberwell in Victoria, South Coast Private in New South Wales, Northside Macarthur Clinic in New South Wales. In addition, the psychiatric unit formerly operating at Lingard Private Hospital was re-located to its sister facility, Toronto Private Hospital in New South Wales.

The following graph, Figure 2.2, summarises the changes in hospital enrolments since the inception of the CDMS at the beginning of the 2001-2002 financial year. As can be seen in the graph, during the period between 2007 and 2009 a number of hospitals did withdraw from participation in the CDMS, however, by 2010 all those hospitals were again enrolled. Allowing for that dip in enrolments, the underlying number of private hospitals with psychiatric beds has steadily increased since 2001, such that the number of enrolled hospitals has now almost doubled.

Figure 2.2: Number of actively participating Hospitals in each year since submission of data to the CDMS was initiated in the first quarter of 2002.

2.4 Preparation of Standard Quarterly Reports

Under the National Model participating Hospitals are requested to submit their data to the CDMS on a quarterly basis, with submissions generally being due no later than ten weeks following the end of the quarter. An exception is made for the July–September submissions normally due in mid–December, with the deadline extended to mid–January in the following year.

The CDMS aims to begin preparation of Standard Quarterly Reports (SQRs) in the last week of the month in which submissions are due. Submissions received after the beginning of the report preparation process are included in the next quarter's report run. Hospitals are asked that any data not submitted by the due date is submitted at the earliest opportunity thereafter, regardless of how late that may be. Both Hospitals' and Payers' SQRs include statistics for the current quarter and the current twelve months. For example, the report for the quarter ending 31 Dec 2014 was based on all separations between 1 Jan 2014 and 31 Dec 2014. As a consequence, the CDMS cannot prepare SQRs regarding a hospital in a given quarter if the hospital's data for that quarter or an earlier quarter's data within the relevant 12 month period is missing.

Table 2.2 below provides an historical analysis of the timeliness of Hospitals' submissions to the CDMS. Submissions are defined as 'On Time' if they are prepared and submitted to the CDMS on or before the Scheduled Due Date; they are defined as 'Overdue' if they are up to 14 days late; they are defined as 'Very Late' if they are between 15 and 91 days overdue; and are defined as 'Extremely Late' if they are more than 91 days overdue.

Generally, two thirds of participating hospitals are able to submit their data before the due date, whilst 10% to 15% are so late with their submissions that they affect the timing of report preparation or must be excluded from a given quarter's report run. Submission of data from Hospitals that have been excluded due to lateness from a previous report run are actively followed up, with their submissions, no matter how overdue, being included in subsequent report runs. As a consequence, SQRs for previous quarters are re-created so that changes in aggregate statistics for any given quarter consequent upon the inclusion of previously missing data are accurately reflected in all hospitals' reports.

Due to the effect that missing data will have on the accuracy of the reported statistics, the preparation of SQRs is generally delayed until 90% of the expected data has been received. As can be seen from the details reported in Table 2.3, that requirement can lead to significant delays in the preparation and distribution of SQRs.

Table 2.2: Timeliness of Hospitals' data submissions to the CDMS, for each quarter since April 2013 (due in by Sep 2013).

Period	Hospitals N	On Time	Overdue	Very Late	Extremely Late	Missing
2nd Quarter of 2013	58	57%	17%	16%	10%	0%
3rd Quarter of 2013	59	63%	20%	12%	5%	0%
4th Quarter of 2013	61	46%	25%	21%	8%	0%
1st Quarter of 2014	63	49%	33%	6%	11%	0%
2nd Quarter of 2014	63	54%	27%	13%	6%	0%
3rd Quarter of 2014	63	56%	30%	8%	5%	2%
4th Quarter of 2014	63	68%	17%	10%	0%	5%
1st Quarter of 2015						

Table 2.3: The effect of submission delays on the availability of data analysis and the timeliness of the preparation of SQRs by the CDMS, for each quarter since April 2013.

	Volume of data received by key dates			Report preparation and distribution		
	Submission due date	Overdue date	Preparation start date	Distribution due date	Preparation start date	Actual distribution date
2nd Quarter of 2013	64%	82%	89%	27-Sep-13	29-Oct-13	25-Nov-13
3rd Quarter of 2013	60%	85%	94%	07-Feb-14	27-Feb-14	06-Mar-14
4th Quarter of 2013	37%	77%	95%	28-Mar-14	30-May-14	06-Jun-14
1st Quarter of 2014	51%	85%	88%	27-Jun-14	07-Jul-14	28-Jul-14
2nd Quarter of 2014	58%	87%	90%	26-Sep-14	21-Oct-14	14-Nov-14
3rd Quarter of 2014	53%	88%	90%	09-Jan-15	16-Feb-15	16-Mar-15
4th Quarter of 2014	67%	83%	100%	30-Mar-15	27-Apr-15	12-May-15

2.4.1 Changes in the volume of data handled by the CDMS

The following two tables provide details regarding the exact volume of HCP, OMP and PEx data submitted to the CDMS by participating Hospitals during the period covered by this report.

Table 2.4: Total volume of HCP, OMP and PEx data submitted by participating Hospitals to the CDMS in respect of the Overnight Inpatient service setting, for each quarter since April 2013.

	HCP records	OMP records			PEx records	
	Overnight	Occasions	HoNOS	MHQ-14	PEx	Hospitals
2nd Quarter of 2013	9,410	18,093	16,349	13,726	0	0
3rd Quarter of 2013	9,608	18,534	17,038	14,105	0	0
4th Quarter of 2013	9,702	18,058	16,414	13,414	1,468	17
1st Quarter of 2014	9,136	18,538	16,650	14,010	2,227	21
2nd Quarter of 2014	10,132	19,658	17,688	14,950	2,396	22
3rd Quarter of 2014	10,225	19,871	18,076	15,064	2,618	27
4th Quarter of 2014	10,485	19,475	17,657	14,898	3,509	27
1st Quarter of 2015	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Table 2.5: Total volume of HCP, OMP and PEx data submitted by participating Hospitals to the CDMS in respect of the Ambulatory Care service setting, for each quarter since April 2013.

	HCP records		OMP records			PEx records	
	Sameday	O'night for Sameday	Occasions	HoNOS	MHQ-14	PEx	Hospitals
2nd Quarter of 2013	52,436	162	4,627	3,262	2,674	0	0
3rd Quarter of 2013	56,587	191	4,656	3,474	2,910	0	0
4th Quarter of 2013	52,005	205	4,059	2,971	2,497	481	13
1st Quarter of 2014	50,907	138	4,271	3,130	2,736	429	14
2nd Quarter of 2014	55,525	177	5,261	3,684	3,117	571	20
3rd Quarter of 2014	60,961	144	6,043	4,131	3,505	513	20
4th Quarter of 2014	56,306	162	5,406	3,835	3,080	679	18
1st Quarter of 2015	n.a	n.a	n.a	n.a.	n.a.	n.a.	n.a.

The volume of data being handled by the CDMS has increased substantially since the CDMS's inception in 2001. That change in the volume of data handled by the CDMS is a natural consequence of the ongoing submission of data by hospitals that have participated since the CDMS's inception, together with the addition of data being submitted by newly enrolled hospitals, particularly since 2009.

In the 2013-2014 financial year the CDMS received 263 data submissions containing just over 750,000 records from participating hospitals, up from 136 submissions containing approximately 313,00 records received in the CDMS's first full year of operation in 2002-2003. As a consequence the volume of data available for analysis is also continually increasing, with the total volume of records included in the CDMS data warehouse now approaching 6,000,000.

2.5 Implementation of the PMHA–PEx measure and reporting process

Development and distribution of resources for hospitals

A key lesson from both the ongoing implementation of the PMHA's National Model by private hospitals and from the CPoC Pilot Study conducted in 2006 is that: (i) the provision of clear and detailed guidance regarding the data collection process; and (ii) the capacity to obtain detailed local reports for the data being collected, are both essential to the ongoing success of the implementation of any routine assessment process of the outcomes and experiences of care.

Accordingly, preparation for the implementation of the PEx survey collection and reporting process began with the development of a detailed Implementation Guide[1] and a set of survey templates for participating hospitals. The Guide includes information regarding the rationale for the collection and analysis of information on patients' experiences of care and the process by which the PMHA's PEx Survey had been developed. That background information is followed by a detailed exposition of the data collection protocol that identifies when the PEx Survey should be offered, how the Surveys should be offered and collected, and other important points regarding the collection process.

The PEx Implementation Guide and the accompanying PEx Survey templates were distributed to all participating hospitals at the end of September 2013.

Preparation for implementation also involved enhancements to the HSMdb database application provided by the CDMS to participating Hospitals. HSMdb provides them with an effective means to record, submit and make local use of the data they collect under the PMHA's National Model. Its use by all but one participating Hospital is one of the reasons for the relative ease most Hospitals have had in implementing the data collection and has also very substantially contributed to the efficiency with which the CDMS has been able to operate.

The enhancements to HSMdb consisted in the addition of a comprehensive PEx Survey data entry function to enable all coded response data together with patients written comments to be recorded together with an addition to the data submission functions that ensured

1 Morris-Yates, A. (2013) *The PMHA's National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures: Patient Experiences of Care Survey (PEx) Implementation Guide for Hospitals (Version 1-0, August 2013).* Canberra, Australian Medical Association.

that all relevant PEx data was included in the standard data extract for submission to the PMHA's CDMS. The PEx item response data, but not the free text comments that patients may have provided, is now included in the quarterly data submission made to the CDMS. Hospitals that submit PEx Survey data are provided with Standard Quarterly Reports that provides detailed aggregate statistics regarding Patients' Experiences of Care in the same way that statistics are currently provided on outcomes and service utilisation.

Also added to HSMdb was a comprehensive local analysis and reporting function for PEx Surveys. The local reports have a similar format to the PEx Standard Quarterly Reports that are now being provided to participating hospitals that submit PEx Survey data to the CDMS. Unlike the SQRs however, the local reports include the comments made by survey respondents. Also, unlike the SQRs, local reports are capable of being generated for any specified Month, Quarter or Year for which the hospital has recorded data.

The enhanced version of HSMdb described above was distributed to all participating hospitals in the second week of October 2013.

Progress with implementation

Implementation of the PMHA's Patient Experiences of Care Survey by private hospitals with psychiatric beds that participate in the benchmarking service provided by the PMHA's CDMS is entirely voluntary. The costs of the additional services involved in supporting Hospitals implementation of the PEx Survey and the analysis and reporting to hospitals of information derived from submitted data has been absorbed at no additional charge within the standard subscription fees paid by hospitals. The implementation of the PEx Survey has been strongly supported by the Australian Private Hospitals Association's Psychiatry Committee. During the development of the new PEx Survey and the initial rollout of the supporting resources, ospitals were kept up to date with progress via the PMHA Newsletters.

Since the distribution of the Implementation Guide, Survey templates and the enhanced version of the HSMdb software, progress with implementation has been monitored through the data submitted to the CDMS by participating Hospitals.

Data in respect of the first period when PEx Survey data could have been collected and submitted, the quarter ending 31 December 2013, indicated that the PEx Survey was initially implemented by eighteen Hospitals. As of the most recent period for which data has been submitted, the quarter ending 31 March 2015, thirty Hospitals have now implemented the PEx Survey. The identity and location of those Hospitals is provided in the following listing.

Private hospitals that, as of 31 March 2015, have implemented the PMHA's PEx Survey

The Adelaide Clinic; Gilberton, SA

The Albert Road Clinic; South Melbourne, Vic

Belmont Private Hospital; Carina, Qld

Calvary Private Hospital; Bruce, ACT

Currumbin Clinic; Currumbin, Qld

Dudley Private Hospital; Orange, NSW

Fullarton Private Hospital; Parkside, SA

The Hobart Clinic; Rokeby, Tas

Hollywood Private Hospital; Nedlands, WA

Kahlyn Day Centre; Magill, SA

Maitland Private Hospital; East Maitland, NSW

The Marian Centre; Wembley, WA

Mayo Private Hospital; Taree, NSW

North West Private Hospital; Burnie, Tas

Northside Cremorne Clinic; Cremorne, NSW

The Northside Clinic; Greenwich, NSW

Northside Macarthur Clinic; Campbelltown, NSW

Northside West Clinic; Wentworthville, NSW

Perth Clinic; West Perth, WA

St John of God Hospital Burwood; Burwood, NSW

St John of God Pinelodge Clinic; Dandenong, Vic

St John of God Hospital Richmond; Richmond, NSW

South Pacific Private; Curl Curl, NSW

St Vincent's Private; Darlinghurst, NSW

The Sydney Clinic; Bronte, NSW

Toowong Private Hospital; Toowong, Qld

Warners Bay Private Hospital; Warners Bay, NSW

Wesley Hospital Ashfield; Ashfield, NSW

Wesley Hospital Kogarah; Kogarah, NSW

Wyndham Clinic; Werribee, Vic

2.6 Preparation and publication of the Annual (financial year) Statistical Reports.

In addition to the SQRs, the CDMS continues to produce a public 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.

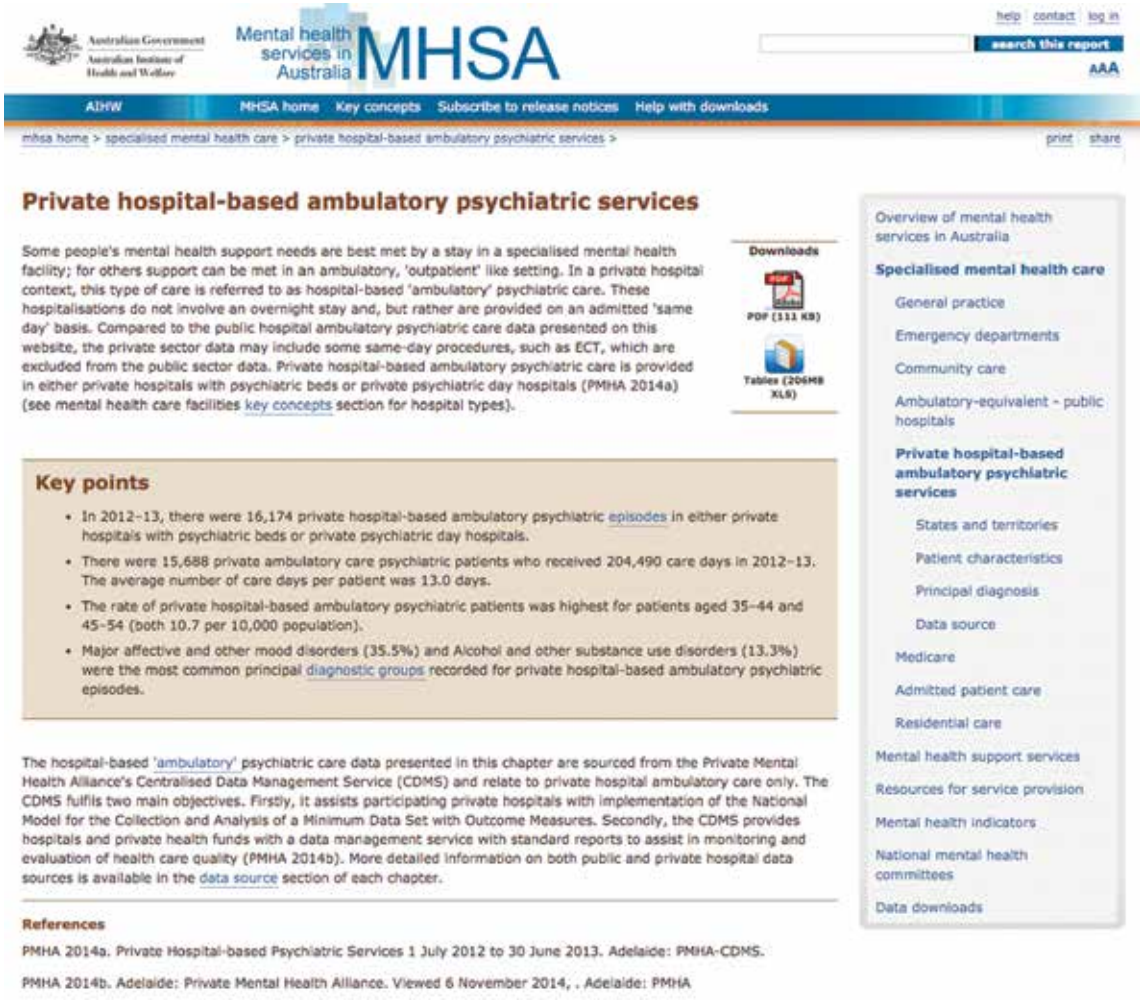
A copy of the most recent ASR is available from the PMHA Website at www.pmha.com.au

2.7 AIHW's report on Mental Health Services in Australia

During the course of FYs 2013–15, the Australian Institute of Health and Welfare (AIHW) incorporated statistics from the PMHA's CDMS into the AIHW's report on *Mental health services in Australia* (MHSA) in a chapter devoted to *Private hospital–based ambulatory psychiatric services.* The introduction to the Chapter and its associated downloads appears on the AIHW MHSA website as follows.

This is a substantive achievement for the private sector made possible by all our participating private Hospitals that collect and submit their data to the CDMS under the *PMHA's National Model for the Collection and Analysis of a Mi*nimum Data Set with Outcome Measures.

The whole chapter can be downloaded here: http://mhsa.aihw.gov.au/services/pmha/



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Private hospital-based ambulatory psychiatric services

Some people's mental health support needs are best met by a stay in a specialised mental health facility; for others support can be met in an ambulatory, 'outpatient' like setting. In a private hospital context, this type of care is referred to as hospital-based 'ambulatory' psychiatric care. These hospitalisations do not involve an overnight stay and, but rather are provided on an admitted 'same day' basis. Compared to the public hospital ambulatory psychiatric care data presented on this website, the private sector data may include some same-day procedures, such as ECT, which are excluded from the public sector data. Private hospital-based ambulatory psychiatric care is provided in either private hospitals with psychiatric beds or private psychiatric day hospitals (PMHA 2014a) (see mental health care facilities key concepts section for hospital types).

Downloads

PDF (111 KB)

Tables (206MB XLS)

Key points

- In 2012–13, there were 16,174 private hospital-based ambulatory psychiatric episodes in either private hospitals with psychiatric beds or private psychiatric day hospitals.
- There were 15,688 private ambulatory care psychiatric patients who received 204,490 care days in 2012–13. The average number of care days per patient was 13.0 days.
- The rate of private hospital-based ambulatory psychiatric patients was highest for patients aged 35–44 and 45–54 (both 10.7 per 10,000 population).
- Major affective and other mood disorders (35.5%) and Alcohol and other substance use disorders (13.3%) were the most common principal diagnostic groups recorded for private hospital-based ambulatory psychiatric episodes.

The hospital-based 'ambulatory' psychiatric care data presented in this chapter are sourced from the Private Mental Health Alliance's Centralised Data Management Service (CDMS) and relate to private hospital ambulatory care only. The CDMS fulfils two main objectives. Firstly, it assists participating private hospitals with implementation of the National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures. Secondly, the CDMS provides hospitals and private health funds with a data management service with standard reports to assist in monitoring and evaluation of health care quality (PMHA 2014b). More detailed information on both public and private hospital data sources is available in the data source section of each chapter.

References

PMHA 2014a. Private Hospital-based Psychiatric Services 1 July 2012 to 30 June 2013. Adelaide: PMHA-CDMS.

PMHA 2014b. Adelaide: Private Mental Health Alliance. Viewed 6 November 2014, . Adelaide: PMHA

Overview of mental health services in Australia

Specialised mental health care

- General practice
- Emergency departments
- Community care
- Ambulatory-equivalent - public hospitals
- **Private hospital-based ambulatory psychiatric services**
  - States and territories
  - Patient characteristics
  - Principal diagnosis
  - Data source
- Medicare
- Admitted patient care
- Residential care

Mental health support services

Resources for service provision

Mental health indicators

National mental health committees

Data downloads

2.8 Independent Hospitals Pricing Authority Mental Health Costing Study

On 12 February 2014, IHPA engaged HealthConsult to undertake a Mental Health National Costing Study (MHNCS) to inform the development of the Australian Mental Health Care Classification. The MHNCS was undertaken at a sample of Australian public hospitals, community mental health services and at a minimum of three private hospitals. The four private hospitals that participated in the MHNCS are set out below.

- St John of God Pinelodge in Victoria
- St John of God Richmond in New South Wales
- Toowong Private Hospital in Queensland
- Perth Clinic in Western Australia

In order to facilitate participation in the MHNCS, the PMHA advised Independent Hospitals Pricing Authority (IHPA) that the HSMdb software could be modified to enable the collection of all components of the Mental Health Costing Study Data Request Specification. Accordingly, an agreement between IHPA and the AMA was executed on 19 August 2014 for IHPA to provide $55,000 funding for the AMA to engage the Director of the CDMS to undertake the following.

- Modify the HSMdb and templates for standard data collection for the Mental Health Costing Study.
- Develop forms and detailed Training Manuals and User Guides for clinical and administrative staff.
- Distribution of the above software and other materials to the private hospitals participating in the Mental Health Costing Study.

All participating private hospitals successfully completed the data collection phase of the MHNCS. During February 2015, the CDMS Director assisted these hospitals with cleaning the data in preparation for submission and finalised the data extraction functions within HSMdb to enable the data to be forwarded to IHPA on 26 February 2015. There was a daunting volume of work for staff at all four private hospitals involved in the MHNCS and it is to their credit that the data was collected accurately and submitted on time. In the May 2015 edition of the PMHA Newsletter we expressed our sincere appreciation to the CEOs of the Hospitals listed above and their staff for ensuring the private sector was able to participate in the MHNCS.

2.9 Enabling internet–based access to CDMS Resources and SQRs

During the first half of 2015 the CDMS Director has worked closely with the PMHA Website developers, The Digital Embassy[2], on preparing the PMHA Secure Subscriber management functions within the website. It is expected that by the end of 2015 authenticated Staff members of participating Hospitals and Payers will be able to securely access their organisations' Standard Quarterly Reports and other resources held on the website.

2 http://www.thedigitalembassy.co/

2.10 National Mental Health Commission Review of Mental Health Services and Programmes.

In 2014, the Australian Government asked the National Mental Health Commission (NMHC or Commission) to conduct a National Review of Mental Health Services and Programmes. Over the course of that year, the review examined existing mental health services and programmes across the government, private and non–government sectors. Over the course of 2014, the Commission's review examined existing mental health services and programmes across the government, private and non–government sectors.

The focus of the review was to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community. Programmes and services included those that have as a main objective prevention, early detection and treatment of mental illness, prevention of suicide, mental health research, workforce development and training; and/or the reduction of the burden of disease caused by mental illness.

In May 2014, the Commission made a formal request for the CDMS to provide statistics for the Review. This formal request followed on from a meeting convened by PMHA Executive on 10 April 2014 in Canberra with the CEO of the NMHC, Mr David Butt. Mr Butt had specifically requested to meet with the PMHA Chair, PMHA Deputy Chair, and the CDMS Director to discuss the CDMS data collection. The statistics that were subsequently provided to the NMHC by the CDMS included the following.

- Total charges against Health insurance funds, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13.
- Number of patients by Payment source and patients' Area of usual residence (Jurisdiction and Locality), 2012–13.
- Number of patients by care provided, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13.
- Number of patient episodes by care provided and number of care days, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13
- Overnight inpatients, Mode of separation by patients' Area of usual residence (Jurisdiction and Locality), Australia, 2012–13.

Table 2.6: Total charges (AUD) against Health insurance funds, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13.

	State or Territory				
Locality	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Urban	119,658,502	103,969,530	71,544,619	53,722,144	348,894,795
Non–urban	20,902,396	14,096,763	17,513,684	20,684,107	73,196,950
Total	**140,560,898**	**118,066,293**	**89,058,303**	**74,406,251**	**422,091,745**

Note: Total charges against all Payment sources during 2012–13 was $476,306,571.

Table 2.7: Number of patients by Payment source and patients' Area of usual residence (Jurisdiction and Locality), 2012–13.

	State or Territory				
Payment source	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Health insurance fund	9,331	7,552	5,600	5,824	28,307
Other payers	1,299	643	1,039	566	3,547
Self–funded	88	27	27	30	172
Total	**10,718**	**8,221**	**6,666**	**6,420**	**32,025**

Table 2.8: Number of patients by care provided, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13.

		State or Territory				
Care type	Locality	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Overnight inpatient	Urban	7,313	5,321	4,048	2,876	19,558
	Non–urban	1,514	855	1,311	1,301	4,981
	Total	**8,827**	**6,176**	**5,359**	**4,177**	**24,539**
Ambulatory	Urban	4,035	4,136	2,658	2,967	13,796
	Non–urban	517	334	434	605	1,890
	Total	**4,552**	**4,470**	**3,092**	**3,572**	**15,686**
All care types	Urban	8,985	7,237	5,154	4,816	26,192
	Non–urban	1,733	984	1,512	1,604	5,833
	Total	**10,718**	**8,221**	**6,666**	**6,420**	**32,025**

Table 2.9: Number of patient episodes by care provided and number of care days, by patients' Area of usual residence (Jurisdiction and Locality), 2012–13.

			State or Territory				
Care type		Locality	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Overnight inpatient	Number of patient episodes	Urban	10,093	7,929	6,687	4,264	28,973
		Non–urban	2,023	1,261	1,943	1,926	7,153
		Total	**12,116**	**9,190**	**8,630**	**6,190**	**36,126**
	Number of care days	Urban	210,080	152,900	135,634	80,513	579,127
		Non–urban	44,012	24,496	37,855	35,359	141,722
		Total	**254,092**	**177,396**	**173,489**	**115,872**	**720,849**
	Average care days	Urban	28.7	28.7	33.5	28.0	29.6
		Non–urban	29.1	28.7	28.9	27.2	28.5
			28.8	**28.7**	**32.4**	**27.7**	**29.4**
Ambulatory	Number of patient episodes	Urban	4,672	3,927	2,868	3,174	14,641
		Non–urban	373	312	363	438	1,486
		Total	**5,045**	**4,239**	**3,231**	**3,612**	**16,127**
	Number of care days	Urban	48,667	63,081	39,952	31,349	183,049
		Non–urban	4,893	3589	4,383	6,908	19,773
		Total	**53,560**	**66,670**	**44,335**	**38,257**	**202,822**
	Average care days	Urban	12.1	15.3	15.0	10.6	13.3
		Non–urban	9.5	10.7	10.1	11.4	10.5
		Total	**11.8**	**14.9**	**14.3**	**10.7**	**12.9**

Table 2.10: Overnight inpatients, Mode of separation by patients' Area of usual residence (Jurisdiction and Locality), Australia, 2012–13

		State or Territory				
Mode of separation	Locality	NSW & ACT	Vic	Qld	WA, SA, NT & Tas	Australia
Discharge/transfer to an(other) acute hospital	Urban	161	238	164	82	645
	Non–urban	45	20	44	33	142
	Total	206	258	208	115	787
Discharge/transfer to an(other) psychiatric hospital	Urban					21
	Non–urban					5
	Total					26
Discharge/transfer to a Residential Aged Care service, unless this is the usual place of residence	Urban					79
	Non–urban					12
	Total	57	22	6	6	91
Discharge/transfer to other health care accommodation (includes mother craft hospitals)	Urban					11
	Non–urban					6
	Total					17
Statistical discharge / type change	Urban					98
	Non–urban					28
	Total	43	19	18	46	126
Left against medical advice / discharge at own risk	Urban	312	155	103	30	600
	Non–urban	25	17	34	11	87
	Total	337	172	137	41	687
Statistical discharge from leave	Urban					52
	Non–urban					6
	Total			44		58
Died	Urban					12
	Non–urban					7
	Total					19
Other (includes discharge to usual residence / own accommodation etc.)	Urban	8,926	7,315	6,098	3,836	26,175
	Non–urban	1,911	1,216	1,833	1,857	6,817
	Total	10,837	8,531	7,931	5,693	32,992
Unknown / not supplied	Urban					1,280
	Non–urban					43
	Total	617	173	271	262	1,323
Total	Urban	10,093	7,929	6,687	4,264	28,973
	Non–urban	2,023	1,261	1,943	1,926	7,153
	Total	12,116	9,190	8,630	6,190	36,126

Note: Blank cells indicate the actual value has been supressed due to insufficient cases in that cell or in adjacent cells; insufficient cases being defined as less than five.

In FYs 2015-16, the PMHA will review which of these statistics might now be usefully included and routinely reported on in the CDMS Standard Quarterly Reports (SQRs).

2.11 Development of a CDMS Work Plan for FYs 2015–18

Over the next three financial years from 1 July 2015 to 30 June 2018, the PMHA's CDMS will continue to work 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 in the private sector every quarter.

The CDMS Work Plan for FYs 2015–18 has been developed and approved as a natural extension of the work that has been undertaken since the inception of the CDMS in 2001.

Under the work plan, the CDMS will continue the preparation and provision of SQRs for our participating Hospitals and Payers and the production of Annual Statistical Reports (ASRs) for the private mental health sector. Beyond that, and the upgrade of the HSMdb, the work plan includes the development of criteria and indicators to enable the identification of effective clinical programs.

The objective of this work is to develop criteria and indicators to enable the identification of effective clinical programs, that is, of effective models, or types, of hospital–based care. This work will be done in consultation with the PMHA's working group established to facilitate research using the CDMS data. That working group will include Hospital, psychiatrist, consumer and Health Fund representatives, together with an external scientific advisor and the CDMS Director.

One of the first tasks for the PMHA working group will be to develop a project brief that ensures technical issues, such as how patient groups, models or types of care and effectiveness can be defined and what additional data elements, if any, need to be collected. The aim will be to eventually implement the agreed criteria and indicators within the CDMS's analysis and reporting framework.

2.11 PMHA–CDMS Income and Expenditure

PMHA–CDMS Income and Expenditure for the period 1 July 2013 to 30 June 2014 and 1 July 2014 to 30 June 2015 is set out in Tables 2.6 and 2.7 below.

The Tables have been prepared on a cash basis. Table 2.7 includes a new format for 2014–15 prepared by the AMA at the request of stakeholders. The new format holds stakeholder contributions constant and includes additional budget lines to show how additional income and any aggregated surpluses are being expended.

The PMHA has confirmed that all expenditure has been made in accordance with the *AMA Agreement for Services 20011–13* terms and conditions.

Table 2:6: PMHA–CDMS Income and Expenditure Financial Years 2013–14

PMHA–CDMS FINANCIAL YEAR 1 JULY 2013 TO 30 JUNE 2014			
INCOME (Stakeholder Contributions)			
1. Australian Private Hospitals Association	116,236		
2. Private Healthcare Australia	116,236		
3. Australian Government Department of Health	116,236		
APHA – New Hospital Enrolment	24,500		
Transfer of CDMS Balance From 1 July 2012 to 30 June 2013	27,412		
Transfer of ACSGHC surplus–CDMS 0.4 share	5,250		
AMA Interest stakeholder funds held in AMA bank account	3,857		
Total	**409,727**		
EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	206,896	210,105	–3,209
Infrastructure	38,287	42,118	–3,831
Recurrent and Other Expenses	61,871	64,173	–2,303
PMHA–CDMS Director attending Other Meetings	9,953	8,249	1,705
Workshops	0	12,294	–12,294
Total before AMA Administration Charge	317,007	336,940	–19,933
AMA Administration Charge	31,701	31,701	0
Total after AMA Administration Charge	***348,708***	**368,641**	
Total before AMA Administration Charge	41,086		

Table 2:7: PMHA–CDMS Income and Expenditure Financial Years 2014-15

PMHA–CDMS FINANCIAL YEAR 1 JULY 2014 TO 30 JUNE 2015			
INCOME (Stakeholder Contributions)			
1. Australian Private Hospitals Association	116,303		
2. Private Healthcare Australia	116,303		
3. Australian Government Department of Health	116,303		
New Hospital Enrolment	0		
Total	**348,909**		
EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	207,690	207,361	329
Staffing - Annual Leave	0	-5,343	5,343
Staffing - Long Service Leave	7,874	8,846	-972
Infrastructure	37,561	87,035	-49,474
Recurrent and Other Expenses	53,713	35,406	18,307
PMHA-CDMS Director attending Other Meetings	10,352	8,609	1,743
Workshops	0	30	-30
Total before AMA Administration Charge	317,190	341,944	-24,754
AMA Administration Charge	31,719	31,719	0
Total after AMA Administration Charge	348,909	373,663	-24,754
Total Unexpended Funds	**0**	**-24,754**	

Table 2:7: PMHA–CDMS Income and Expenditure Financial Years 2014-15 (continued)

PMHA–CDMS FINANCIAL YEAR 1 JULY 2014 TO 30 JUNE 2015			
PRIOR YEAR SURPLUS	Budget	Actual	Variance
Prior year surplus carried forward		41,086	
Bank Account Interest		3,564	
IHPA Income		50,000	
IHPA Travel & Other expenses		-7,971	
Infrastructure / other expense		0	
Website/ SQR Viewer expenses		0	
Net Prior Year Surplus		**86,679**	

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 the State Coordinators are/have been representatives on 65 organisations' committees, working groups, reference groups etc throughout the period 2013-2015, 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 2014–15, the Networks National Committee was comprised as follows.

1.	Network Chair	Janne McMahon OAM
2.	Network Deputy Chair	Patrick Hardwick
3.	Network Policy\Governance Officer	Kim Werner
4.	Network Multicultural Adviser	Evan Bichara
5.	Network Coordinator Qld	Norm Wotherspoon
6.	Network Coordinator NSW	Simone Allan
7.	Network Coordinator ACT	Judy Bentley
8.	Network Coordinator Vic	De Backman Hoyle
9.	Network Coordinator SA	Assoc. Prof. Sharon Lawn
10.	Network Coordinator Western Australia	Patrick Hardwick
11.	Network Coordinator Tasmania	Darren Jiggins
12.	PMHA Observer	Mr Philip Plummer

The Network's Coordinators facilitate Advisory Forums in their jurisdictions to provide the National Committee with consumer and carer perspectives on issues of national significance. The Forums also provide an opportunity for State Coordinators to provide feedback on current Network activities.

Over the course of FYs 2013–15, the Network's National Committee held four two day face–to–face meetings, which are set out in Table 3.1, together with the record of attendance.

Table 3.1: Network National Committee attendance 2013–15

REPRESENTATIVES		NETWORK MEETINGS			
		28th	29th	30th	31st
		26–27/08/2013	14–14/04/2014	29–30/09/2014	12–13/03/2015
		Melbourne	Melbourne	Melbourne	Canberra
Chair	Ms Janne McMahon	✓	✓	✓	✓
Governance & Policy Officer	Ms Kim Werner	See below	See below	✓	✓
Multicultural Adviser	Mr Evan Bichara				✓
QLD	Mr Norman Wotherspoon	✓	✓	✓	✓
NSW	Ms Simone Allen			✓	✓
ACT	Ms Kim Werner	✓	✓	See above	See above
	Ms Judy Bentley			✓	✓
VIC	Mr Evan Bichara	✓	✓	✓	✓
	Ms De Backman–Hoyle	✓	✓	✓	Apology
SA	A/P Sharon Lawn	✓	✓	✓	✓
WA	Mr Patrick Hardwick	✓	✓	✓	✓
TAS	Mr Darren Jiggins				✓
PMHA Observer	Mr Philip Plummer	✓	Apology	✓	✓
Minutes Secretary	Mr Phillip Taylor	✓	✓	✓	✓

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

Mr Tim Coombs	Training and Services Development Australian Mental Health Outcomes and Classification Network (AMHOCN)
Professor Allan Fels	Chair, National Mental Health Commission and Patron of the Network.
Ms Samantha Gaval	Private Health Insurance Ombudsman.

3.2 Network State Advisory Forums

The Network's Coordinators facilitate Advisory Forums in their jurisdictions to provide the NC with consumer and carer perspectives on issues of national significance. The Forums also provide an opportunity for State Coordinators to provide feedback on current Network activities. 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.

Table 3.2 sets out the Network Advisory Forums that took place during course of the last two financial years.

Table 3.2: Network Advisory Forums 2013–15

JURISIDICTION	DATE	ACTIVITY	LOCATION	CONVENOR
QLD	17/09/2013	Network QLD Forum	Belmont Private Hospital	Mr Wotherspoon
	18/03/2014	Network QLD Forum	Belmont Private Hospital	Mr Wotherspoon
	16/09/2014	Network QLD Forum	Belmont Private Hospital	Mr Wotherspoon
	7/10/2014	Network QLD Forum	Belmont Private Hospital	Mr Wotherspoon
	17/03/2015	Network QLD Forum	Greenslopes Private Hospital	Mr Wotherspoon
NSW	13/03/2014	Network NSW Forum	St Vincent's Hospital	Ms McMahon
	24/7/14	Network NSW Forum	St Vincent's Hospital	Ms McMahon
VIC	13/09/2013	Network VIC Forum	Albert Road Clinic	Mr Evan Bichara
	1/10/2014	Network VIC Forum	Albert Road Clinic	Mr Evan Bichara/Ms McMahon
SA	17/12/13	Network SA Forum	Adelaide	A/P Lawn
	5/6/14	Network SA Forum	Adelaide	A/P Lawn
	11/12/2014	Network SA Forum	The Adelaide Clinic	A/P Lawn
	19/3/15	Network SA Forum	Adelaide	A/P Lawn
	18/6/15	Network SA Forum	Adelaide	A/P Lawn
WA	17/12/13	Network SA Forum	Adelaide	A/P Lawn
NSW	24/06/2014	Network Tas Forum	Hobart	Ms McMahon
	14/5/15	Network Tas Forum	Hobart	Ms McMahon/Mr Darren Jiggins

3.3 Network Representation at Other Meetings and Events 2013–15

Network Members participated in a range of other meetings and events over the course of FYs 2013–15 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 being involved with and attending meetings of the following.

1. Australian Borderline Personality Disorder Foundation, SA Branch , (Inaugural Member)
2. Australian Capital Territory Collaborative Engagement Forum
3. Australian Commission on Safety and Quality in Healthcare (ASCQHC) Advisory Panel on the National Standards for MH Services
4. Australian Council on Healthcare Standards SA State Advisory Committee (Member)
5. Australian Council on Healthcare Standards Surveys as Consumer Surveyor
6. Australian Doctor Mental Health Seminar
7. Australian National University, Educator for psychological education team for final year medical students
8. Australian Private Hospitals Association Psychiatry Committee
9. Belmont Private Hospital, Creative Writing Workshop
10. Belmont Private Hospital, patient meet and greet
11. Belmont Private Hospital Consumer and Carer Committee
12. Black Dog Institute, CRESP, National Lived Experience Leadership Group
13. Buderim Private Hospital, consumer and carer committee
14. Canberra Hospital Secure Mental Health Unit Commissioning Steering Committee
15. Carers Roundtable, Department of Social Services
16. Carers SA State Advisory Taskgroup Member since 2012.
17. Chermside Hospital, Burnie Brae Mental Health Storytelling
18. Community Mental Health Australia (as Board Member)
19. Consumer/Carer Leadership Research group (since 2014).
20. Consortium for national Carer Project – Carer Guide, (Independent Chair, Project Manager and Guide Development Committee member)
21. Flourish' Mental Health Consumer network in Tasmania Member
22. Medicare Mental Health Advisory Group
23. Mental Health Australia Board Meetings (Board Member)
24. Mental Health Australia Members Policy Forum (three)
25. Mental Health Carers Arafmi Australia (as Board Member)
26. Mental Health Carers Arafmi WA -Helping Minds (formerly ARAFMI)
27. Mental Health in Multicultural Australia (MHiMA) Consumer Representative, Convenor and Founder of both Multicultural Mental Health Groups, The Victorian Spectrum of Cultures MH C/C Support Group
28. Mental Health Nurses Incentive Program Reference Group (Member)
29. Mental Health Peer Workforce Certificate IV Reference Group
30. Mind and Brain Advisory Board
31. NAHSSS Clinical Psychology Scholarships Assessments 2013/2014/2015

32. National Carer Strategy Implementation Reference Group
33. National Disability Insurance Scheme Capacity Building Conferences - Canberra (x2)
34. National Disability Insurance Scheme Conference - Sydney
35. National Mental Health Consumer Carer Forums (NMHCCF) (x2) plus Executive
36. National Mental Health Services Planning Framework Reference Group
37. National Register of Mental Health Consumers and Carers (NRMHCC) (x3)
38. North East Victoria Mental Health Workforce Training Management
39. Parliamentary Advocacy Day - Parliament House (two)
40. Personally Controlled Electronic Record (PECHR) Workshop
41. PMHA (as Consumer and Carer Members)
42. PMHA-CCMWG (as Consumer and Carer Members)
43. Private Hospitals Association of Queensland Psychiatric Committee
44. Royal Australian College of General Practitioners, Carer Subject Matter Expert GP Medical Education Product Reviewer
45. Royal Australian and New Zealand College of Psychiatrists (RANZCP)
46. RANZCP Committee for Research as Australian Consumer Representative
47. RANZCP Committee of Professional Practice as Australian Consumer Representative
48. RANZCP Community Collaboration Committee, as Australian Consumer and Carer Representative (x3)
49. RANZCP Members Advisory Council as Australian Consumer
50. RANZCP Medicare Item Number Working Group
51. Reconnexion Conference 2015 Committee member
52. South Australian Department of Health Human Research Ethics Committee (mental health services, consumer and carer perspectives) Member since 2007.
53. South Australian Health and Medical Research Institute (SAHMRI)
54. South Australian Mental Health Clinical Network
55. South Australian Mental Health Services Margaret Tobin Awards Judge since 2010.
56. South Pacific Private Hospital, Consumer and Carer Advisory Committee
57. Suicide Prevention Australia- National Lived Experience Leadership Group
58. Sunshine Coast Consumer and Carer Advisory Committee
59. TAFE Caboolture Campus, Guest Speaker
60. The Hobart Clinic Board Member
61. The Mental Health Services Conference (TheMHS) Exhibition – Network booth 2013 Melbourne, 2014 Perth
62. The Mental Health Services Conference (TheMHS) Judge for the Achievement Awards of various categories since 2008.
63. Trauma Informed Care and Practice National Task Force
64. Victorian CALD Consumer and Carer Reference Working Advocacy Group
65. Victorian Transcultural Mental Health (VTMH) Centre, Mental Health Culturally and Linguistically Diverse (CALD) Consumer Advocate
66. Western Australian Mental Health Commissioner meeting re National Carer Project
67. Western Australian NMHCCF/NRMHCC Contingent Workshop

3.4 Network Work Plan 2013–15

The title of the Network Work Plan for Financial Years 2013–15 was 'Strengthening Relationships', which required the Network Chair, Ms McMahon, and other National Committee Members to meet with numerous people in order to achieve that goal. This was apart from the routine Network activities and included meetings geared toward strengthening our relationships with the following.

1. Delmont Hospital, Melbourne
2. The Hobart Clinic
3. Flourish, Hobart
4. St Helens private hospital, Hobart
5. Mental Health Carers Tasmania, Hobart
6. Carers Tasmania, Hobart
7. Calvary Healthcare 'St Vincents', Launceston
8. North West Private Hospital, Burnie
9. Mental Health Australia's Chief Executive Officer on several occasions
10. Mental Health Australia's Deputy Chief Executive Officer
11. Australian Government Department of Health and Ageing, Mental Health Director
12. Australian Government Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA)
13. Australian Psychological Society's Executive Officer
14. RANZCP Chief Executive Officer
15. Private Healthcare Australia, Mental Health Committee
16. MIND Australia, Chief Executive Officer
17. Mental Health Carers ARAFMI WA, President and Chief Executive Officer
18. MIND Australia, South Australian General Manager
19. AMA Secretary General, on several occasions
20. Union and Community Sector Budget function at Parliament House
21. Hon Mark Butler MP, former Minister for Mental Health

3.5 THeMHS Network Exhibition booth

The Network maintained an exhibition booth at the annual THeMHS Conference held in Melbourne in 2013 and Perth in 2014.

3.6 Submissions

During FYs 2013-15 the Network's made the following submissions.

- Response to the Australian Commission on Safety and Quality in Health Care National Statement on Health Literacy. Submission provided by the Faculty of Medicine, Nursing and Health Sciences (formally Faculty of Health Sciences), Flinders University, September, 2013.
- Inquiry into the care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD)
- Inquiry into the Social Services Legislation Amendment Bill 2015

3.7 eNews Alerts

The Network has distributed monthly eNews Alerts to their members for each month during the funding period of 1 July 2013 to 30 June 2015 inclusive.

3.8 Face to face meeting Communiques

The Network has introduced Communiques following each face-to-face meeting of the Networks National Committee, which cover key items discussed and decisions taken. This adds transparency to the operations of the Network. Six Network Communiques' were distributed to members over the course of FYs 2013-15.

3.9 Published literature

The Network's South Australian Coordinator, Associate Professor Sharon Lawn, published the following as it relates to mental health consumer and/or carer research.

- Lawn, S., Fleurieu Cancer Network, Koczawara, B. *What is important to research: the cancer consumers' voice*. 2015 Flinders Centre for Innovation in Cancer Survivorship Conference, Adelaide, 6 February, 2015.
- Lawn, S., Delany, T., Pulvirenti, M., McMillan, J. *Moral Framing and Community Treatment Orders*. XXIVth International Association of Law and Mental Health, Vienna, Austria,12-17th July, 2015.
- Lawn, S., Delany, T., Pulvirenti, M., McMillan, J. *Worker and patient moral framings of community treatment orders*. Society for Mental Health Research (SMHR) Conference. Adelaide, Australia, 3-5 December 2014.
- Lawn, S. *Consumer participation in mental health*. Second World Congress on Integrated Care, 2014. 21st Century Integrated Care: serving citizens, patients and communities" Sydney, Australia, 23-25 November, 2014.
- Lawn, S. *Does it take one to know one? Doing consumer-focused health research*. 3rd Annual NHMRC Research Translation Faculty Symposium - Achieving better health outcomes for Australians living with chronic conditions through more effective research translation. Melbourne, Australia, 12-13 November, 2014.
- Fuller, L., Lawn, S. *Family carers' practices or responses endorsed, maintained and further cemented the smoking behaviours of their family members: Why is this?* 24th Annual TheMHS Conference - What we share makes us strong. Perth Convention & Exhibition Centre, Perth, WA, August 26-29, 2014.

3.10 Invited presentations

- Royal Australian and New Zealand College of Psychiatrists,
  - + 2014 Congress, Hobart *beyond impairment*
  - + 2015 Congress, Brisbane *What can people with BPD teach us*
- Plenary Panel Discussion: *When sex gets too hard - The challenges to maintaining intimacy and a fulfilling sexual life*. Society of Australian Sexologists, Panel Speaker, Adelaide, 4 June, 2014.
- ABC Radio 891 Adelaide, Evenings with Peter Goers (Presenter Deb Tribe). *Mental health at Christmas* (with Janne McMahon, OAM). 20 minutes.
- ABC Radio, Peter Goers Soapbox, 7.30-8pm, *Disability and the Right to Vote*, 10 February, 2014. 20 minutes.
- South West Sydney Medical Local *E-News. Encouraging dialogue for improved health outcomes*, 2015

3.11 Membership

Network membership has been steadily increasing since the implementation of the online registration system. At 30 June 2015, there were over 800 Network members as set out in the table below.

Table 3.3: Network Members

LOCATION	NETWORK MEMBERS
Queensland	289
New South Wales	162
Australian Capital Territory	20
Victoria	165
Tasmania	38
South Australia	74
Western Australia	78
Northern Territory	2
NZ	2
USA	1
Malaysia	1
Location not provided	6
Total	838
Network Tas Forum	Hobart

The Network's Queensland Coordinator, Mr Wotherspoon, has recruited more than 100 or so new members to the state of Queensland since his appointment, which has been an extraordinary singular achievement. On that basis, Mr Wotherspoon was appointed as the Network's Membership Officer in 2014. Given Mr Wotherspoon's success, the Network's NC determined that he would be well placed to provide advice on how to increase membership and what type of promotional materials would best suit the Network's needs. It was further agreed that in the position of Membership Officer, he should jointly man the Network's promotional booth at all TheMHS Conferences together with the Chair, Ms McMahon.

3.12 National Carer Project

In 2014 the Network approached a number of organisations and by early 2015 a consortium of 5 had partnered to develop *a national* ***Practical Guide*** *for working with carers of people with a mental illness in Australia.* The Consortium partners are:

- Mental Health Carers ARAFMI WA Inc.
- MIND Australia
- The Network
- Mental Health Australia
- Mental Health Carers ARAFMI Australia

The chair of the project, Mr Patrick Hardwick, (Network Deputy Chair)

> *The main aim of this project is to provide practical guidance to assist providers to work with carers in a meaningful, mutually beneficial way in a partnership approach which will enhance outcomes for consumers.*

The primary outcome of this project will enhance practice in engaging, supporting and working with carers in all areas in which mental health care is provided. There will be national consultations undertaken across Australia in the coming months.

> *We are very pleased to be managing this project, these are exciting times',* said the Chair of the Network Ms Janne McMahon, (Project Manager) who added *'there is a real need for an new, up-to-date guide, which is practical, nationally focussed and current.*

The Network is grateful to the AMA Secretary General, Anne Trimmer (a corporate lawyer), who kindly assisted pro bono with the drafting of some of the final arrangements that needed to be in place to enable the project to proceed.

Stage One – Core Principles

Stage One of the project involves the development of robust nationally consistent core principles on best practice for working with carers of people with a mental illness and psychosocial disability. These core principles will be directed at supporting the range of mental health providers across both the private and public mental health sectors and community managed organisations.

Stage Two – A Guide for Working with Carers

The core principles will then form a strong foundation for Stage Two of the project, which involves the development of a *Practical Guide for Working with Carers of People with a Mental Illness in Australia* (Guide) and a communication and marketing strategy.

Stage Three – Dissemination and uptake

Stage Three involves the dissemination of the guide consistent with the communication and marketing strategy.

Project Governance and Personnel

As Chair of the Network, I will be responsible for managing the Project. Mrs Judy Hardy has been appointed as the Project Officer. A Project Control Group (PCG) is being established comprised of the following representatives who will oversee the Project.

1. Mr Patrick Hardwick (Independent Chair)
2. Ms Debbie Childs ARAFMI WA
3. Frances Sanders MIND Australia
4. Ms Kylie Wake Mental Health Australia
5. Ms Janne McMahon OAM Chair Network
6. Ms Jane Henty, Mental Health Carers Arafmi Australia

A Guide Development Committee (GDC) will work with the project officer in the development of the guide. The GDC will include the following representatives.

1. Mr Patrick Hardwick Chair, President Arafmi WA (Independent Chair)
2. Ms Debbie Childs, Executive Director, Arafmi WA
3. Ms Kerry Hawkins, Board Member, ARAFMI WA
4. Ms Kylie Wake, Mental Health Australia
5. Ms Margaret Springgay National Mental Health Consumer Carer Forum (TBC)
6. Ms Jane Henty, Executive Officer, Mental Health Carers Arafmi Australia
7. Ms Janne McMahon Network Chair and Executive Officer
8. Ms Frances Sanders MIND Australia
9. Ms Lyn Woolford, President, Carers Australia SA (TBC)
10. Dr Aaron Groves, Chief Psychiatrist, South Australia
12. Ms Gina Smith, Service Provider Private psychiatric hospital sector, Adelaide
13. Dr Caroline Johnson, Royal Australian College of General Practitioners (TBC)
14. Dr Maria Tomasic, Royal Australian and New Zealand College of Psychiatrists
15. Ms Kym Ryan, Australian College of Mental Health Nurses
16. Ms De Backman–Hoyle Carer private sector Carer representative

The Network's thanks goes to Arafmi WA and MIND Australia for funding this important project and to Ms Anne Trimmer, Secretary General at the AMA for assisting the Network with documentation relating to this Project. This is an exciting national project for the Network and consolidates its sincere commitment toward mental health carers.

3.13 Network Income and Expenditure

Network CDMS Income and Expenditure for the periods 1 July 2013 to 30 June 2014 and 1 July 2014 to 30 June 2015 is set out in the Tables 3.4 and 3.5 below. The Tables have been prepared on a cash basis. Table 3.5 reflects a new format for FYs 2014–15, prepared by the AMA at the request of stakeholders.

The new format holds stakeholder contributions constant and includes additional budget lines to show how additional income and any aggregated surpluses are being expended. The PMHA has confirmed that all expenditure has been made in accordance with the *AMA Agreement for Services 2013–15* terms and conditions.

Table 3.4: Network Income and Expenditure Financial Years 2013–14

NETWORK 1 JULY 2013 TO 30 JUNE 2014			
NETWORK INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Medical Association (AMA)	13,180		
2. Australian Private Hospitals Association	13,180		
3. Australian Health Insurance Association	13,180		
4. Beyondblue	10,000		
5. Australian Government Department of Health	107,154		
Royal Australian & NZ College of Psychiatry (RANZCP) 2013/2014	16,735		
Australian Psychological Society Donation 2013/2014	5,000		
Transfer of NN Balance from 1 July 2012 to 30 June 2013	32,965		
Donations received from prior years	19,875		
Donations & Interest received in the current year	780		
Payment out of Donations	–1,790		
AMA Interest stakeholder funds held in AMA bank account	2,826		
Total	**233,085**		
NETWORK EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	107,980	105,245	2,735
Infrastructure and Other Costs	5,673	8,822	–3,149
Network and Other Meetings	39,429	42,873	–3,444
Network Representation at Other Meetings or Events	12,201	11,158	1,043
Total before AMA Administration Charge	165,283	168,098	–2,816
AMA Administration Charge	16,528	16,528	0
Total after AMA Administration Charge	181,811	184,626	
Total Network Funds Remaining	**48,459**		

Table 3.5: Network Income and Expenditure Financial Years 2014–15

NETWORK 1 JULY 2014 TO 30 JUNE 2015			
NETWORK INCOME (Stakeholder Contributions)	**Contribution**		
1. Australian Medical Association (AMA)	13,576		
2. Australian Private Hospitals Association	13,576		
3. Australian Health Insurance Association	13,576		
4. Australian Government Department of Health	110,369		
Royal Australian and New Zealand College of Psychiatry Donation	17,237		
Total	**173,334**		
NETWORK EXPENDITURE	**Budget**	**Actual**	**Variance**
Staffing	107,980	102,487	5,493
Infrastructure and Other Costs	5,843	14,112	-8,269
Network and Other Meetings	40,612	37,603	3,009
Network Representation at Other Meetings or Events	12,378	11,138	1,240
Total before AMA Administration Charge	166,813	165,340	1,473
AMA Administration Charge	16,681	16,681	0
Total after AMA Administration Charge	183,494	182,021	1,473
Total Unexpended Funds	**-15,160**	-13,687	
PRIOR YEAR SURPLUS			
Prior year surplus carried forward		29,594	
Bank Account Interest		1,853	
SA Bank Account		19,880	
Network Carer Project Income		0	
Network Carer Project Expenses		-3,011	
Other expenses from PY surplus		0	
Other expenses frm SA Bank A/c		0	
NET PRIOR YEAR SURPLUS		**48,316**	

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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 2013 to 30 June 2015 for the following activities:

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

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.

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Birdanco Nominees Pty Ltd
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Practising as
RSM Bird Cameron
ABN 65 319 382 479

Major Offices in:
Perth, Sydney,
Melbourne, Adelaide,
Canberra and Brisbane

RSM Bird Cameron is a member of the RSM network. Each member of the RSM network is an independent accounting and advisory firm which practises in its own right. The RSM network is not itself a separate legal entity in any jurisdiction.

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);

a) present fairly the transactions of the Agreement for 1 July 2013 to 30 June 2015; and

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

RSM Bird Cameron

Canberra, Australian Capital Territory
Dated: 16/9/2015

RODNEY MILLER
Director

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