Australian Government
Department of Health and Ageing

PRIVATE HEALTH INSURANCE CIRCULAR

Medical Benefits Division
Private Health Insurance Branch
Mail Drop Point 401
GPO Box 9848 Canberra ACT 2601

PHI 44/10
12 July 2010

GUIDELINES FOR DETERMINING BENEFITS FOR HEALTH INSURANCE PURPOSES FOR PRIVATE MENTAL HEALTH CARE (2010 EDITION)

This Circular supersedes PHI Circular 48/07 - Guidelines for Determining Benefits for Health Insurance Purposes for Private Patient Hospital Based Mental Health Care (2007 Edition).

The Guidelines have been endorsed by the Private Mental Health Alliance. Details regarding the Alliance are described in the Introduction section of the Guidelines, which are attached to this Circular.

Any inquires about the application of the Guidelines may be directed to either Peter Callanan (ph 02 6289 9940) or Michael Faithfull (ph 02 6289 3539), Acute Care Division, Australian Government Department of Health and Ageing.

GUIDELINES FOR DETERMINING BENEFITS FOR HEALTH INSURANCE PURPOSES FOR PRIVATE MENTAL HEALTH CARE

2010 EDITION

TABLE OF CONTENTS

Introduction ---- 3

Principles ---- 3

Service Provision ---- 5

Private Hospital–based Services ---- 6

1. Care delivery ---- 7

2. Choice of setting ---- 7

3. Patient Acuity, Level of Distress and Disability ---- 8

    3.1. Admitted overnight services ---- 8

    3.2. Admitted same–day patient and community services ---- 9

    3.3. Community, hospital–in–the–home, and outreach type services ---- 9

4. Treatment and care options ---- 9

5. Quality standards ---- 11

6. Staffing ---- 12

    6.1. Mental Health Professionals ---- 12

    6.2. Staffing levels ---- 14

    6.3. Professional development ---- 14

    6.4. Admitted same–day patient services ---- 15

7. Facilities ---- 15

    7.1. Hospitals ---- 15

Services Provided Outside the Hospital Setting ---- 17

Guidelines Review ---- 18

References ---- 18

Glossary ---- 19

Introduction

The private sector provides a range of mental health services that are delivered by a variety of service providers and across a number of service settings including community, office and hospital–based. Payment for private mental health services and treatments is made through a variety of mechanisms including the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme, private health insurance arrangements and third party payers, including the Australian Government Department of Veterans' Affairs, compensation insurers and individuals who fund their own care.

Services provided by psychiatrists, GPs, psychologists, nurses, occupational therapists and social workers in private practice may attract Medicare benefits. Private health insurers may also pay benefits for a range of ancillary services. Overnight, admitted day only, outreach, outpatient and community patient services, provided by private hospitals, may attract benefits paid by private health insurers and third party payers, whilst the private medical practitioner component of services delivered while a patient receives hospital–based care and services, may continue to attract benefits through the MBS.

These Guidelines have been endorsed by the Private Mental Health Alliance (PMHA)[1] and were developed by the PMHA's Collaborative Care Models Working Group.[2] They include advice that is applicable, in some instances, to both the hospital–based and office–based settings.

The Guidelines cannot be prescriptive and, at present, are primarily intended to provide guidance for hospitals and health insurers in determining health insurance benefits for private patient hospital–based mental health care. This includes same–day, half–day, overnight and approved outreach services as well as community and outpatient services, where applicable.

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

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 The PMHA is a national industry alliance that resulted from the 2007 restructure of its antecedent, the Strategic Planning Group for Private Psychiatric Services (SPGPPS). This industry alliance has been operating since 1996 to address issues related to funding, classification, quality of care, outcome measurement, consumer and carer participation and related topics as they affect the private mental health sector. PMHA is currently comprised of representatives of the Australian Medical Association, Australian Health Insurance Association, Australian Private Hospitals Association, the Private Mental Health Consumer Carer Network (Australia), and the Australian Government Department of Health and Ageing, and the Department of Veterans' Affairs.

2 Since the 2007 restructure, the PMHA has been further expanded to include a Collaborative Care Models Working Group. In addition to the organisations participating on PMHA, the CCMWG includes representatives from The Royal Australian and New Zealand College of Psychiatrists, the Australian College of Mental Health Nurses, the Australian Psychological Society, the Australian Association of Social Workers, and the Australian Association of Occupational Therapists.

1.2. Private patients have the right to the Doctor of their choice

1.3 Health Insurance benefits and funding models will support the provision of high quality, evidence–based care

1.4 Consumer, carer and family participation will be included in all aspects of private mental health service provision, with the specific permission of the consumer.

1.5. Priority will be given to the most appropriate, evidence–based[3] and cost–effective treatment options delivered in the most appropriate environment.

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

1.7. Health insurers, hospitals and office–based practitioners are expected to develop funding models in support of the continuum of care.

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

- National Health Act 1953
- Health Insurance Act 1973
- Private Health Insurance Act 2007
- Disability Discrimination Act 1992
- Australian Government Privacy Act 1998
- Private Health Insurance (Accreditation) Rules 2008
- National Mental Health Policy and Plan
- National Standards for Mental Health Services (NSMHS)
- A model for data collection and analysis that enables the monitoring and evaluation of improvement in the quality of services, in accordance with the NSMHS. It is strongly recommended that such data be analysed and used within a collaborative framework that enables benchmarking with best practice.[4]
- National Health Data Dictionary
- National Practice Standards for the Mental Health Workforce
- Relevant State and Territory Mental Health Acts
- State and Territory Private Hospital and Day Hospital Facility Licensing Acts

1.9 Hospitals, Health Insurers and office–based practitioners 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.

---

3 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 National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private Hospital–based Psychiatric Services.

1.10 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 for negotiation between hospitals and health insurers, and the Australian Government through its regulatory function.

1.11 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.

1.12 University affiliation and collaboration are encouraged.

1.13 Office–based mental health services should actively engage in recognised quality assurance processes.

Service Provision

People with a mental illness or mental disorder, require access to a comprehensive range of services, with an emphasis on coordination, integration and individualised care.

Mental health services should be funded and delivered according to a continuum of care model and a range of specialist treatment and support services should be available.

Such services may include the following.

- Preventative care.
- Early intervention.
- Crisis assessment.
- Domiciliary/community care.
- Outpatient services.
- Day, half–day, partial–day and evening services.
- Hospital programs.
- Admitted overnight services.
- Maintenance and supportive care.
- Patient and carer education.
- Discharge planning.
- Leave as part of the process for preparing for discharge.
- Self management and recovery.
- Hospital treatment services provided outside the hospital setting.

Funding for some of these services will be provided by health insurers, while other services will be funded through the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme, the Australian Government, State and Territory and Local Governments, third party funders, and by the patients themselves.

Private Hospital–based Services

Section 121.5 of the *Private Health Insurance Act 2007* (Act), which commenced on 1 April 2007, describes the meaning of *hospital treatment* as follows.

(1) *Hospital treatment* is treatment (including the provision of goods and services) that:

(a) is intended to manage a disease, injury or condition; and

(b) is provided to a person:

(i) by a person who is authorised by a hospital to provide the treatment; or

(ii) under the management or control of such a person; and

(c) either:

(i) is provided at a hospital; or

(ii) is provided, or arranged, with the direct involvement of a hospital.

The Act, also provides a platform for health insurers to cover a wide range of services provided outside the hospital including hospital–substitute treatment, and programs that help their members better manage their health, such as chronic disease management programs.

Under the Act, services are classified as either *hospital treatment* or *general treatment*.

> *Hospital treatment* is defined under Section 121–5 of the Act as treatment that is intended to manage a disease, injury or condition that is provided to an insured person by a hospital, or arranged with the direct involvement of a hospital.
>
> *General treatment* is defined under Section 121–10 of the Act as treatment that is intended to manage or prevent a disease, injury or condition, and is not *hospital treatment*.

Hospital–substitute treatment is a subset of *general treatment* and is defined under Section 69–10 of the Act. It is treatment provided by a provider that is not a declared hospital, but which substitutes for an episode of hospital treatment, i.e. it is the same treatment that is usually provided by a hospital.

It is not mandatory for health insurers to cover these services. It is up to health insurers to decide the services they pay benefits for and to determine that the services provide value for money in terms of cost outlays and health outcomes for their members. Providers that wish to provide services outside of hospital must contact health insurers and establish an agreement before health insurance benefits can be paid.

1. 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.[5] 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.
- Care provided must also be documented in an individual care plan and be transparent based on, for example, the use of Clinical Care Pathways, Clinical Practice Guidelines,[6] and Clinical Notes.
- Priority must be given to the most appropriate effective and cost–effective treatment options for each individual patient.
- Evidence–based Best Practice in relation to treatment models.[7]

2. 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 in the home.
- Geographical considerations.

---

5 PMHA has endorsed the National Standards for Mental Health Services, where applicable, for implementation in private sector mental health services.

6 Clinical Practice Guidelines (or 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.

7 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.

3. Patient acuity, level of distress and disability

Patients should have:

- a diagnosed psychiatric illness classified by either ICD–10–AM or DSM–IV–TR 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, where available, should be considered as an alternative to admitted overnight patient services.

3.1 Admitted overnight services

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

- High risk of harm to self, or others.
- Incapacitating symptoms or distress. This 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.
- The need to establish the nature of a 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, his or her family/carer.

Admitted overnight length–of–stay should be determined by the patient's treating psychiatrist in accordance with individual patient clinical need and clinical best practice[8], not by length of program.

8 Clinical best practice is defined in this context as those clinical interventions that have been judged to be most effective at delivering a particular clinical outcome.

3.2 Admitted same–day patient 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 complexity 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.

3.3 Community, hospital–in–the–home, and outreach type services

Community, hospital–in–the–home and outreach type services that are provided by private hospitals should meet all applicable guidelines and be delivered by appropriately trained and qualified health professionals. Patients can receive such services as a direct substitution for admitted overnight, or admitted same–day care. It is expected that psychiatrists and hospitals will regularly communicate with each other to reassess the appropriateness of this level of care for the patient.

4. Treatment and care options

Treatment and care options should comply with any relevant clinical guidelines regarding treatment of any specific disorders (see Footnote 6).

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 with reference to relevant Clinical Practice Guidelines (see Footnote 6).

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, office–based, 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);
- 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).[9]
- Specific post–natal mental health services where babies should usually accompany their mother during her admission.[10]
- 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.
- Recovery.
- Drug and alcohol program following assessment (and treatment if necessary) by a psychiatrist.

5. 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.
- 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.

9 The Royal Australian and New Zealand College of Psychiatrists, Guidelines on the Administration of Electroconvulsive Therapy (ECT), can be obtained from their website at: http://www.ranzcp.org/resources/clinical-memoranda.html. The Australian and New Zealand College of Anaesthetists, T1 Recommendations of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthesing Locations - Interim Review 2008, are available from their website at: http://www.anzca.edu.au/resources/professional-documents/pdf/T1.pdf

10 Royal Australian and New Zealand College of Psychiatrists Position Statement #57 – Mothers, Babies and Psychiatric Inpatient Treatment.

- Ongoing peer review and/or clinical supervision as appropriate for all health professionals involved in patient care.
- RANZCP Clinical Practice Guidelines (see Footnote 6).
- Patient, family and carer participation and feedback mechanisms.
- The quality initiatives of the PMHA.

6. Staffing

All treatment, irrespective of care setting, is to be provided by appropriately trained and qualified health professionals who are registered, where registration is required in states and territories or otherwise eligible for membership of their relevant professional bodies, with substantiated and relevant clinical experience in the forms of treatment, therapy and care they provide.

It is acknowledged that the medical practitioner component (for example Psychiatrist, General Practitioner, Anaesthetist, Physician) of private hospital–based treatment is provided by a private medical practitioner operating under the MBS. The relationship between the private hospital and the private medical practitioner is not usually an employment or contractual one and is in general defined only by the credentialing process.

6.1 Mental Health Professionals

For the purpose of these Guidelines, Mental Health Professionals and their relevant training, experience, registration and accreditation, are identified as follows.[11]

Psychiatrists

Psychiatrists are medical specialists who have undergone approved training and examination processes to obtain the qualification of Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP), or its approved equivalent. Credentialing requires that a psychiatrist be fully registered in accordance with relevant Australian state, territory, or national legislation and carries appropriate medical defence insurance. There should be evidence of participation in Continuing Medical Education (CME) and an understanding by the psychiatrist to abide by the relevant bylaws of the hospital they are working in.

Psychiatric Registrars

Psychiatric Registrars are medically qualified practitioners who are approved trainees in the Royal Australian and New Zealand College of Psychiatrists Psychiatric Training Program. They must be fully registered in accordance with relevant Australian state, territory, or national legislation, comply with the bylaws of the appropriate hospital, and have an approved supervisor under the RANZCP guidelines.

11 On 1 July 2010, a new National Law, *the Health Practitioner Regulation National Law Act 2009*, came into effect to regulate 10 health professions through nationally consistent legislation. Further information can be obtained from the Australian Health Practitioner Regulation Agency (AHPRA) website at: http://www.ahpra.gov.au

Psychologists

Psychologists must be must be fully registered in accordance with relevant Australian state, territory, or national legislation, and have the knowledge, skills and experience to competently deliver psychological interventions. All Psychologists undertake at least 6 years of training to be fully registered. There are two common pathways to registration: either a four–year undergraduate degree followed by two years of supervised practice (internship), or completion of a postgraduate Masters or Doctorate degree following the four–year undergraduate qualification.

Clinical Psychologists

Clinical Psychologists must be fully registered psychologists who are eligible for membership of the Australian Psychological Society College of Clinical Psychologists. There are several pathways to eligibility. The main pathways are completion of an accredited Masters Degree in clinical psychology (or equivalent training and experience) plus additional supervised experience and professional development, or completion of an accredited professional Doctorate in clinical psychology.

Nurses

Registered and *Enrolled Nurses* and *Nurse Practitioners* are educated to practice across a broad range of health settings, including mental health, and must be registered in Australia.

Clinical Care Professionals

Clinical Care Professionals are appropriately trained and adequately supervised individuals, with clearly identified and documented statement of accountabilities.

Social Workers

Currently there is no legal registration for Social Workers in any State or Territory in Australia. However the Australian Association of Social Workers (AASW) is the standard setting body for social work and most employers require eligibility for membership of the AASW.

Social Workers are required to complete an accredited four year Bachelor of Social Work (BSW) degree or a Master of Social Work (Qualifying) (MSW) degree in order to gain entry into the profession of social work and to meet the minimum eligibility requirements for AASW membership.

An accredited *mental health social worker* is eligible to provide services under Medicare programs and is a member of the AASW who has been assessed by AASW as meeting the *Practice Standards for Mental Health Social Workers* (AASW 2008). In addition, an accredited mental health social worker is required to have a minimum of two years supervised social work practice in a mental health or related field.

Occupational Therapists

Occupational Therapists are tertiary qualified health professionals who complete a four-year undergraduate degree or a two-year post-graduate entry level masters degree, with specific training in mental health competencies.

6.2 Staffing levels

Each mental health unit/service will be staffed according to occupancy rates, the current severity of illness experienced by patients, special individual needs and age–specific needs and vulnerabilities.

Appropriately trained Mental Health Professionals will make up the majority (minimum 60%) of the staffing numbers.

Hours per patient day will be an average of 4 hours, with the aim of achieving 4.2 hours, per patient day over 7 days.

Therapy services provided by Mental Health Professionals should be available seven days a week for Admitted Overnight patients.

Twenty four hour cover for Admitted Overnight patients, through a roster for Consultant Psychiatrists, or hospital registrars/medical officers or both, are encouraged.

6.3 Professional Development

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*. It is recognised that private hospitals provide training and clinical placements for a range of students including Nurses, Allied Health and Medical.

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 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).

6.4 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 four and a half 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 two and a half hours of structured therapeutic contact per day, except where agreement has been reached for alternative arrangements.

7. 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.

7.1 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, the guidelines for ECT of the Royal Australian and New Zealand College of Psychiatrists, and those of the Australian and New Zealand College of Anaesthetists (see Footnote 9).

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.

Smoking areas Where permitted, dedicated smoking areas for patients should be functional but discourage lengthy personal interactions or individual isolation. Nicotine Replacement Therapy should be routinely offered to all patients who smoke and dedicated program/s should promote withdrawal, assist abstinence and encourage alternatives within the context of the management of their mental illness.

Services Provided Outside the Private Hospital Setting

As detailed earlier in these Guidelines, the *Private Health Insurance Act 2007* provides a platform for health insurers to cover a wide range of services provided outside the hospital including hospital–substitute treatment, and programs that help their members better manage their health (such as chronic disease management programs).

Under the Act, services are classified as either hospital treatment or general treatment. Hospital treatment is defined under Section 121–5 of the Act as treatment that is intended to manage a disease, injury or condition that is provided to an insured person by a hospital, or arranged with the direct involvement of a hospital. General treatment is defined under Section 121–10 of the Act as treatment that is intended to manage or prevent a disease, injury or condition, and is not hospital treatment.

Hospital–substitute treatment is a subset of general treatment and is defined under Section 69–10 of the Act. It is treatment provided by a provider that is not a declared hospital, but which substitutes for an episode of hospital treatment, i.e. it is the same treatment that is usually provided by a hospital.

It is not mandatory for health insurers to cover these services. It is up to health insurers to decide the services they pay benefits for and to determine that the services provide value for money in terms of cost outlays and health outcomes for their members. Providers that wish to provide services outside of hospital must contact health insurers and establish an agreement before health insurance benefits can be paid.

Given the current reforms that are taking place and the evolving nature of service provision outside of the hospital setting, the PMHA has agreed that this section of these Guidelines will be the subject of ongoing further development. In the interim, the PMHA has released a comprehensive discussion paper that sets out in more detail how the private sector is changing. Copies of the Discussion Paper are available from the PMHA website at:

http://www.pmha.com.au/pmha/Publications

Guidelines Review

These Guidelines shall be reviewed on a biennial basis by the PMHA in consultation with the following organisations.

- Australian Health Insurance Association
- Australian Private Hospitals Association Australian
- Australian Medical Association
- The Royal Australian and New Zealand College of Psychiatrists
- Australian College of Mental Health Nurses
- Australian Psychological Society
- Australian Association of Social Workers
- Association of Occupational Therapists
- Australian Government Department of Health and Ageing
- Australian Government Department of Veterans' Affairs
- Private Mental Health Consumer Carer Network (Australia)

References

1. Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–11.
2. National Mental Health Plan 2009–14.
3. National Standards for Mental Health Services.
4. National Practice Standards for the Mental Health Workforce.
5. Private Health Insurance (Health Insurance Business) Rules.
6. Private Health Insurance (Benefit Requirements) Rules.
7. Private Health Insurance (Accreditation) Rules.

Glossary

AHMAC	Australian Health Ministers' Advisory Council
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, office–based and community care. Care may continue through a series of phases for an individual patient.
Hospital–based	Hospital Treatment provided to a patient of a hospital participating in an approved program.
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.
NSMHS	National Standards for Mental Health Services
Office–based	Treatment provided to a patient by practitioners working in private practice.
PMHA	Private Mental Health Alliance
RANZCP	The Royal Australian and New Zealand College of Psychiatrists