PMHA | PRIVATE MENTAL HEALTH ALLIANCE

Australian Medical Association

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Australian Private Hospitals Association

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Australian Health Insurance Association

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Australian Government Department of Health and Ageing

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Private Mental Health Consumer Carer Network (Australia)

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beyondblue: the national depression initiative

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Our Newsletter

Second Edition March 2009

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- **PMHA–CDMS**
- **Guidelines for Determining Benefits**
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Our Newsletter provides a brief summary of some of the issues being progressed by our Private Mental Health Alliance, and its Centralised Data Management Service (CDMS). As such it is intended to stimulate discussion and debate concerning the delivery of mental health services in the private sector.

Our Newsletter does not necessarily represent the views of participating organisations, unless otherwise stated.

Further information on the PMHA and its CDMS can be obtained from the PMHA Website at www.pmha.com.au.

From the Chair

Philip Plummer

The theme of the Second Edition of *Our Newsletter*, deals with the area of PMHA activity that involves informing and affecting practice within the sector.

Principles for Funding Mental Health Care

We believe that any new models of mental health service delivery in the private sector should be able to be tested against criteria that provide significant incentives for the implementation of evidence–based best practice and maximise coordination between all relevant providers of health services to improve the coordination of patient care. What those criteria should be is reported on later in this Edition

PMHA's Centralised Data Management Service (PMHA–CDMS)

In this Edition, the Chair of the PMHA–CDMS Management Committee, Dr Bill Pring and the CDMS Director, Allen Morris–Yates, provide an update on:

- the provision of CDMS Standard Quarterly Reports;
- new Hospital enrolments;
- the Annual (Financial Year) Report; and
- the revision of the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital–based Psychiatric Services*.

Guidelines for Determining Benefits

PMHA is currently reviewing the *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care*.

These Guidelines assist in determining facility selection and appropriate funding levels for private health insurance purposes. The Guidelines can also be of assistance to State/Territory health authorities and their public hospitals in the treatment of Medicare and privately insured patients. The last revision was in 2007 when lot of reform was taking place. This is a good time for the review because we are beginning to better understand the impact of some of those reforms and how the Guidelines might be expanded.

Mental Health Standing Committee (MHSC)

The MHSC reports to the Australian Health Ministers' Conference through the Australian Health Ministers' Advisory Council and the Health Policy Priorities Principal Committee.

I attended the last meeting of the MHSC in Melbourne on Friday, 6 February 2009 with our PMHA Deputy Chair, Moira Munro. Together we continue to ensure the private sector view is represented in the complex range of issues on the MHSC agenda. Some of those issues are as follows.

- The revision of the National Mental Health Policy and development of the Fourth National Mental Health Plan. *Dr Bill Pring* and *Moira* represent the PMHA on the reference group overseeing this important work.
- National Comorbidity Collaboration (NCC). *Carol Turnbull* has been appointed to represent PMHA on the Collaboration.
- National Perinatal Depression Initiative Working Group. *Dr Choong–Siew Yong* has been appointed to represent PMHA on this Working Group.
- Nationally Agreed Building and Design Guidelines, *Janne McMahon* and *Carol Turnbull* represented the private sector view at the recent workshop hosted by ACT Health on the Guidelines.

KPMG Evaluation of the Better Access Initiative

We have participated in the evaluation of this Initiative being conducted by KPMG for the Australian Government. We believe that this Initiative is expanding the role of the private sector and improving access to Psychologists, GPs and allied health professionals. Our major general concern is that, at present, there is no measurement of the patient outcomes being achieved under the Initiative.

Fact Sheet Update

Our draft Fact Sheet is currently with PMHA stakeholders for discussion with their constituencies.

Philip Plummer is the PMHA Independent Chair.

Principles for Funding Private Mental Health Service Delivery

Phillip Taylor

Since our last Newsletter, the PMHA's Collaborative Care Models Working Group (CCMWG) has developed a set of principles for funding mental health service delivery in the private sector.

Issues

Some of the issues that arose in the development of the principles included the following.

- A wide range of health professionals now work in private practice and provide services outside of the traditional hospital setting in the community.
- Coordination between services and providers across both the private and public sectors should be directed at achieving an appropriate mix of mental, physical, and social support for people with a mental illness.
- The importance of reducing incentives for the provision of clinically unnecessary, or inappropriate care.
- Financial incentives should not be used to change care practices. Funding should follow an appropriate care pathway, rather than create incentives to provide care in a particular way.
- Existing and new models of funding and service delivery should be able to be evaluated from the consumer and carer perspective.

Principles

The Principles are set out below.

The development of new models of private mental health service delivery and their associated funding arrangements should meet the following criteria.

1. *Provide significant incentives for the implementation of evidence–based best practice models of service delivery.*
2. *Maximise coordination between all relevant providers of health services to improve the coordination of patient care. This includes the coordination between:*
   a) *Providers who work independently.*
   b) *Providers who work in the public sector and private sector.*
   c) *Providers of services other than health services such as housing and protective agencies.*
3. *Eliminate or significantly reduce incentives for the provision of clinically unnecessary or inappropriate use of overnight inpatient care, or any other form of hospital–based, or other psychiatric care. New models of service delivery and their associated funding arrangements should be judged on the following criteria.*
   a. *The effectiveness with which the needs of consumers and their carers are met.*
   b. *The efficiency with which the required services are able to be delivered.*
   c. *The extent to which financial risk is equitably shared between providers and payers, or is controlled by other mechanisms.*

It is acknowledged that private health insurers and other payers are not able to fund all the services that it may be desirable to have available.

Models of service delivery that clearly require increased expenditure by payers should also meet the following additional criteria.

1. *The disease, syndrome or condition for which services are to be delivered should be a recognised psychiatric condition.*
2. *The proposed model of service delivery and its constituent therapeutic interventions should be based on evidence that they represent current best–practice.*[1]

The development of new models of service delivery with associated funding arrangements are encouraged to provide appropriate funding for the implementation of evidence–based best practice models of service delivery.

1. *This does not imply that the model of service delivery or all of its components must be evidence–based in the strict sense of that term. It is acknowledged that many aspects of service delivery and certain therapeutic interventions used in psychiatry may not have a firm evidentiary base. Accordingly, this criteria specifies that services should be modelled on what can be shown to be recognised by authoritative clinical consensus to be current best practice*

To further enhance these Principles, our consumer and carer representatives are working on criteria to facilitate evaluation of models of funding and service delivery from the consumer and carer perspective.

Phillip Taylor is the PMHA Director and the current Chair of the CCMWG.

PMHA–CDMS

Dr Bill Pring and Allen Morris–Yates

As readers will know, the PMHA is responsible for oversight of the operation of the *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital–based Psychiatric Services* (National Model) and its Centralised Data Management Service (PMHA–CDMS).

Over 75% of private hospitals with psychiatric beds (Hospitals), are participating. These Hospitals are collecting two standardised measures of clinical status, one clinician–completed rating scale (HoNOS) and one patient–completed questionnaire (MHQ–14), at admission and discharge from episodes of care. Together with data collected under the Hospital Casemix Protocol (HCP), the information regarding patients' clinical status is used in the generation of aggregate statistics every quarter regarding Hospitals' workload (casemix) and the outcomes of the care provided.

Standard Quarterly Reports

Every quarter, Standard Quarterly Reports are generated by PMHA's CDMS and distributed to both Hospitals and private health insurers that pay benefits for psychiatric care (Health Insurers). There was some delay in this report delivery due to late data submission, but Reports for the 4th quarter of 2008 were distributed in February 2009.

New Enrolments

In 2008, two new Hospitals subscribed to the PMHA and its CDMS. They are:

- Essendon Private Hospital, located in Victoria
- The Marian Centre located in Western Australia.

Both hospitals have been provided with training and software set–up support.

Other Hospitals who wish to subscribe can download a copy of the enrollment procedure from the PMHA website at:

http://www.pmha.com.au/cdms/PublicDocumentss

Annual (Financial Year) Report

The delivery of an Annual Statistical Report (Report) for all stakeholders is currently in the pipeline that will promulgate information about the provision of mental health care by private hospital–based services.

In the first instance, a consultation draft of the Report will be made available to the PMHA for review. The Report will then be finalised and, with the PMHA's approval, made available to all PMHA stakeholders. Additionally, the development of this Report will help to inform the preparation of a revised edition of the National Model (see below). All PMHA stakeholders will be fully involved in this process in an open and transparent manner to ensure that both the content of the Annual Report and the preparation of a revised edition of the National Model, meet all stakeholders requirements.

Preparation of the revised edition of the National Model

The preparation of a revised edition of the National Model is underway and will involve the following key issues being addressed.

1. *The clinical classification used as the primary stratification factor for reporting will need to be revised.* Specific problems that need addressing include simplification of the existing classification, removal of classes with very low numbers; and identification of important co–morbid conditions. A discussion paper outlining the issues and options is under development.

2. *Revision of the National Model for the identification, analysis and reporting of episodes of ambulatory care.* The current Model is not meeting Hospitals and Health Insurers requirements. A discussion paper outlining the issues and options is under development.

3. *Submission of HCP data to the PMHA–CDMS by Health Insurers and Other Payers.* Currently, Hospitals that do not participate in the PMHA–CDMS account for between 20% and 25% of activity. Provision of HCP data to the PMHA–CDMS by the Australian Government would enable the PMHA–CDMS to generate more complete statistics for benchmarking and national reporting purposes.

4. *Revision of information models for Providers and Payers.* The current information model used within the data warehouse only partially accounts for changes in ownership and mergers of both Providers and Payers. A new model is under development.

Dr Bill Pring is the Chair of the PMHA–CDMS Management Committee and Allen Morris–Yates is the Director of the PMHA's CDMS.

Review of the Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care

Mr Peter Callanan

The private sector provides a range of mental health care services for which benefits are payable under the Australian Government's 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 insurers. In addition, overnight and admitted day–only patient services provided by private hospitals attract benefits paid by both Medicare and private health insurers. Insurers may also pay benefits for a range of ancillary services. The remainder are services covered by other third party payers, including the Australian Government Department of Veterans' Affairs, compensation insurers, or people who fund their own care.

The Guidelines

The *Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital–based Mental Health Care* are reviewed by the PMHA on a regular basis and assist in determining facility selection and appropriate funding levels for private health insurance purposes.

The Guidelines may also be of assistance to State/Territory health authorities and their public hospitals in the treatment of Medicare and privately insured patients.

The Guidelines are **not** intended to be prescriptive, but rather to provide guidance for hospitals and health insurers in the determining health insurance benefits for private patient hospital–based mental health care. This includes same–day, half–day, overnight and approved outreach services.

What they cover

The Guidelines currently address the following.

Service Provision

Care Delivery

Choice of Setting

Patient Acuity, Level of Distress and Disability in general, and more specifically in relation to:

- Admitted Overnight Services; and
- Admitted Same Day Patient and Community Services

Treatment and Care Options

Quality Standards

Staffing Levels, Supervision and Contact Hours for:

- Outpatient and Community Services;
- Admitted Same–day Patient Sevices;
- Same–day Programs – *full–day*;
- Same–day Programs – *half–day*;
- Admitted overnight Services; and
- Admitted Outreach Services.

Facilities, including for Hospital's:

- Therapy Rooms;
- Lounge/recreation rooms;
- Interview rooms;
- Dining Rooms;
- Electroconvulsive Therapy rooms;
- Special programs; and
- Wards.

The Guidelines also include an Addendum that addresses the assessment and recognition of alcohol and drug programs and services for hospital–based private patients.

Guideline review – how to participate.

The PMHA's Collaborative Care Models Working Group is currently reviewing the 2007 version of the Guidelines in consultation with the private sector. The Working Group believes that the Guidelines should now attempt to encompass more than private hospital–based treatment and care. A copy of the Guidelines appears at ***Appendix A*** of this Newsletter. Any comments readers might wish to make on the Guidelines would be most welcome and should be forwarded by email, before close of business on **30 April 2009**, to:

ptaylor@pmha.com.au

Mr Peter Callanan is the Director of the Commonwealth Department of Health and Ageing, Private Health Insurance Branch.

Stakeholder Round–Up

This section of *Our Newsletter* provides a brief snapshot on some of our stakeholders activities.

Australian Medical Association

Since the last Edition of this Newsletter, the AMA has expanded its consultative AMA Psychiatrist Group (AMAPG) to now include the following representatives.

Dr Choong–Siew Yong (Chair)	Dr Thomas Paterson
Dr David Alcorn	Dr Bill Pring
Professor Paul Skerritt	Dr Martin Nothling
Dr Gary Galambos	Dr Yvonne White

The formation of the AMAPG was undertaken to better involve other active AMA members in issues related to the provision of psychiatric services in the private and public sectors and the broader reforms of mental health service delivery that are underway. AMAPG is not a formal AMA committee, but rather an informal communication vehicle to seek input from members. We are hoping that this will be a useful forum for identifying key issues of concern to AMA psychiatrists and to 'road test' possible policy positions that the AMA might be considering. In the longer term, should more psychiatrists become interested in participating, then a more formalised structure will be considered.

Australian Private Hospitals Association

The Australian Private Hospitals Association (APHA) recently appointed Barbara Carney to replace Paul Mackey as the Director of Policy and Research for the APHA. After 7 years with APHA, Paul accepted a position as Director, Policy at the Pharmaceutical Society of Australia (the professional body for pharmacists). Barbara has been Head of Government Relations and Regulatory Affairs for Insurance Australia Group. She was Chief of Staff and Senior Policy Adviser to Federal Health Minister Dr Michael Wooldridge and his successor, Senator Kay Patterson. Barbara has also consulted on government relations to the telecommunications, banking and financial services sectors. In the 1980s to mid 1990s, she worked in a number of policy and program delivery roles in the Federal public sector, including the Health Department. Barbara's PhD is in political history. Barbara can be contacted as follows.

Dr Barbara Carney
Director, Policy and Research
Australian Private Hospitals Association
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Australian Health Insurance Association

The Australian Health Insurance Association Mental Health Committee (MHC) has appointed Mr Greg Kovacs to the PMHA to represent Health Insurers with Ms Helen Eriksson. Greg is the General Manager of Projects and Committees for the AHIA. Due to recent industry consolidation, membership on the MHC has declined. The AHIA is currently undertaking a drive to increase membership of the Committee.

The AHIA is strongly committed to improved outcomes for patients in the Mental Health arena, particularly in regard to the collection of outcome measures. Health Insurers believe that the collection, aggregation and benchmarking of utilisation and outcome data is one of the best ways that hospitals can demonstrate their commitment to improving the efficiency and effectiveness of services for health fund members accessing their services and receiving care. It is in the interest of a sustainable private mental health sector that private health insurance benefits are applied appropriately to meet relevant clinical needs. The AHIA commends the work conducted by Allen Morris-Yates at the CDMS and encourages the proactive use of CDMS data by all private mental health stakeholders represented on the PMHA.

Consumers and Carers

The Private Mental Health Consumer Carer Network (Australia) [Network] continues to advocate on behalf of private mental health consumers and their carers on a range of issues and in a number of national forums, including the PMHA. Two examples of recent work are set out below.

Submission to the Australian Government Department of Health and Ageing (DoHA), Private Industry Branch on the ability of health insurers to conduct pilots projects. While the Network supported health insurers conducting pilot projects, we felt that terms of two years can engender a sense of 'business as usual' for consumers, rather than participation in a pilot. We also want to see a clear outline for the conduct, scope and purpose of any pilot project. An independent formal evaluation and appropriate transitional arrangements are also critically important to consumers and carers.

Submission on the National Health and Hospitals Reform Commission, Interim Report. The Network has concerns with the option where a fund holding authority purchases services, particularly when such services usually end up capped. We also pointed out that any options for funding health services should empower consumers to make informed choices and not compromise clinical decision making.

The Network also made submissions to the *Senate Select Committee on Men's Health*, and to DoHA on both the *Primary Health Care Strategy* and the *Access to Allied Psychological Services* (ATAPS) initiative.

Australian Government

The development of a whole of government Fourth National Mental Health Plan is well underway. The *Working Group* developing the Plan has met on a number of occasions. The *Reference Group* overseeing the development of the Plan, held meetings in December 2008, January 2009 and will meet again on 31 March in Melbourne. Consultations took place in February and March and a National Forum is proposed for April to consider the draft Plan and ways forward to implementation once endorsed by Australian Health Ministers' Council. Dr Ruth Vine is the lead consultant for the development of the Plan. The Department of Health and Ageing has also contracted Bill Buckingham, Associate Professor Jane Pirkis, and Margaret Goding to assist in the reporting of consultations with Ministerial Advisory Councils and to develop the monitoring and evaluation elements of the Plan.

How to Contact Your Representatives

NOMINATING ORGANISATION	PMHA REPRESENTATIVES AND THEIR CONTACT DETAILS	
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Private Mental Health Consumer Carer Network (Australia) engage, empower, enable choice in private mental health	Ms Janne McMahon (Consumers) PO Box 542 Marden SA 5070	P: 08 8336 2378 F: 02 6273 5337 E: jmcmahon@senet.com.au
	Mrs Ruth Carson (Carers) PO Box 32 FOSTER VIC 3960	P: 03 5682 1303 F: No Fax E: r.carson@dcsi.net.au
AMA	Dr Choong–Siew Young PO Box W84 WAREEMBA NSW 2046	P: 02 9881 8888 F: 02 9881 8899 E: csyong1@mac.com
	Dr Bill Pring Delmont Consulting Rooms 300 Warrigul Road GLEN IRIS VIC 3146	P: 03 9808 5552 F: 03 9805 7372 E: bpring@ozemail.com.au
Australian Private Hospitals Association	Ms Moira Munro (Deputy Chair) Chief Executive Officer Perth Clinic 29 Havelock Street WEST PERTH WA 6005	P: 08 9488 2970 F: 08 9488 2977 E: moiram@perthclinic.com.au
	Ms Carol Turnbull Chief Executive Officer Ramsay Healthcare SA 33 – 36 Park Terrace GILBERTON SA 5081	P: 08 8269 8100 F: 08 8269 7307 E: turnbullc@ramsayhealth.com.au
AHIA	Mr Greg Kovacs General Manager (Projects & Committees) Australian Health Insurance Association Unit 17G, Level1 2 King Street DEAKIN ACT 2600	P: 02 6202 1000 F: 02 6202 1001 E: greg@ahia.org.au
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Australian Government Department of Health and Ageing	Ms Robyn Milthorpe Acting Director Monitoring and Evaluation Section Mental Health Reform Branch Department of Health and Ageing Mail Drop 23, GPO Box 9848 CANBERRA CITY ACT 2601	P: 02 6289 8374 F: 02 6289 8788 E: robyn.milthorpe@health.gov.au
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PHI 48/07

GUIDELINES FOR DETERMINING BENEFITS FOR HEALTH INSURANCE PURPOSES FOR PRIVATE PATIENT HOSPITAL BASED MENTAL HEALTH CARE (2007 EDITION)

PREAMBLE

The private sector provides a range of mental health 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 insurers. In addition, overnight and admitted day-only patient services provided by private hospitals attract benefits paid by both Medicare and private health insurers. Insurers may also pay benefits for a range of ancillary services. The remainder are services covered by other third party payers, including the Australian Government Department of Veterans' Affairs, compensation insurers, or people who fund their own care.

It is anticipated the Guidelines will be reviewed on a regular basis and will assist in determining facility selection and appropriate funding levels for private health insurance purposes. The Guidelines may also be of assistance to State/Territory health authorities and their public hospitals in the treatment of Medicare and privately insured patients.

This circular supersedes Circular PHI 18/04 issued on 7 April 2004. These latest Guidelines have been endorsed by the Private Mental Health Alliance (PMHA)[1] and it is recognised they cannot be prescriptive. The Guidelines are intended solely to provide guidance for hospitals and health insurers in determining health insurance benefits for private patient hospital-based mental health care. This includes same-day, half-day, overnight and approved outreach services.

Definition of Terms as applied in these Guidelines (2007 Edition)

Hospital-based	Hospital Treatment provided to a 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 community care. Care may continue through a series of phases for an individual patient.
*Mental Illness or Disorde*r	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] The PMHA is a national industry alliance comprising representatives of the Australian Medical Association, Royal Australian and New Zealand College of Psychiatrists, Australian Health Insurance Association, consumers, carers, Australian Private Hospitals Association and the Australian Government Department of Health and Ageing.

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 insurers 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.

- Private Health Insurance Act 2007
- National Health Act 1953
- Health Insurance Act 1973
- Relevant State and Territory Mental Health Acts
- State and Territory Private Hospital and Day Hospital Facility Licensing Acts
- Australian Government Privacy Act 1998
- Disability Discrimination Act 1992
- National Health Data Dictionary
- 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.
- National Mental Health Policy

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

1.8 Applications for funding of private hospital–based mental health services must demonstrate there is a need for such services. Decisions regarding approval and level of funding remain a matter between hospitals and health insurers, and the Australian Government through its regulatory function.

[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.

1.9 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 insurers, while other services will be funded through the Medicare Benefits Schedule, 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
- Leave as part of the process for preparing for discharge.

3. CARE DELIVERY

It is strongly recommended that hospitals, where applicable to privately insured patients, meet the principles for guiding the delivery of care as recommended by the National Standards for Mental Health Services[3] This 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).
- Reference to the patient's social, cultural and developmental context.
- 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 appropriate for the individual patient.

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

- Care provided must also be documented and transparent based on, for example, the use of Clinical Care Pathways, Clinical Practice Guidelines[4], and Clinical Notes.
- Priority must be given to the most appropriate effective and cost–effective treatment options for each individual patient.

4. CHOICE OF SETTING

The following factors need to be considered when selecting the most appropriate setting for care delivery:

- Patient acuity, level of distress and disability
- Level of social support
- Evidence-Based Best Practice. 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.

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 (half or full-day), or attendances at outpatient services, should be considered as an alternative to admitted overnight 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.

[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.

Admitted overnight length of stay should be determined by individual patient clinical need, 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 co morbidity 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.

Admitted same day services should only be provided when that treatment environment is the best for the individual patient.

5. TREATMENT AND CARE OPTIONS

At all times, in the selection 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 (see footnote 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.

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]).
- Specific post-natal mental health services where babies should usually accompany their mother during her admission.[6]
- 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.
- Education, promotion, prevention and support services.

6. QUALITY STANDARDS

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

- Recognised by the Australian Government Department of Health Ageing for private health insurance purposes

[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, Circular HBF 799 PH528 of 26 September 2002.

[6] Royal Australian and New Zealand College of Psychiatrists Position Statement #57 - Mothers, Babies and Psychiatric Inpatient Treatment.

- Licensed by a State/Territory as a Private Psychiatric Facility.
- 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 *National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital–based Psychiatric Services*.
- Mechanism for clinical case review of patients.
- Ongoing peer review and/or clinical supervision as appropriate for all health professionals involved in patient care.
- RANZCP Clinical Practice Guidelines (see Footnote 4).
- Patient, family and carer participation and feedback mechanisms.
- The quality initiatives of the PMHA.

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 and Enrolled 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) **Clinical Care Professional** appropriately trained and adequately supervised, with clearly identified and documented statement of accountabilities.

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

(vi) **Nurse Therapists** who are registered nurses and 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 credentialed 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. Therapy services provided by allied health professionals should be available seven days a week. 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.

7.4 Admitted Outreach Services

Approved Outreach Programs meet all applicable Guidelines and in addition:

- At all times, patients on such a program are there as a direct substitution for Admitted Overnight or same day care.
- Outreach Services are not a substitute for community-based care.

- It is strongly recommended that psychiatrists reassess their patients during the period that they are on an Approved Outreach Program for the appropriateness of this level of care.

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 jurisdiction to another. The following minimum requirements are strongly recommended.

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 specifically provide psychiatric care 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 patients and same-day patient's relaxation. Access to a safe outside leisure area. Private areas should also be set aside for admitted overnight patients 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 patients and same-day patients, day patients and staff.

Electroconvulsive Therapy (ECT): If ECT is administered, separate preoperative, procedure, and post-operative rooms must be available. Hospitals must comply with State and Territory licensing requirements for ECT where they exist, and the Royal Australian and New Zealand College of Anaesthetists *Guidelines for Electroconvulsive Therapy* (see footnote 5).

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, must include screens or curtains to ensure individual privacy for each patient. Each facility should have an appropriate number of single bed wards designed and positioned to permit observation and monitoring of progress of high risk patients.

9. GUIDELINES REVIEW

These Guidelines shall be reviewed on an annual basis by health insurers, service providers, the RANZCP, and consumers and carers, in consultation with the Australian Government Department of Health and Ageing, and the PMHA.

10. REFERENCES

1. National Practice Standards for the Mental Health Workforce.
2. National Standards for Mental Health Services endorsed by the AHMAC National Mental Health Working Group December 1996. Canberra: National Mental Health Strategy, January 1997.
3. National Mental Health Plan 2003-2008
4. Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011.
5. Private Health Insurance (Health Insurance Business) Rules 2007.
6. Private Health Insurance (Benefit Requirements) Rules 2007.

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
NSMHS	National Standards for Mental Health Services
PMHA	Private Mental Health Alliance
RANZCP	The Royal Australian and New Zealand College of Psychiatrists

Addendum to Guidelines

GUIDELINES FOR ASSESSMENT AND RECOGNITION OF ALCOHOL AND DRUG PROGRAMS AND SERVICES FOR HOSPITAL-BASED PRIVATE PATIENTS

1. INTRODUCTION

Data from the PMHA CDMS has shown that substance abuse and dependency is a major issue for private sector mental health services.

The following guidelines have been developed to promote evidence based practice and to assist in determining facility selection and appropriate funding levels for private health insurance.

These guidelines have been endorsed by the PMHA. They are additional to those contained in PHI 48/07 and need to be read in conjunction with them.

2. SERVICE PROVISION

Substance use and dependency services should be integrated with mental health services and funded according to a continuum of care model which specifically addresses the following:

- Assessment
- Detoxification
- Harm Minimisation
- Abstinence
- Relapse prevention
- Co morbidity

3. TREATMENT AND CARE OPTIONS

Comprehensive assessment should be undertaken. Nationally validated tools and Guidelines should be used for assessment, detoxification and treatment, where possible. Routine pathology tests should also be considered. These would include the following:

- Carbohydrate Deficient Transferrin (CDT)
- Full blood examination
- Liver Function Tests
- Urine Drug Screens

Detoxification should be undertaken in a medically controlled environment on the basis of medical assessment that takes account of the level of dependence. Following detoxification, treatment should be matched to individual needs identified as a result of comprehensive assessment.

Current evidence suggests that continued inpatient services should focus on people with co-morbid conditions or other complicating factors. Treatment for other patients should be provided in an ambulatory setting.

3.1 Alcohol

Initial screening should be undertaken using an internationally recognised tool such as the Alcohol Use Disorder Identification Test (AUDIT) to determine a patient's level of risk and the need for further assessment. In relation to assessing alcohol withdrawal, the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) should be the instrument used.

Care deliver for patients identified as requiring specific treatment for alcohol abuse or dependency should, where applicable to private patients, comply with the following Australian Government publications:

- *Guidelines for the Treatment of Alcohol Problems*
- *Alcohol Practice Guidelines for practitioners helping veterans with alcohol problems*

Recommended treatments for alcohol abuse and dependency include:

- Brief interventions
- CBT
- MET
- 12 step approaches
- Acamprosate
- Naltrexone

3.2 Cannabis and Other Psychostimulant Drugs

There are currently no validated assessment tools for monitoring the withdrawal and treatment of cannabis or other psychostimulant drugs. These tools are currently being developed and it is expected that they will be implemented and included in the Guidelines, once validated.

3.2.1 Cannabis

It is recognised that Cannabis use can hasten the early onset of symptoms and complicate and exacerbate mental disorders. Private hospital programs need to take an integrated approach to treatment.

4. STAFFING

All patients admitted should be under the care of an appropriately credentialed medical practitioner. All treatment and care should be delivered by staff with appropriate alcohol and drug qualifications and experience.