National Network of Private Psychiatric Sector Consumers and their Carers

# SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

NATIONAL NETWORK SECRETARIAT
CANBERRA

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# 1 SUMMARY

It is the belief of the Australian community that the public sector mental health system is in 'crisis'. While this may not yet apply to the mental health services provided in the private sector, there are serious concerns emerging in relation to the practices of private health insurance funds (or Health Fund(s)) that we believe will, in time, impact on the **whole** mental health sector, if action is not taken.

In Australia, more people are treated privately than publicly and some issues are clearly common to both sectors. Adequate and appropriate standards of service provision, continuous quality improvement, and a comprehensive definition of consumer and carer participation, are needed for both sectors.

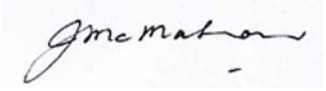
For the purposes of this Submission a ***consumer*** is a person using, or who has used, a private sector mental health service. A ***carer*** is a person, other than a service provider, whose life is affected by virtue of their close relationship with a private sector mental health consumer, or who has a chosen caring role with such a consumer. The carer may be a family member, partner, friend, neighbour, or paid helper, who is regularly caring for a person with a mental illness.

People who access mental health services within the private sector generally report better continuity of treatment and care. They do, however, have to contend with issues, which are different to public sector consumers. These issues include the following.

- The impact of changes to private health insurance legislation on the funding of private inpatient services.
- Variations in funding coverage of psychiatric services between Health Funds.
- Limitations in access to services as a result of tendering processes for psychiatric services.
- Substantial 'out-of-pocket' costs in a number of situations.

It has been demonstrated, particularly since the implementation of the National Mental Health Strategy in 1992, that the lived experiences of consumers and their carers provide a rich source of information about the quality, effectiveness, accessibility and appropriateness of mental health services. They know what does, and what does not, work for them.

It is the collective thoughts and lived experiences of private sector consumers and their carers, expressed through the *National Network of Private Psychiatric Sector Consumers and their Carers* (or National Network) that have informed this Submission.



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# 2. KEY ISSUES

In accordance with the Terms of Reference for the *Senate Select Committee on Mental Health*, the National Network has prioritised the eight key issues, which we consider to be crucial to the delivery of effective mental health services in the Australian private sector. In this Submission, those key issues are set out and expanded upon under the following Sections.

**Section 6** **Private Health Insurance Funds** addresses Term of Reference (d), *The appropriate role of the private and non-government sectors;*

**Section 7** **Primary Carers – Inclusion,** addresses Term of Reference (g), *The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;*

**Section 8** **Availability of Services Across the Continuum of Care – Implications**, addresses Term of Reference (b), *The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;*

**Section 9** **Use of Low Dose Atypical Anti-psychotic Medication in the Private Sector**.

**Section 10** **Integration – Optimal Outcomes**

Sections 10.4 and 10.5 further address Term of Reference (d) *The appropriate role of the private and non-government sectors;*

**Section 11** **Education and Training** for health professionals, teachers, and consumers and their carers is addressed in this section in relation to Term of Reference (g) *The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness*, and additional portion of (i), *education of the mental health workforce.*

**Section 12** **Consumer and Carer Participation in the Private Mental Health Sector** addresses Term of Reference (i), *Opportunities for reducing the effect of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated*

**Section 13** **The National Standards for Mental Health Services,** addresses Term of Reference (o), *The adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards*

**Section 14** **The Remaining Terms of Reference as they Apply to the Private Mental Health Sector**, are addressed in this Section.

# 3 SUMMARY OF RECOMMENDATIONS

**RECOMMENDATION 1**

That the necessary steps be undertaken to amend the section of the *National Health Act 1953,* which governs private health insurance, to ensure *portability* between private health insurance funds. The amendments must ensure that once a private health insurance fund member has served a waiting period with one private health insurance fund, they are not required to serve another waiting period, should they elect to change their health insurer, on the same level of cover.

**RECOMMENDATION 2**

That the *Carer Allowance* be reviewed, as a matter of urgency, to enable those people caring for someone with a mental illness to be eligible for the Allowance (currently, Carers are not eligible because of the nature of the illness and requirements of the Carers Allowance). The amount paid under the Carer Allowance also needs to be reviewed, as the current amount is manifestly inadequate to sustain Carers in their full-time caring role.

**RECOMMENDATION 3**

That the *Guidelines for determining benefits for health insurance purposes for private patient hospital-based mental health care* be strengthened to ensure that mental health services provided in private hospitals with psychiatric beds comply with the Guidelines. Compliance with the Guidelines should also be a requirement of approved accreditation authorities in Australia.

**RECOMMENDATION 4**

That urgent changes to the Pharmaceutical Benefits Schedule are required to enable psychiatrists in private practice to prescribe atypical anti-psychotic medication to treat disorders other than schizophrenia and Bipolar 1 Disorder.

**RECOMMENDATION 5**

That there be greater collaboration between the health and education systems to effect significant changes in mental health education and training, including curriculum reform in the school and tertiary sectors; combined training programs for health professionals, consumers and their carers; and the development of more resources to reduce stigma and discrimination in the mental health sector.

**RECOMMENDATION 6**

That to overcome barriers to meaningful consumer and carer participation, all organisations involved in the funding and delivery of treatment and care in the private mental health sector should:

(a) implement appropriate in-service education, that includes consumers and their carers as educators; and

(a) formulate and adopt a comprehensive definition of consumer and carer participation for their organisations.

**RECOMMENDATION 7**

That the *National Standards for Mental Health Services* be reviewed, as a matter of urgency, to ensure that they are appropriate for proper implementation by mental health services in both the public and private sectors. Private sector mental health consumers and their carers must be included in the review process.

**RECOMMENDATION 8**

That urgent review of current State and Territory Mental Health Acts be undertaken to deal with impediments, such as those that prevent involuntary admissions to appropriate settings in the private psychiatric hospital-based sector. Urgent development of one National Mental Health Act for Australia is required which will enable the removal of barriers to continuity of care between States and Territories.

# 4 INTRODUCTION

The *National Network of Private Psychiatric Sector Consumers and their Carers* (hereafter National Network) represents Australians who contribute to Health Funds and who receive treatment and care, within the Australian private sector, for their mental illness or disorder.

The National Network seeks to promote the interests of members of the community requiring these services, and to promote effective advocacy as the driving force behind all changes in mental health services delivered in private sector settings. Since the beginning of 2002, the National Network has become an integral part of key policy and decision-making processes affecting many Australians.

The role of the National Network is to be the authoritative voice concerning the policy and practices of provider and funder organisations as they affect consumers and their carers using private sector mental health services.

The National Network welcomes this opportunity to make a submission to the *Senate Select Committee on Mental Health.* It represents an opportunity to raise issues of concern for people directly involved in the receipt of mental health services, and those that care for them, in private sector settings. These include treatment and care from psychiatrists in private practice, general practitioners (GP(s)) and private hospitals with psychiatric beds (or Hospital(s)).

The National Network would welcome the opportunity to discuss any of the issues raised in this Submission and would like to work together with the *Senate Select Committee on Mental Health* in a positive way to ensure that those who will be most affected by the findings of the Committee, that is consumers and their family carers, have direct input into it.

# 5 THE PRIVATE MENTAL HEALTH SECTOR

In Australia, the private sector treats over half (50-60%) of all people seen by the Australian specialist mental health sector. It employs 16% of the national mental health workforce and provides 16% (approximately 1500) of total psychiatric beds. The private sector provides a range of mental health care, which includes the services provided by psychiatrists in private practice, which are funded through the Medicare Benefits Schedule, and inpatient and Day Only services provided currently by 46 private hospitals with psychiatric beds, for which Health Funds pay benefits. Over 90% of people with a mental health problem or mental disorder seeking inpatient mental health services in the private sector are privately insured. The remainder are people covered by other third party payers including the Australian Government Department of Veterans Affairs, compensation insurers or people who fund their own care. The following table provides an indication of the extent of the contribution to specialised mental health care in Australia made by private hospitals in 1999-2000.

| Overnight separations with specialised psychiatric care (1999-2000) | Separations | Patient days |
|---|---|---|
| Public acute hospitals | 63,635 | 927,332 |
| Public psychiatric hospitals | 15,568 | 1,153,859 |
| Private hospitals | 20,126 | 341,265 |
| Total | 99,329 | 2,422,456 |

By 2001-2002, the number of patient days spent in private psychiatric hospitals had increased by 23% and Separations were 28% more, relative to 1999-2000. The Australian Institute of Health and Welfare has also estimated that during 2002-2003, private hospitals provided 68% of all Same-day mental health services, and 91% of all Same-day Alcohol Use Disorder and Dependence services[1]. The same report showed that private hospitals also provided 43% of all hospital-based psychiatry services and treated almost 100,000 patients. Despite the limitations of this data, it is evident that there has been substantial growth in the private psychiatric hospital sector since the beginning of the National Mental Health Strategy[2].

In the private sector, 43 of the 46 (93%) Australian private hospitals with psychiatric beds have implemented the *Strategic Planning Group for Private Psychiatric Services (SPGPPS), National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based, Psychiatric Services*[3]. Through participation in the National Model, Hospitals and Payers are able to clearly evaluate and monitor the quality and effectiveness of the care provided by those participating Hospitals.

# 6 PRIVATE HEALTH INSURANCE FUNDS

The National Network calls on the Senate Select Committee on Mental Health to address the steady attempt by private health insurers to restrict their coverage for services that are accessed by private consumers who have a chronic mental illness. The National Network understands the complexities faced by the private health insurance industry in determining their products, and making decisions about the allocation of scarce funding resources in an environment of escalating health care costs. The National Network, however, holds serious concerns whenever *psychiatric* and *rehabilitation* services are targeted in an attempt to reduce the effect of rising costs. Mental illness is usually chronic, not episodic as the Terms of Reference imply. The question that needs to be asked, for example, is whether people with renal failure requiring constant dialysis should be denied this treatment. Additionally, would co-payments be applied to this treatment. The answer is obviously, no. Renal dialysis is chronic, why then single out psychiatry and rehabilitation.

Fundamentally, the key issues the National Network is concerned about include ***portability*** between health funds, ***exclusionary*** health insurance products, ***limitations*** on benefits paid for hospital-based care, ***co-payments*** for Day Programs, and ***disputes*** between Hospital providers and health funds.

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1 Australian Institute of Health and Welfare (AIHW) (2004), *Australian hospital statistics 2002–03*. AIHW cat. no. HSE 32. Canberra: AIHW (Health Services Series no. 22).

2 Department of Health and Ageing (2003), *National Mental Health Report 2004, Eighth Report – Summary of changes in Australia's Mental Health Services under the National Mental Health Strategy 1993-2002*, pp: 34-40, Commonwealth of Australia, Canberra.

3 Morris-Yates A and the Strategic Planning Group for private Psychiatric Services Data Collection and Analysis Working Group (2000) *A National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Psychiatric Services.* Commonwealth of Australia, Canberra.

3 Portability is provided for in paragraphs (1a)-(1f) of schedule 1 to the National Health Act 1953. These paragraphs were introduced by the Community Services and Health Legislation Act 1988.

### *Portability*

The National Health Act 1953 governs Health Funds and provides for *portability* between Funds[4]. That is, once a Health Fund member has served a waiting period with one Health Fund, they are not required to serve another waiting period, should they elect to change insurers, with the proviso that the level of private health insurance cover remains the same. However, the wording concerning *portability* in the National Health Act is unclear and subject to differing legal interpretations.

The Private Health Insurance Ombudsman (PHIO) has acknowledged that it is probable that the wording of the legislation does not prohibit the imposition of waiting periods for Hospital Purchaser Provider Agreement Benefits in some transfer situations. The PHIO has also stated that:

> *It is my view, following appropriate research and discussions that the intent of the drafters and the legislators was to prohibit the imposition of waiting periods in such circumstances.*[5]

This uncertain legal situation has permitted several private health insurance funds to undermine the meaning of the portability legislation. In the most recent and concerning case, the Australian Government, Department of Health and Ageing (DoHA) approved an application from the Health Fund, Australian Unity, to impose a twelve-month limitation for benefits only for *psychiatric* and *rehabilitation* services. This meant that consumers of private psychiatric services transferring to Australian Unity would have their benefits paid at the default level, which would leave the consumer with significant out-of-pocket expenses, regardless of the level of their private health insurance cover.

While the PHIO is concerned about the current *portability* situation, they have been advised that they are powerless to act, as the DoHA is entitled to approve changes such as those sought by Australian Unity. The National Network has tried several times to have this issue addressed by DoHA. The Department has advised that the whole issue of *portability* is under review and that it is not currently in a position to make a decision. The review has been on-going for over a year.

Though concerns about the restrictions on *portability* have been raised by the National Network and the Mental Health Council of Australia, nothing has been done. This is despite public reassurances of the Minister for Health and Ageing, The Hon. Mr Tony Abbott MP, that this would be addressed. This matter must be resolved to protect Australians against discriminatory practices.

### *Exclusionary health insurance products*

Health Funds are allowed by law to offer a product that excludes benefits being paid for certain types of procedures. Common ones include products targeted towards the young, which exclude certain cardiac procedures or hip and knee replacements. The problem is that it is difficult, if not impossible, to accurately assess one's risk of contracting a particular condition or suffering a particular injury. Health Funds are prohibited, by law, from excluding payment of benefits for mental health services. They are, however, allowed to pay only a basic rate for some services. The default rate can be $150 to $200 per day below the actual service cost.

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5 Private Health Insurance Ombudsman (2000), *A Review of Portability Arrangements for Private Health Insurance*, Australian Government Department of Health and Ageing under Circular, HBF 688 PH 428.

Health insurance products are complicated and consumers and their carers find it difficult to ascertain exactly what their private health insurance fund will or will not pay for, and whether or not their Health Fund will pay for the full range of services in a particular private hospital.

***Limitations***

A few Health Funds have also been applying *limitations* to the number of occasions of a service that they will fully fund in a calendar year.

***Co-payments***

The introduction of *co-payments* for persons attending Day Program activities has been done without any recognition of the patient's prior membership of the Health Fund. This places a large cost-burden upon the person with a chronic illness.

***Disputes***

Health Funds contract with Hospitals for the level of benefits paid for services and this contractual environment is generally highly commercially competitive, with constant breakdowns in negotiations. The d*isputes*, which arise between hospital service providers and Health Funds can cause great distress to consumers and their carers. In some cases, the consumer is forced to find a new treating psychiatrist, because they do not have visiting rights to the private hospital that is the subject of the dispute.

If Health Funds continue to be allowed to sidestep some of their prudential obligations, then over time consumers will terminate their private health insurance, putting even more pressure upon the public mental health system.

**RECOMMENDATION 1**

**That the necessary steps be undertaken to amend the section of the *National Health Act 1953*, which governs private health insurance, to ensure *portability* between private health insurance funds. The amendments must ensure that once a private health insurance fund member has served a waiting period with one private health insurance fund, they are <u>not</u> required to serve another waiting period, should they elect to change their health insurer on the same level of cover.**

# 7 PRIMARY CARERS - INCLUSION

The role, adequacy of education, and support for primary carers in private sector settings is not currently supported to the extent it should be. Any programs provided by private hospitals with psychiatric beds aimed at educating and supporting carers, are not financially recognised by private health insurance funds. Hospitals providing this type of program do so at the expense of that facility. The result is that access to this type of education and support is either very limited or non-existent in private psychiatric hospital settings.

## 7.1 General Practitioners (GP(s)) as carers

The role of the GP is important to note here. Because of the non-existence of case workers, or case managers, upon discharge from acute inpatient settings in the private sector (other than the 12 of the 46 private psychiatric hospitals that offer Australian Government approved Outreach services), GPs often finds themselves being required to fulfil the role of a *type* of carer.

Mental illness and the provision of care by primary health care services is gaining greater significance and Australian Government support. Many privately insured consumers do not have access to a multi-disciplinary team, case manager or community services. While GPs attempt to fill that gap, their links to psychiatric services are limited, and with busy practices they do not have the time to take on this extra workload. While many health issues are complex and need specialist ongoing intervention, the role that GPs play is crucial for private sector consumers and their family carers.

## 7.2 The role of primary carers

The National Network feels the Terms of Reference do not adequately address the indispensable role of carers in the provision of mental health services in Australia. In this context, **a primary carer** may be defined as a family member, partner, friend, neighbour, or paid helper, who regularly cares for a person with a mental illness. According to the National Mental Health Strategy:

> *...consumer and carer input is essential if improvements in service delivery are to be achieved.*

Clearly, the Strategy recognises that carers are one of the key stakeholders in mental health. Yet, in practice, the role of the carer in service delivery is often ignored, rejected or seriously undervalued. In some cases, this appears to be a response to the requirement that consumer privacy be protected. Whether this is a pretext, or a reality, is debatable. The carer's rights are not observed nearly so assiduously. This has particular significance when the consumers are young people who are still the financial and psychological responsibility of their parents. Issues identified by carers that would help to reduce tokenistic interaction between carers, consumers and health professionals, and give due recognition to the fundamental role of carers in service delivery, include the following.

- The indispensable role of carers and their contribution to the wellbeing of consumers must be officially acknowledged.
- Carers should be consulted and have real input, where appropriate, in the formulation of patient treatment plans, including admission, medication requirements, patient progress and discharge.
- Carers require greater access to health professionals including doctors, psychologists and primary nurses, when the person they are caring for is hospitalised. Greater utilisation of their knowledge of consumers and their 'lived experiences' is also needed.
- Carers need substantially more educational opportunities for gaining the information and skills necessary for self-care and utilising community resources, especially support groups and crisis services.
- The lack of support groups for carers in rural areas remains a pressing issue.
- It is imperative that there be financial support for geographically isolated carers in order to meet travel and accommodation costs when patients are admitted to urban hospitals.
- There should be funding of respite for carers, as well as for consumers.
- Legalistic information, such as privacy guidelines and requirements for becoming a full-time carer and/or power of attorney, should be made more readily available to carers.

- In the light of their diverse and demanding responsibilities, it is clear that *full-time* carers require a much higher level of remuneration than they currently receive.
- A more committed education campaign to destigmatise mental illness, especially in rural areas, would benefit carers as well as consumers in terms of relationships with family members, friends, and the general community.

**Recommendation 2**

**That the *Carer Allowance* be reviewed, as a matter of urgency, to enable those people caring for someone with a mental illness to be eligible for the Allowance (currently, Carers are not eligible because of the nature of the illness and requirements of the Carers Allowance). The amount paid under the Carer Allowance also needs to be reviewed, as the current amount is manifestly inadequate to sustain Carers in their full-time caring role.**

# 8 AVAILABILITY OF SERVICES ACROSS THE CONTINUUM OF CARE – IMPLICATIONS

The Australian public mental health sector provides a range of services that include intensive case management, crisis teams, mobile community teams and after hours care. The National Network is not aware of respite care provision. The private mental health sector has some way to go in being able to provide similar services.

The National Network brings to the attention of the Senate Select Committee on Mental Health the *Guidelines for determining benefits for health insurance purposes for private patient hospital-based mental health care*.[6]

The Guidelines appear at **Appendix A** to this Submission.

The Guidelines are intended to assist Health Funds when approving psychiatric care programs for the purpose of paying private health insurance benefits. They cover the range of services that can be delivered by private hospitals with psychiatric beds. As such they provide an excellent guide to the kind of services that *should* be provided across the continuum of care. In reality, many of the services identified in the Guidelines are not necessarily available in all private hospital-based settings. For example, approved Outreach services are limited to only 12 of 46 facilities, there are no ***dedicated*** after hours crisis services, and respite care is non-existent. Ideally, if the full range of services were provided, then consumers and their carers would indeed have a true continuum of care incorporating a number of different services that could be provided in a variety of settings. Health Funds have difficulty in appropriating funding for these specific services. There needs to be an appreciable shift, including regulatory or legislative changes, to enable funding models to be developed to support these types of services, which are currently denied private sector consumers and their carers.

The Guidelines state:

> *It is recognised that people with a mental illness, or mental disorder ideally require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care.*

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6 Commonwealth Department of Health and Ageing Circular, HBF 694 PH 433, *Guidelines for determining benefits for health insurance purposes for private patient hospital-based mental health care.*

*There should be a range of specialist treatment and support services available for patients. Funding for some of these services will be provided by health funds, while other services will be funded through the CMBS, the Australian Government, State and Territory and Local Governments, other funders, and by the patients themselves.*

*The continuum of care may include the following.*

- *Early intervention*
- *Crisis assessment*
- *Domiciliary/community care*
- *Outpatient services*
- *Day, half-day, partial-day and evening services*
- *Hospital programs*
- *Admitted overnight services, where necessary*
- *Maintenance and supportive care*
- *Patient and carer education*
- *Preventative care*
- *Discharge Planning*

Additionally, the Guidelines call for care delivery as follows:

*Care delivery should, where applicable to private patients, meet the principles for guiding the delivery of care as recommended by the National Standards for Mental Health Services*[7]*, and should include the following.*

*Choice, and access to a range of treatment options in consultation with the patient and, where appropriate, their family or carer(s).*

- *Social, cultural and developmental context, meeting social and cultural values, beliefs and practices.*
- *Continuous and coordinated care delivered via a range of services across a variety of care settings.*
- *Comprehensive individualised care, access to treatment and support services able to meet specific needs during the various stages of the individual's illness.*
- *Treatment in the most facilitative environment.*
- *Care, which is documented and transparent, for example, through the use of Clinical Care Pathways and Clinical Practice Guidelines.*[8]
- *Priority given to the most appropriate effective and cost–effective treatment options."*

Whilst these Guidelines provide guiding principles, there is no requirement for private hospitals with psychiatric beds, nor private health insurance funds, to implement them as part of their contractual arrangements under their Hospital Purchaser Provider Agreements. The Guidelines are also not recognised by the authorised accreditation agencies in Australia, as part of the accreditation processes. No reference is made to the

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7 Commonwealth of Australia (1997), *National Standards for Mental Health Services endorsed by the AHMAC National Mental Health Working Group December 1996, National Mental Health Strategy*.

8 Clinical Practice Guidelines (CPGs) are systematically developed statements intended to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. Their main purpose is to improve health outcomes for patients by improving the practice of clinicians. As they become available, CPGs for psychiatric disorders are placed on the internet at http://www.ranzcp.org.

Guidelines in the Australian Government's National Standards for Mental Health Services.

After much consideration, the National Network believes these Guidelines represent current best practice for private sector mental health services. As guidelines, however, they lack the ability to have any real impact on the sector. There is no requirement on hospitals and health funds to demonstrate that the best practice articulated in the Guidelines, is actually being followed.

**RECOMMENDATION 3**

**That the *Guidelines for determining benefits for health insurance purposes for private patient hospital-based mental health care* be strengthened to ensure that mental health services provided in private hospitals with psychiatric beds comply with the Guidelines. Compliance with the Guidelines should also be a requirement of approved accreditation authorities in Australia.**

# 9 USE OF LOW DOSE ATYPICAL ANTI-PSYCHOTIC MEDICATION IN THE PRIVATE MENTAL HEALTH SECTOR

Apart from patients with a diagnosis of schizophrenia, and very recent approval for maintenance use for Bipolar 1 Disorder, the new atypical anti-psychotics are not approved under the Pharmaceutical Benefits Schedule to be used for any other conditions in private practice.

There is strong evidence that these medications can be used in low doses to very usefully treat other disorders, particularly mood disorders. Currently, psychiatrists working in the public hospital system are able to prescribe these medications for disorders other than schizophrenia and bi-polar 1 disorder. Psychiatrists in private practice, however, are not. This effectively prohibits them from providing evidence-based best practice for a great many of their patients. This is a bureaucratic decision based entirely on cost. There is a strong argument for the Senate Select Committee to investigate and correct this anomaly.

**RECOMMENDATION 4**

**That the urgent changes to the Pharmaceutical Benefits Schedule are required to enable psychiatrists in private practice to prescribe atypical anti-psychotic medication to treat disorders other than schizophrenia and Bipolar 1 Disorder.**

# 10 INTEGRATION – OPTIMAL OUTCOMES

## 10.1 Integration between psychiatrists and GPs

There is a commonality of purpose between GPs and psychiatrists – they are providing a service to the same individual. It follows that there is a need for effective communication between the two providers so that service delivery is seamless, coherent and cohesive. Such holistic care optimizes health outcomes. The National Network strongly supports the new MBS Items *291 Referred patient assessment and management* and *293 Review of referred patient assessment and management*. These Items ensure there is a written management plan provided to the GP and to the patient. The aim is for GPs to be able to manage patients, particularly those with high prevalence conditions, such as depression and anxiety, on their own. It is anticipated that this will enable

psychiatrists to concentrate on those people with complex needs who require specialist management, such as schizophrenia, bipolar disorders, treatment resistant conditions, or difficult personality problems.

## 10.2 Integration between public and private mental health sectors

Integration and partnerships between public and private mental health services and the ability of consumers to traverse seamlessly between settings is required if optimal outcomes are to be achieved. For example, a person may be admitted to the public sector setting during an acute exacerbation of their illness under the care of a multidisciplinary team. When discharged, they return to their treating psychiatrist in private sector office-based practice setting. Whilst this appears to be an ideal situation, the facts are that once the consumer enters the public mental health sector, there is very little, if any, consultation with their treating private psychiatrist. Medication regimes are often changed, treatments altered, and discharges occur without the private psychiatrist being aware of such changes. This represents the norm rather than isolated incidences. In these cases, there is a communication breakdown between sectors, and this needs to be addressed.

Unfortunately, despite the efforts made under the National Mental Health Strategy, it seems that Federal, State and Territory Governments continue to fail to recognise that the private mental health system actually exists, other than the work being done by consultant or visiting private psychiatrists who are an integral component of the public mental health sector. There are areas where the public sector has expertise that is lacking in the private sector. Community mental health nurses give public sector consumers better support and comprehensive care, once in the system, the problem is in accessing these services in the first place. The public system also has multi-disciplinary teams that provide intensive case management that the private sector lacks.

## 10.3 Integration between consumers, their carers, and service providers

A consumer's 'lived experience' together with a service providers 'clinical experience', forms a powerful combination. This therapeutic relationship, sometimes lasts for several years, producing enhanced outcomes, unique to health care. The National Network believes the importance of this therapeutic relationship is misunderstood and undervalued by Governments and policy makers.

As discussed previously in *Section 7, Sub-section 7.2 – The role of primary carers***,** carers are all too often prohibited from inclusion in many services. Outcomes can only improve if, with the consumer's permission, carers are integrated more into the care delivery.

## 10.4 Integration between rural and remote communities and mental health services

People needing mental health services in rural and remote areas of Australia are severely disadvantaged due to the unavailability of services, outside major metropolitan centres. Metropolitan centres concentrate on provision of services to locally accessible consumers and are not able to consider the provision of support outside of that area. Resources are too stretched to undertake this development and to reach out to the isolated. The result is often that the first point of call for someone in crisis is the GP, ambulance, or police. There is an argument that these providers should have a higher level of training in the management of people suffering from a mental illness than their city counterparts.

Greater integration of urban-based psychiatrists and rural-based GPs, consumers and their carers can be achieved by use of the new e-technologies such as telepsychiatry.

This is already under way in the private sector, but to a limited extent. Federal, State and Territory Governments need to take responsibility and put in place the necessary measures to enable the provision of this type of service more broadly.

Urban-based providers in the private sector should encourage their consumers and carers in rural and remote communities to make greater use of government, non-government, community mental health services, resources and support groups where available. It must be acknowledged, however, that heightened stigma in rural and remote communities remains an obstacle to the utilisation of mental health services partly due to the size of the communities and the close association people have with each other in social, community and employment situations.

### 10.5 Integration between psychologists and hospital-based care

There is a need for greater integration of psychologists into the private psychiatric hospital setting. Psychologists 'value add' to service provision, particularly in behavioral focused therapies. Psychologists play a far greater role in service delivery in the public sector than they do in the private sector.

The main avenue for private sector consumers to access psychologists is through those in private practice. The cost of these services are prohibitive ($120-$150 per one hour session) and unless consumers contribute to high cost, top cover benefits tables of private health insurance funds, they pay for these services themselves. This is no longer appropriate, and the Australian Government needs to take responsibility and address this situation.

### 10.6 Integration between Ambulance and Police Services

There is a need for ambulance and police services to be better integrated including better understanding of the unique situations that mentally ill consumers, and their families sometimes face. The sad reality is that there are situations when police are the first port of call in mental health related crisis. These have been widely, sensationally and adversely publicised in the media. These situations are far from satisfactory for the consumer, for their family, or for the officers concerned. Better use of public sector mobile acute crisis mental health teams, or greater role for the ambulance services, is required in these circumstances.

## 11 EDUCATION AND TRAINING

*Education* is the key to long-term, sustained reform of community attitudes to mental illness. The promotion of mental health is critical in arousing interest in specific issues, whilst education is targeting longer-term knowledge and learning goals. Education needs to have a strong mental health focus in the education of medical practitioners, nurses, therapists, the media, and the community.

Adequacy of *training* should have a national measure that can be judged by service users and their carers. Having a training strategy as part of the National Mental Health Plan that focuses on consumer and carer participation is essential if service provision is to be delivered in the most effective, cost efficient manner.

The Senate Committee's Terms of Reference have identified key target audiences for education programs, which should also include programs reaching out to our ethnic communities. For many non-English speaking communities, mental illness is a "closed" or taboo subject. Avenues for identifying the mental health needs of these communities should be deemed a priority.

The National Network supports efforts of organisations, such as *beyondblue*, *Mental Illness Education Australia* and *Mindmatters*, in the education of youth concerning mental health and mental illness.

### 11.1 The health and teaching professions

Teacher training should be reviewed to ensure it includes an appropriate mental health module with professional updates provided during the career path of the teacher. Such a module should include input from mental health professionals, as well as mental health consumers and their carers. Often people in recovery from a mental illness can share their lived experiences with others. That experience and knowledge should be used.

Education should aim at destigmatising mental illness and at demystifying it. The more it is spoken about, the more it moves to acceptance and the less it is feared. The Australian mental health system needs to make education one of its central planks.

### 11.2 Consumers of private mental health services

The National Network supports efforts to identify what training needs might be most appropriate for consumers, especially upon discharge from the private mental health sector. Encouragement of those with mental health issues to pursue careers in the mental health sector is very important for they have a unique understanding and a compassionate perspective. Training is also required for consumers and their carers as their advocacy in service provision increases.

For a number of consumers, basic budgeting skills, seeking some type of meaningful employment, conflict resolution skills and communication skills, can assist them to achieve their full personal potential.

### 11.3 Carers of people receiving treatment and care in private sector settings

Many of the same, or similar issues also refer to carers. Caring for a person with chronic, whole-of-life mental illness brings with it many challenges.

Additionally, the role of training needs to provide clinical as well as advocacy, referral, social and support skills for primary carers. Carers should have input into the training priorities of health providers to give a balanced approach to treatment plans and other areas, which affect the person they care for.

The critical role of carers needs to be acknowledged in all admission, treatment and discharge processes, in office-based psychiatry, and all relevant committees.

**Recommendation 5**

**That there be greater collaboration between the health and education systems to effect significant changes in mental health education and training, including curriculum reform in the school and tertiary sectors; combined training programs for health professionals, consumers and their carers; and the development of more resources to reduce stigma and discrimination in the mental health sector.**

## 12 CONSUMER AND CARER PARTICIPATION IN THE PRIVATE MENTAL HEALTH SECTOR

### 12.1 The last 10 years

Progress with delivery of mental health services in Australia is well documented. The establishment and focus of the initial National Mental Health Strategy was clearly to

improve the quality of mental health service delivery in Australia. A central platform was the realisation that consumer and carer input was essential, if improvements to service delivery were to be achieved.

The rights of public sector consumers and their carers have been significantly promoted over the last ten years due to the affirmative action afforded them by the Strategy. The Strategy focussed primarily on the public sector with the input from consumers and their carers drawn largely from those with experience in public sector services.

The first National Mental Health Strategy came to an end in mid-1998. The second National Mental Health Plan, as endorsed by Health Ministers, proposed a focus for partnerships in service reform. Given this focus on partnerships, it was crucial that mechanisms be developed to facilitate the participation of private sector consumers and their carers in these processes.

## 12.2 Is it meaningful?

In terms of how this has progressed, it would be fair to say that consumer and carer participation is, as a general rule, still needing urgent and substantial development, by stakeholders involved in the funding and provision of treatment and care in private mental health settings. This includes significant changes in attitude toward meaningful participation.

Particular emphasis must be placed on the commercial, or for-profit, context in which the private mental health sector operates. The National Network believes that this commercial requirement severely limits meaningful consumer and carer participation in service delivery processes. Policy and planning input at the hospital level is very limited or non-existent, including participation and involvement in the education, recruitment and training of staff. Whereas the public mental health sector has embraced this involvement, there is a very long way to go in the private sector. In practice, almost all consumer and carer participation in policy and planning at the hospital level is restricted at this time.

In most private psychiatric hospitals the task of fostering consumer and carer participation is the responsibility of a few individuals, rather than all staff acknowledging that they have a responsibility to encourage meaningful consumer and carer participation. More in-service education, including consumers and their carers as educators, is urgently required to overcome tokenistic staff support for their participation, and to assist in the formulation of a more comprehensive definition of consumer and carer participation.

The promotion of recovery-focussed care through consumer and carer involvement, peer support, and consumer-operated services, are the ultimate goals. The sad reality is that only a very small number of private hospitals with psychiatric beds try to involve consumers and their carers in recovery-focussed care and peer support. Indeed, one hospital provider denied the request by their Consumer and Carer Advisory Committee to provide peer support because of fear of litigation against their organisation. Fear of litigation is a real and serious obstacle to consumer and carer participation.

The National Network is not aware of any private mental health facility that encompasses consumer-operated services within its organisation. Of course, consumers and their carers have access to support services operated by non-government organisations, but these are not truly consumer-operated services.

Regarding private health insurance funds, as far as the National Network can establish, it would appear that there is no mental health consumer or carer participation in policy, planning and decision-making processes of these organisations.

**RECOMMENDATION 6**
**That to overcome barriers to meaningful consumer and carer participation, all organisations involved in the funding and delivery of treatment and care in the private mental health sector should:**

**(b) implement appropriate in-service education, that includes consumers and their carers as educators; and**

**(c) formulate and adopt a comprehensive definition of consumer and carer participation for their organisations.**

# 13 National Standards for Mental Health Services

In terms of continuous quality improvement in the private sector, a very small number of private sector mental health consumers are now participating in external accreditation review teams, with no carer representation in these processes. There is a serious need to increase awareness and understanding of the *National Standards for Mental Health Services* (NSMHS) amongst both hospital providers and consumer and carer representatives.

The current situation of accreditation by private hospitals with psychiatric beds against the NSMHS in the private mental health sector is entirely voluntary. At the date of this Submission, only 4 of the 46 private hospitals with psychiatric beds have undertaken an *In-depth Review* of their services against the NSMHS. The NSMHS were originally designed for application to public mental health services and endorsed by the Australian Health Ministers Advisory Council, National Mental Health Working Group in December 1996.

The NSMHS, at present, include some criterion, which are not applicable and do not reflect, how services are delivered in private hospitals with psychiatric beds. A review process for the NSMHS is urgently required to make them applicable to **both** the public and private sectors. This is extremely important in the private sector to ensure consumers get the best possible treatment which can be benchmarked and open to scrutiny by all stakeholders.

**RECOMMENDATION 7**

**That the *National Standards for Mental Health Services* be reviewed, as a matter of urgency, to ensure their proper implementation by mental health services in both the public and private sectors. Private sector mental health consumers and their carers must be included in the Standards review process.**

# 14 THE REMAINING TERMS OF REFERENCE AS THEY APPLY TO THE PRIVATE MENTAL HEALTH SECTOR

**(a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;**

As mentioned previously, the *National Mental Health Strategy 1992-1998* was entirely public sector focused. The private mental health sector and the consumers and their

carers were not referred to, nor were any actions taken during these years to focus on the similar issues confronting them.

The *Second National Mental Health Plan 1998-2003* was about promotion and prevention, development of partnerships in service reform, and quality and effectiveness of service delivery. The second Plan was again very strongly biased toward the public mental health sector.

Included in the Third National Mental Health Plan 2003-2008, was a strong emphasis on service responsiveness, accountability and integration in mental health care.

There is an urgent need to recognise that privately insured consumers and their carers have the right to access high quality health care, which promotes recovery, and there must be an adequate mix of services, for this to occur.

### (b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

The National Network has responded with concern, to this Term of Reference in greater detail as one of our eight priority areas in this Submission. Detailed information is contained in *Section 8, Availability of services across the continuum of care – implications.*

### (c) opportunities for improving co-ordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

*Section 10 – Integration – optimal outcomes*, of this Submission sets out in detail the need for greater integration between all parties.

We would also like to point out that for a great number of consumers, the concept of an *episode of care*, as it is referred to in this Term of Reference, translates into a continuous struggle with chronic mental illness. They are required to live this struggle moment-by-moment and day-by-day. For chronic cases, there is no notion of a singular *episode of care*.

### (d) the appropriate role of the private and non-government sectors;

We have outlined a number of pressing issues relating to the private mental health sector. These are included in the previous Sections in greater detail and have been prioritised by the National Network as issues of concern for private sector mental health consumers and their families. The Sections of this Submission relevant to this Term of reference are as follows.

*Section 6* *Private Health Insurance Funds*

*Section 7* *Primary Carers - Inclusion*

*Section 8* *Availability of Services Across the Continuum of Care – Implications*

*Section 9* *Use of Low Dose Atypical Anti-Psychotic Medication in the Private Sector*

*Section 10* *Integration - Optimal Outcomes*

*Section 11* *Education and Training*

*Section 12* *Consumer and Carer Participation in the Private Mental Health Sector*

At the Third National Forum of the SPGPPS (the private sector's peak Private Mental

health Alliance), held in 2002, over 123 Delegates gathered to consider reforming funding models to facilitate innovation in service delivery and sought to identify practical actions that are achievable in the short-term, while recognising that long-term action will be necessary to effect systemic change. Delegates included representatives from the following stakeholder groups.

- Private Hospitals
- Private Health Insurance Funds
- Psychiatrists in Private Practice
- General Practitioners
- Consumers and their carers
- Commonwealth Government

In response to the issue of mental health consumers and their carers not having a voice in private sector mental health services the Forum agreed to:

> *Enhance Consumer and Carer participation in the design, delivery and evaluation of private sector mental health services, so that Consumer and Carer participation becomes the driving force in all elements of change.*[9]

The commitment of the Australian Private Hospitals Association (APHA) and the SPGPPS to this goal led to the establishment of the National Network in August 2002. Funding support is now provided from the Australian Medical Association (AMA), The Royal Australian and New Zealand College of Psychiatrists (RANZCP), beyondblue, the APHA, and the Australian Health Insurance Association (AHIA).

The National Network has not attracted any Government funding despite the submission of a detailed project brief to the DoHA in 2001, followed by a further written submission in 2002 requesting Government support. Both requests were declined. DoHA has also declined to provide funding to support the activities of National Network in equal partnership with the AMA, RANZCP, beyondblue, APHA, and the AHIA. Under the Australian Government State Health Agreements, States receive funding from the DoHA to deliver services and some of that funding is used for the payment of full-time consumer and carer consultant positions.

The private hospital-based sector is slowly embracing the establishment of Consumer and Carer Advisory Committees or Consumer Consultants, where this participation is either voluntary, or attracts a small honorarium.

## (e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

There is a common misconception that private sector consumers and their carers are financially secure. While that may be the case for some, many people make sacrifices to pay for private health insurance, so that they can be maintained in the private mental health sector. This affords them security in knowing that access to care is far more readily accessible and timely.

As mentioned previously in this Submission, only 12 of 46 private hospitals with

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[9] Strategic Planning Group for Private Psychiatric Services (SPGPPS) *National Forum 2002, Innovative Models of Service Delivery and Funding for Private Sector Mental Health Services*, Edited Forum Proceedings, SPGPPS Secretariat, AMA Federal Office, Canberra, Australia

psychiatric beds provide approved Outreach services. These episodes of ambulatory care are paid for by private health insurance funds. Providing access to these approved Outreach services is an established way of limiting the number of inpatient admissions for chronic illnesses and disorders and reducing length of stay, if hospitalisation occurs. In effect, it is keeping people out of acute inpatient settings.

Many people who are discharged from private psychiatric hospitals, having been treated for an acute episode of their mental illness, then re-enter the "public domain". They can, therefore, experience the same difficulties in respect of access to public housing, employment and social support services.

Because they do not have a caseworker, they usually rely upon these social supports being provided in the non-government sector. In particular, persons with chronic mental illness and no, or little immediate family support are very much affected.

It must be remembered that young people can still be covered under their parents family health insurance cover until the age of 23, with most health funds.

The unmet need of consumers in supported accommodation, particularly those experiencing a mental health crisis, is often not identified as many of these services are under resourced and under staffed. Many people in this situation do not have their mental health issues identified.

**(f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;**

There are particular problems for the youth in this country. Whilst many are covered until age 23, in most cases their private health cover is paid by parents contributing to family cover under their health insurance funds. There are no support mechanisms in the private sector. Child and youth mental health services are provided entirely by the public sector.

The issues for the significant number of our non-English speaking background communities need to be recognized in this special needs group.

A recent report from the Health Insurance Commission *Hospital Statistics 2002-2003* showed that 91% of same-day drug and alcohol services were provided in the private sector.

The geographic distribution of private psychiatrists is a major problem that has resulted in a lack of services in rural and remote areas of Australia. There are very few resident private psychiatrists in the country regions of Australia. This also applies to private hospitals with psychiatric beds, which are generally located in the major capital cities. Consumers and their families are required to leave familiar surroundings and support networks, and travel to the city for treatment and hospitalization.

There is also a severe lack of support for carers of patients outside the metropolitan area. These issues have been expanded upon in *Sub-section 7.2 – The role of primary carers* of this Submission.

A lack of mental health emergency teams in rural areas exacerbates the problem of delays in treatment of an escalating illness. This situation usually results in police intervention. This is clearly not a welcomed option for any concerned.

The private sector is not well equipped to deal with complex and co-morbid conditions.

These consumers, although privately insured, often find the care they require is better provided in the public mental health sector, because of their special and complex needs. This is not ideal, as it perpetuates the drain on scarce resources and results in a public sector that is overburdened, under resourced, and only able to focus on chronic and severe mental illnesses.

The special needs of the elderly need to be noted. As people age, their financial situation declines and many struggle to meet the cost of private health insurance cover. Psychiatric illness in the elderly is often ignored when they are hospitalised for other medical or physical reasons. There is a need for early intervention in treating, for example, depression among the elderly before it becomes severe.

Access Economics has forecast that, by 2050[10], there will be a four-fold increase in the number of dementia cases. In the absence of any projected breakthrough in prevention and/or treatment of dementia, the care for these people is going to be an appreciable and additional health cost. Public policy and treatment programs need to recognise this, while at the same time recognising that the incidence of mental illness in the elderly will also be significant and will need to be responded to. A cost shifting situation must not be allowed to develop whereby funding allocated for the treatment of mental illness is shifted to fund dementia treatment and care programs.

### (g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

The National Network believe this to be a priority issue, and we have made a detailed response previously to this Term of Reference in *Section 7 – Primary carers and Sub-sections 7.1 and 7.2*, of this Submission.

### (h) the role of primary health care in promotion, prevention, early detection and chronic care management;

We believe there is limited and poor case management in the private sector, particularly in chronic case management where increasingly health funding issues are emerging. The general pathway is to discharge the consumer into the care of their GP, or an approved Outreach service (if available), for a period of time. Again, of the 46 private hospitals with psychiatric beds, only 12 have approved Outreach services.

Chronic care management is a very difficult area. Health Funds do not have the funding models in place to properly support psychiatric rehabilitation services. The National Network is currently lobbying for change in this particular area. For change to occur, there may well need to be regulatory or legislative change. The role of primary health care is discussed in more detail in *Sub-section 7.1 – General Practitioners as carers* of this Submission.

### (i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

Consumer and Carer involvement, peer support and consumer-operated services has been

[10] Access Economics, Canberra (2005), *Dementia Estimates and Projections: Australian States and Territories* for Alzheimer's Australia.

considered in more detail in *Section 12 – Consumer and Carer participation, and Sub-sections 12.1 and 12 2* of this Submission.

**(j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;**

This Term of Reference is not applicable to service provision in a private sector setting.

**(k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimizing treatment refusal and coercion;**

The National Network is concerned that the practice of detention is open to abuse, including *medication induced restraint*. Detention, when it is an alternative to proper treatment and care, is coercion. Service settings must comply with all Human Rights Instruments.

In the private sector, there are only three states, South Australia, Queensland and Western Australia in which the Mental Health Acts of these jurisdictions allow private psychiatric hospitals to detain involuntary patients. This is an area of concern for the National Network. Apart from these three jurisdictions, people with private health insurance who are involuntary admissions under their respective State or Territory Mental Health Acts, are firstly admitted and treated in the public sector (including closed wards and seclusion). There is no choice, even though they hold private health insurance. The right of these consumers to be patients, *even as detained patients* in private hospitals with psychiatric beds, is ignored. There must also be acceptance by Health Funds that this is a legitimate treatment option. Health Funds need to have in place the funding models to support this treatment option. Preliminary investigation of this issue by the SPGPPS showed the following for Queensland and South Australia.

***South Australia***

2001 180 people detained with 21 needing transfer to a closed public facility

2002 151 people detained with 10 needing transfer to a closed public facility

2003 102 people detained with 11 needing transfer to a closed public facility

2004 80 people detained with 8 needing transfer to a closed public facility

***Queensland***

2004 239 detained across the 3 metropolitan hospitals in Brisbane

Clearly, the main barriers to private hospitals being able to take involuntary patients, are the differences in Australian States and Territories Mental Health Acts. This is but one small example of the cross-jurisdictional disruption to continuity of care caused by such differences in the Mental Health Acts.

**RECOMMENDATION 8**

**That urgent review of current State and Territory Mental Health Acts be undertaken to deal with impediments, such as those that prevent involuntary admissions to appropriate settings in the private psychiatric hospital-based sector. Urgent development of one National Mental Health Act for Australia is required which will enable the removal of barriers to continuity of care between States and Territories.**

## (l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

The adequacy of the education in de-stigmatising mental illness needs constant monitoring. The National Network recalls the excellent television coverage by the Australian Government during the first National Mental Health Strategy. Funding, both federal and state, to organizations such as *beyondblue* has seen an appreciable shift in community attitudes, acceptance, de-stigmatising and normalizing mental illness, particularly depression.

Despite these initiatives, the National Network is concerned however about the continued general lack of education in the community. There is a need to promote education particularly in frontline staff engaged in disability support services, Centrelink, employment access agencies and in rural areas.

There still remains a reluctance in small rural area communities to seek the assistance of mental health services because of stigma and its impact on social and employment situations.

## (m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

There are privately insured people who rely on public support services such as public housing, Centrelink, disability support and employment services. There is a lack of cohesion between these agencies. Because of the lack of community-based case managers in the private sector, consumers are clearly disadvantaged. Case managers play an important role in assisting consumers traverse between agencies.

As mentioned previously in this Submission under *Sub-section 7.1- General practitioners as carers*, GPs often find themselves forced into this role in an attempt to assist consumers in the private sector. Clearly their assistance is limited, for a range of reasons, and this is not appropriate use of their skills or time.

## (n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

Access to the latest research is imperative, to enhance our understanding of mental health issues. It is critical funding, time and manpower, be committed to ongoing research and best practice initiatives. Through research we can achieve better mental health outcomes.

**(o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and**

As mentioned earlier, to improve the quality, availability, and utilization of information regarding private sector mental health services, the SPGPPS established an independent Centralised Data Management Service (CDMS) in 2001 to support the implementation of the *SPGPPS National Model for the Collection and Analysis of as Minimum Data Set with Outcome Measures for Private, Hospital-based, Psychiatric Services.* The National Model has put in place systems for the routine collection of clinical data to enable the relative effectiveness of various models of mental health service delivery to be evaluated across 43 of the 46 Australian private Hospitals with psychiatric beds. There is, however, a piece of the picture missing. A nationally consistent, routinely collected ***Consumer Perceptions of Care*** measure is needed. The National Network strongly supports the development and introduction of such a measure for use in the private hospital-based setting.

In *Section 13 – National Standards for Mental Health Services* of this Submission, we discuss in greater detail the urgent need to review, amend and apply these Standards to **both** the public and private sector, and to reflect current service delivery in private hospitals with psychiatric beds.

**(p) the potential for new modes of delivery of mental health care, including e-technology.**

Telepsychiatry is one way of providing care to consumers in regional and remote areas. Increasingly, private psychiatric hospitals are installing this technology, however the question remains as to who finances the set-up costs. The issue for private sector services is the lack of capital funds to allow private hospitals to install this technology.

There is real capacity in the private system for the adoption and use of e-technology. There is a good argument for the Australian Government to provide resources to cover the capital funding for this installation and ongoing availability.

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# GUIDELINES FOR DETERMINING BENEFITS FOR HEALTH INSURANCE PURPOSES FOR PRIVATE PATIENT HOSPITAL-BASED MENTAL HEALTH CARE

## PREAMBLE

The private sector provides a range of mental health care services for which benefits are payable under the Medicare Benefits Schedule. Services provided by psychiatrists in private practice attract Medicare benefits, as do those services provided in private hospitals, which also attract benefits from private health funds. In addition, overnight and admitted day-only patient services provided by private hospitals attract benefits paid by both Medicare and private health insurance funds. Funds may also pay benefits for a range of ancillary services. The remainder are people covered by other third party payers, including the Australian Government's Department of Veterans' Affairs, compensation insurers, or people who fund their own care.

In 1987, the Australian Government in consultation with health funds, private hospitals with psychiatric beds (hospitals) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP), finalised a set of *Guidelines for Determining Benefits for Psychiatric Inpatients*. The Guidelines were intended to assist health funds when approving psychiatric care programs for the purposes of health insurance benefits. These original Guidelines were distributed by the Australian Government, under cover of HBF Circular No 100, dated 8 September 1987.

In 2000, a Working Party comprising representatives of RANZCP, health funds and hospitals revised the Guidelines, in consultation with the then Commonwealth Department of Health and Aged Care (CDHAC), Private Health Industry Branch. The revised Guidelines were titled, *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital-based Psychiatric Care*. The Guidelines were endorsed by the Strategic Planning Group for Private Psychiatric Services (SPGPPS)[1] on 23 February 2001 and distributed under cover of the CDHAC HBF Circular No 694 PH 433, 5 March 2001.

The Guidelines are now reviewed on an annual basis and will assist in determining facility selection and appropriate funding levels for private health insurance purposes.

It is recognised that the Guidelines cannot be prescriptive and are intended solely to provide guidance for hospitals and health funds in the determining of health fund benefits for private patient hospital-based mental health care.

## Definition of Terms as applied in these Guidelines

| | |
|---|---|
| *Hospital–based* | Services provided to an admitted patient of a hospital participating in an approved program. |
| *Continuum of care* | The provision of the necessary range of multidisciplinary services and care that is provided across a range of settings appropriate for people with a mental illness or mental disorder. Phases of treatment include pre–admission assessment, admission, immediate assessment and intervention, continued diagnostic evaluation and refinement of treatment, clarification of treatment goals and discharge criteria, progress towards and achievement of goals, discharge, and transition to appropriate aftercare or follow up. A full continuum of care ranges from acute admitted (overnight) treatment to day hospital, outpatient, rehabilitation and |

[1] The SPGPPS is a national industry alliance comprising representatives of the RANZCP, Australian Medical Association, Royal Australian College of General Practitioners, consumers, carers, Australian Health Insurance Association, Australian Private Hospitals Association, and the Australian Government's Department of Health and Ageing, and Department of Veterans' Affairs.

community care. Care may continue through a series of phases for an individual patient.

*Mental Illness or Disorder* The term mental illness, or disorder is used in these Guidelines to refer to a diagnosed psychiatric illness, or disorder classified under either ICD-10-AM or DSM-IV-R.

## 1. PRINCIPLES

The following key principles underpin these Guidelines.

1.1. Private patients have a right to high quality private mental health services focused on symptomatic and functional recovery.

1.2. Consumer, and where appropriate, family/carer participation will be encouraged in all aspects of private mental health service provision.

1.3. Priority will be given to the most appropriate, evidence-based and cost–effective treatment options delivered in the most appropriate environment.[2]

1.4. The Guidelines support private mental health care services being delivered in accordance with a continuum of care and encourage hospitals to provide care in this manner.

1.5. Health funds and hospitals are expected to develop funding models in support of the continuum of care.

1.6. Private mental health services should comply with the following, where applicable.

- National Health Act 1953
- Health Insurance Act 1973
- Relevant State and Territory Mental Health Acts
- Australian Government Privacy Act 1998 (as amended)
- National Health Data Dictionary
- SPGPPS Glossary of Terms: Speaking a Common Language and Towards a common electronic language
- National Standards for Mental Health Services (NSMHS)
- National Practice Standards for the Mental Health Workforce (NPSMHW)
- In accordance with the NSMHS a model for data collection and analysis enabling the monitoring and evaluation of improvement in the quality of services provided by the hospital. It is strongly recommended that hospitals analyse and use such data within a collaborative framework that enables benchmarking with best practice.
- Disability Discrimination Act
- National Mental Health Policy

[2] While it is acknowledged that evidence-based practice can be applied in the majority of cases, there will be situations where evidence-based practice cannot be applied, due to the complexity of some psychiatric problems and the nature of some forms of psychotherapeutic treatment.

1.7. Both hospitals and health funds are encouraged to develop the appropriate expertise to implement these Guidelines to achieve high quality, consumer and service outcomes, in accordance with best practice.

1.8 Approval and funding of private hospital–based mental health services should ideally reflect demonstrated need for services. However, ultimate decisions remain a matter between hospitals, health funds, health fund members, and the Australian Government through its regulatory function.

1.9 Private hospital-based mental health services should actively engage in recognised quality assurance processes, including review of services against the National Standards for Mental Health Services, by an independent accreditation agency and implementation of quality assurance plans arising from such external review.

## 2. SERVICE PROVISION

It is recognised that people with a mental illness, or mental disorder ideally require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care.

There should be a range of specialist treatment and support services available for patients. Funding for some of these services will be provided by health funds, while other services will be funded through the CMBS, the Australian Government, State and Territory and Local Governments, other funders, and by the patients themselves.

Mental health services should be delivered and funded according to a continuum of care model. The continuum of care may include the following.

- Early intervention
- Crisis assessment
- Domiciliary/community care
- Outpatient services
- Day, half-day, partial-day and evening services
- Hospital programs
- Admitted overnight services, where necessary
- Maintenance and supportive care
- Patient and carer education
- Preventative care
- Discharge Planning

## 3. CARE DELIVERY

Care delivery should, where applicable to private patients, meet the principles for guiding the delivery of care as recommended by the NSMHS,[3] and should include the following.

- Choice, and access to a range of treatment options in consultation with the patient and, where appropriate, their family or carer(s).
- Social, cultural and developmental context, meeting social and cultural values, beliefs and practices.

[3] The SPGPPS has endorsed the NSMHS, where applicable, for implementation in private sector mental health services.

- Continuous and coordinated care delivered via a range of services across a variety of care settings.
- Comprehensive individualised care, access to treatment and support services able to meet specific needs during the various stages of the individual's illness.
- Treatment in the most facilitative environment.
- Care, which is documented and transparent, for example, through the use of Clinical Care Pathways and Clinical Practice Guidelines (see footnote 4).
- Priority given to the most appropriate effective and cost–effective treatment options.

## 4. CHOICE OF SETTING

The following factors need to be taken into consideration when selecting the most appropriate setting for delivery of care.

1. Patient Acuity, Level of Distress and Disability
2. Level of social support
3. Funding options
4. Evidence-Based Best Practice (see Footnote 1)

### 4.1. PATIENT ACUITY, LEVEL OF DISTRESS AND DISABILITY

Patients should have:

- a diagnosed psychiatric illness classified by either ICD-10-AM or DSM–IV-R and have a level of distress, and/or disability that demonstrably impacts on their ability to function in day-to-day living and their relationships with others; and
- require specialised intervention, treatment or support in an appropriate care setting or range of settings, with an expected measurable outcome.

It is acknowledged that early intervention, for people with a mental illness or mental disorder, is particularly important in minimising the impact of first episodes, the incidence of relapse, maximising recovery and reducing the length of hospital stay. Direct admission to an appropriate same-day program, or attendances at outpatient services (half or full-day), rather than overnight services, should be considered as an alternative to admitted patient services.

#### 4.1.1 Admitted Overnight Services

Following mental health assessment by the treating psychiatrist, level of distress and/or disability is assessed as acute, serious or severe as evidenced by, but not confined to:

- high risk of harm to self or others;
- incapacitating symptoms or distress, which may be evidenced by a highly disorganised state impacting on self care and/or physical health, including inability to comply with treatment, resulting in a need for 24 hour care;
- need to establish the nature of a serious disorder, initiate and/or stabilise complex treatment modalities, such as pharmacotherapy and Electroconvulsive Therapy (ECT);
- significant problems in initiating treatment or continuing treatment in another setting.

As patient acuity, dysfunction and available support change, the patient should, as soon as possible, be relocated to an appropriate level in the continuum of care, in consultation with the patient and, where appropriate, their family/carer.

Admitted overnight length of stay should be determined by individual patient acuity, not by length of program.

### 4.1.2 Admitted Same Day Patient and Community Services

Admitted same-day services should be the setting of choice for early intervention and when the patient exhibits a level of acuity, distress, or disability that is assessed as:

- manageable risk of harm to self or others; and
- lower indicators of severity and comorbidity than those necessitating admitted overnight stay; and
- able to comply with treatment and self care; or
- able to cope with their usual environment.

As patient acuity, distress and disability, and available supports change, the patient should, as soon as possible, be relocated to an appropriate level in the continuum of care, in consultation with the patient and, where appropriate, their family/carer(s) and with consideration of funding options.

All occasions of service must be determined on an individual basis. This may include participation in a structured program of defined interventions and duration, where it is indicated by best practice

## 5. TREATMENT AND CARE OPTIONS

At all times, in the selections of treatment options, the focus needs to be on individual needs and restoration or stabilisation of function, taking into account environmental factors for the patient, patient preferences and the patient's support systems.

Care options should include a comprehensive continuum of care model, incorporating appropriate multidisciplinary services and care across a range of settings appropriate for the patient, including access to 24-hour psychiatric emergency care, and with reference to relevant Clinical Practice Guidelines[4].

Phases of treatment include pre–admission assessment, admission, immediate assessment and intervention, continued diagnostic evaluation and refinement of treatment, clarification of treatment goals and discharge criteria, progress towards and achievement of goals, discharge, and transition to appropriate aftercare or follow up. A full continuum of care ranges from intensive admitted overnight treatment to day hospital, outpatient, rehabilitation and community care.

[4] Clinical Practice Guidelines (CPGs) are systematically developed statements intended to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. Their main purpose is to improve health outcomes for patients by improving the practice of clinicians. As they become available, CPGs for psychiatric disorders are placed on the internet at http://www.ranzcp.org.

It is expected that program modules designed to develop/increase skill levels to prevent or minimise relapses will be primarily conducted on a same-day, outpatient, half or full-day basis, where possible and clinically appropriate.

Admission, treatment and care must be under the supervision of the attending psychiatrist irrespective of care setting.

Treatment and care options based on biopsychosocial principles, should be negotiated with the patient and, where appropriate, their family/carer(s). It is acknowledged that there will be two possible scenarios:

1. the patient is able to make an informed decision regarding the involvement of their family/carer(s) in their treatment and care options; or
2. the patient is unable to make an informed decision concerning the involvement of their family/carer(s).

In the second situation, the attending psychiatrist is responsible for determining the level of involvement of family/carer(s) in the consideration of treatment and care options.

A care plan should be developed as part of the assessment process and documented prior to commencement of specialist treatment. Regular reviews of the care plan should occur at intervals appropriate to the care setting and include those members of the multidisciplinary team involved in the treatment. Care plans and reviews must always reflect the needs of the patient. and include those members of the multi-disciplinary team and appropriate and relevant families/carers.

The care plan should:

- document chosen treatment and care options;
- take into account transitions in levels of care;
- include discharge planning
- clearly state goals and outcomes. For example, detail functional improvement, and include an estimate of length/duration of treatment(s); and
- be developed collaboratively and regularly reviewed with the patient, and with the patient's informed consent, their carers and be available to them.

Care and treatment options should be selected from Evidence-based treatment choices, such as the following.

- Individual, group, family and other psychotherapies.
- Psychopharmacotherapy.
- Electroconvulsive Therapy (in accordance with guidelines of the RANZCP and the Australian and New Zealand College of Anaesthetists[5]).
- Other Evidence-based treatment modalities.
- Specific rehabilitation and education services to facilitate return of function.
- Outreach services to facilitate return of function, maintain function or prevent relapse.

[5] The Royal Australian and New Zealand College of Psychiatrists, *Guidelines on the Administration of Electroconvulsive Therapy (ECT),* can be obtained from the internet at: http://www.health.gov.au/privatehealth/providers/circulars02-03/799_528.htm

- Education, promotion, prevention and support services.

## 6. QUALITY STANDARDS

Service providers should implement appropriate quality improvement processes taking account of relevant sections of the NSMHS and the National Practice Standards for the Mental Health Workforce, including but not limited to the following.

- Accreditation by an industry recognised body.
- Demonstrated quality improvement activities.
- Ongoing collection and benchmarking of industry agreed and validated outcome measures, both patient and clinician rated.
- Data collected are stored and reported in a manner which ensures confidentiality and complies with relevant legislation and the SPGPPS National Model.
- Mechanism for clinical case review of patients.
- Ongoing peer review and/or clinical supervision as appropriate for all health professionals involved in patient care.
- Patient, family and carer participation and feedback mechanisms.
- The quality initiatives of the SPGPPS.

## 7. STAFFING LEVELS, SUPERVISION AND CONTACT HOURS

All treatment, irrespective of care setting, is to be provided by appropriately trained and qualified health professionals.

The term ***Professional*** is defined as:

(i) **Psychiatrists**

(ii) **Psychiatric Registrars**.

(iii) **Registered Nurses** with either a minimum of two years experience in psychiatry, a postgraduate qualification in psychiatry, or with a certificate from a recognised professional program approved by the relevant College of Nursing (or by its equivalent overseas or interstate body). Sixty percent (60%) of the nursing staff should meet this experience level but the desired level is 75% subject to availability of appropriately trained staff.

(iv) **Allied Health Professionals** with proven/substantiated and relevant clinical experience in direct therapy, who are registered members of their relevant professional body.

(v) **Nurse Therapists** who are registered nurses who have completed postgraduate qualifications in a specialist therapy discipline and have proven/substantiated and relevant clinical experience in direct therapy.

There must be a continuing education and development program for staff, which takes cognisance of the National Standards for Mental Health Services and National Practice Standards for the Mental Health Workforce.

All clinical staff must be credentialled by the service and participate in regular peer evaluations and reviews. Clinical case assessments must be performed where appropriate and

documented. Clinical supervision of all nursing and allied health professional staff, including nurse therapists, must be undertaken on a regular basis.

All staff must be aware of, and comply with, the obligations specified under the Privacy Act 1998 (as amended).

### 7.1 Outpatient and Community Services

Services must be delivered by appropriately trained and qualified health professionals.

### 7.2 Admitted Same-day Patient Services

Services must be delivered by appropriately trained and qualified health professionals for specific contact hours. Contact hours include:

- Participation in group therapy programs that have clearly defined clinical outcome goals
- One-to-one counselling sessions.

Contact hours should not include time allocated for meal and tea breaks, unless they are part of an eating disorders program.

**Same-day Programs – *full-day***

A minimum number of five hours of structured therapeutic contact hours per day, except where agreement has been reached for alternative arrangements.

**Same-day Programs – *half-day***

A minimum number of three hours of structured therapeutic contact per day, except where agreement has been reached for alternative arrangements.

### 7.3 Admitted Overnight Services

Services must be delivered by appropriately trained and qualified health professionals. The minimum standards for staffing for admitted overnight patient services are as follows.

a) The minimum number of professional hours per patient day will be an average of 4.2 hours per patient day over a seven (7) day period. Notwithstanding any criteria agreed in respect of individual programs, at least fifteen percent (15%) of these 4.2 professional hours will include therapy by allied health professionals with relevant experience and will exclude any psychiatrist consultation time. Registrars, medical officers and staff specialists are eligible for inclusion based on direct patient contact hours only.

b) Twenty-four hour access through a roster for consultant psychiatrists or hospital registrars/medical officers, or both are encouraged.

University affiliation and collaboration are encouraged.

## 8. FACILITIES

Facilities must be licensed by the relevant State/Territory health authority or approved as equivalent by the Australian Government Department of Health and Ageing. Licensing arrangements vary significantly from one location to another. The following minimum requirements are therefore suggested.

### 8.1 Hospitals

A hospital building or unit designed and built specifically for the purpose of providing psychiatric care, or another type of hospital building which has been converted or modified to meet the special purposes and incorporates the following.

**Therapy rooms:** There should be sufficient purpose designed rooms to cater for the needs of all admitted overnight and same-day patients, based on the **maximum** size of groups not exceeding 12 participants.

**Lounge/recreation rooms:** Properly furnished rooms and/or areas should be set aside for admitted overnight and same-day patient relaxation. Access to an outside leisure area is recommended. Private areas should also be set aside for admitted overnight to meet with relatives and friends.

**Interview rooms:** There should be an adequate number of rooms provided for use by clinicians to interview/consult with patients on a confidential basis.

**Dining rooms:** Fully equipped dining rooms should be provided adequate to meet the needs of the total service including admitted overnight and same-day patients, day patients and staff.

**ECT Facilities:** If ECT is administered, three rooms should ideally be available (pre-operative, procedure, post-operative) and should be designed to permit a direct flow of patients. Hospitals must comply with State licensing requirements for ECT where they exist. In all States guidelines for the administration of ECT are to be in accordance with those set by the Royal Australian and Australian and New Zealand College of Anaesthetists.

**Facilities for specialist programs:** Hospitals providing specialist programs, e.g. ICU, Parent/Infant Units, Alcohol Detoxification Programs must be able to demonstrate the existence of appropriate facilities and equipment. In some cases this may require the designation of specific special purpose areas within the hospital.

**Wards:** Wards should be comfortable with adequate bathroom facilities and, in shared wards, screens or curtains to ensure individual privacy for each patient

Each facility should have an appropriate number of single bed wards to permit observation and monitoring of progress.

## 9. GUIDELINES REVIEW

These Guidelines shall be reviewed on an annual basis by health funds, Service Providers, the RANZCP, and consumers and carers, in consultation with the Australian Government Department of Health and Ageing, and the SPGPPS.

These Guidelines were last reviewed in December 2003.

## 10 REFERENCES

1. Australian Health Ministers' Conference. Mental health: statement of rights and responsibilities. Canberra: AGPS, 1991.
2. Criteria for NSW Psychiatric Hospitals formulated by the NSW Joint Funds/PHA-NSW Psychiatric Working Party (1 April 1998).
3. National Practice Standards for the Mental Health Workforce

4. National Standards for Mental Health Services endorsed by the AHMAC National Mental Health Working Group December 1996. Canberra: National Mental Health Strategy, January 1997.
5. Strategic Planning Group for Private Psychiatric Services. Strategic Plan 2000–2003. Kingston, ACT: SPGPPS/AMA, September 1999.

## 11 GLOSSARY

AHMAC Australian Health Ministers' Advisory Council

AMA Australian Medical Association

NHMRC National Health and Medical Research Council

NPSMHW National Practice Standards for the Mental Health Workforce (in draft)

NSMHS National Standards for Mental Health Services

RANZCP The Royal Australian and New Zealand College of Psychiatrists

SPGPPS Strategic Planning Group for Private Psychiatric Services