

Mental Health Inquiry  
Productivity Commission  
GPO Box 1428, Canberra City, ACT 2601

Dear Sir/Madam

The Australian Private Hospitals Association welcomes the opportunity to make a submission to the Productivity Commission's inquiry into the social and economic benefits of improving mental health.

The private hospital sector is a significant provider of specialist mental health care for with patients with the full range of psychiatric conditions: depression and affective disorders, psychotic disorders, post-traumatic stress disorders, anxiety disorders, alcohol and substance abuse eating disorders and personality disorders.

Private psychiatric hospitals relieve pressure on public psychiatric hospitals and public community mental health services. They meet the needs of people requiring acute psychiatric care in an environment less stressful than a public psychiatric facility. They care for patients when they are too acutely unwell to be cared for in their own home and they provide services that are not otherwise available through the public health system. The attached report provides an overview of the types of service that are provided.

As employers of around 64,000 FTE staff, private hospital operators are also very much aware of the need to support their employees to deliver services in what can be both rewarding and demanding circumstances. Multidisciplinary, team-based approaches to delivering services are central to ensuring the delivery of quality care.

Private hospitals also works with around 15,000 medical specialists who are not employed by private hospitals but who have the right to admit and treat patients in the facilities by whom they have been credentialed. The private hospital sector has been pleased to work with professional bodies and medical colleges in initiatives to promote mental health and wellbeing within the medical and clinical workforce.

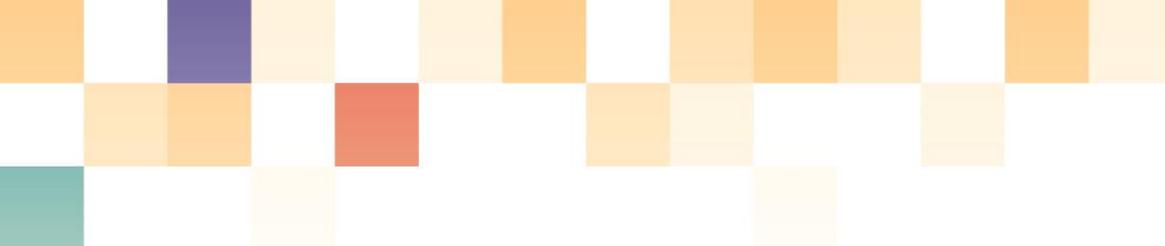
The majority of the clinical workforce within the private hospital sector is regulated by the various boards working with Australian Health Professionals Regulatory Agency and the sector is heavily dependent on this process ensuring consumers are protected from practitioners who for one reason or another might present a risk to patients. It is also important that this regulatory system works in such a way that those with mental health issues are enabled and encouraged to obtain appropriate support and treatment.

APHA would be pleased to provide any further information that might be of assistance to the Productivity Commission.

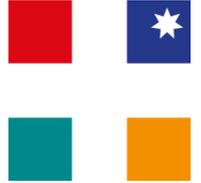
Yours sincerely



**Lucy Cheetham**  
**Director Policy and Research**  
**5 April 2019**



Australian  
**Private Hospitals**  
Association



# Improved models of care – Mental Health

25 September 2018

Australian Private Hospitals Association ABN 82 008 623 809

## Contents

Executive Summary.....	1
The role of private hospitals in mental health.....	3
Who do private hospitals treat?.....	3
Growth and Changes Over Time.....	5
What is the nature of acute psychiatric care in the private hospital sector? .....	7
Assessment .....	8
Treatment Planning and Implementation .....	8
Treatment Delivery .....	9
Overnight In-Patient Care.....	9
Ambulatory Care.....	10
Outreach Care (including Hospital-in-the Home).....	12
Efficient and effective use Private Health Insurance for people with a mental health condition .....	13
Providing access to services not otherwise available .....	13
Hospital services, complementing community and home-based care .....	14
Evidence based and accredited .....	15
Recognising Therapeutic Relationships and Responsibility for Risk .....	15
Private Hospitals in Australia .....	17
The Australian Private Hospitals Association .....	17

# Executive Summary

---

The purpose of this paper is to briefly outline some of the issues involved from APHA's perspective in ensuring that private health insurance can be used to deliver maximum value to consumers in the areas of specialist mental health.

For the purposes of this discussion, value is understood both in terms of benefit to the individual receiving care, value to private health insurance policy holders as a whole in ensuring that private health insurance remains affordable and fit for purpose and value to Australian tax payers through reduced reliance on publically funded health services. In a broader sense the timely, effective and appropriate use of specialist mental health also deliver dividends to both individuals and tax-payers as a whole to by enabling individuals to live productive lives and avoid or reduce reliance on disability and aged care services.

In this context it is important that government policy settings:

- ensure the sustainability of the private health insurance as an effective means of ensuring timely and affordable access to health care
- ensure safety and quality in the delivery of evidence based health care services
- ensure that within these constraints, markets operate to the benefit of consumers and that consumers are supported and protected from the disadvantages they face as a result of major information asymmetries.

The intent of this paper is to outline the diversity in models of care provided in the private hospital sector. It is important to note that some of the terms used including "admitted", "same-day", "in-patient", "ambulatory", "outreach", "sessional" are used elsewhere with a variety of interpretations. Terminology, usage and interpretation varies across jurisdictions and contexts. This paper will not attempt to reconcile terminology and interpretations used elsewhere with those used within this paper for the purposes of distinguishing the models described. Similarly this paper has not attempted to align the models of care in use with any particular terminology used or provisions made in the regulation of private health insurance.

APHA contends that the specialist services delivered by private hospitals in specialist mental health meet a unique and essential role in the continuum of mental health services required to meet the needs of Australians with acute psychiatric conditions. While it is clear that home-based, community-based and outreach services complement patient services delivered in or at a hospital and deliver measurable benefit to individuals, it cannot be assumed that increased funding of such services through private health insurance would directly result in a reduction in the overall outlays in psychiatric benefits.

The extent to which innovation has been constrained by regulatory factors rather than commercial imperatives is uncertain. APHA is currently giving careful consideration to the extent to which regulatory reform may be required and how best to enable well targeted, evidence based innovation without at the same time generating new sources of demand that

could frustrate the government's aim to ensure that private health insurance is both affordable and fit for purpose.

One thing is clear, private hospital operators are not adverse to change. They have shown themselves adaptable in the past and many are already actively innovating to provide community based, outreach and hospital in the home services in a variety of areas with the support of a range of payers.

Specialist mental health services currently account for less than 4 percent of private health insurance benefit outlays. Noting that timely access to each of these services significantly reduces the risk of future costs in health, disability, aged care and lost productivity, these services are clearly already playing an essential role in ensuring the efficiency of the health systems as a whole.

Future reform proposals need to be carefully evaluated to ensure that they build on the value already provided by the private hospital sector's role in mental health by ensuring that the sector is able to continue to provide evidence based care within a solid framework of good clinical governance, safety and quality.

# The role of private hospitals in mental health

---

## Who do private hospitals treat?

Private hospitals play a crucial role in treating people with severe mental disorders. Private psychiatric hospitals provide treatment to a case mix mirroring the spread of mental health disorders in the community and deliver care across the entire spectrum of mental health diagnoses from moderate to severe high prevalence disorders through to severe low prevalence disorders.

The Australian Institute of Health and Welfare (AIHW) estimates that four million people experienced a common mental disorder in 2015. Of these around 720,000 had a severe mental disorder, about 1.2 million people experienced a moderate disorder and 2.5 million people had a mild disorder<sup>1</sup>. Severe mental disorders cover a range of conditions. Around 120,000 people (based on a prevalence of 0.5 percent<sup>2</sup>) with a severe mental disorder, were living with psychotic illness – including schizophrenia, schizoaffective disorder, bipolar disorder and delusional disorder while the other 600,000 were living with a range of conditions including severe depression, severe anxiety, eating disorders, and severe personality disorders.

Of necessity public hospitals must give priority to involuntary admissions and those patients most at risk of doing immediate harm to themselves or others, consequently it is generally acknowledged that public sector services focus hospital treatment primarily on the low prevalence disorders. Public hospital psychiatric wards are often stretched to capacity and unable to meet the demand for admitted patient care. Apart from this issue of limited capacity, historical differences in case mix mean that the knowledge and skill base of public psychiatric facilities is less focused on high prevalence mood and anxiety disorders and more focused on the management of psychotic illness.

The model of care in public sector due to the nature of the patient population who often are treated under involuntary treatment orders due to lack of insight into their mental health disorder necessitates a custodial and often adversarial approach. Patients with high

---

<sup>1</sup>Mental Health Services in Australia, Australian Institute of Health and Welfare, Australian Government, Canberra, last updated 3 May 2018

<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies> Accessed 1 June 2018.

<sup>2</sup> In 2010 it was estimated that 0.5% of the population were living with a psychotic illness. People living with psychotic illness, 2010, VA Morgan et al, Australian Government, 2011 [http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/\\$file/psych10.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/717137a2f9b9fcc2ca257bf0001c118f/$file/psych10.pdf). Accessed 1 June 2018.

prevalence disorders are more likely to actively seek treatment for their mental illness. The therapeutic relationship with the treating team is more cooperative.

Due to this history, public hospitals have not developed to the same degree the knowledge and skill-base to manage non-psychotic disorders on an in-patient, ambulatory, outreach or private consultation basis. Therefore patients with moderate to severe high prevalence mental health disorders are the most common diagnoses treated in private psychiatric hospitals. In the absence of private psychiatric hospital treatment, patients suffering these mental health disorders do not have a public sector treatment alternative when they require hospitalisation.

In 2016-17, private psychiatric hospitals treated 39,328 people, just 6.5 percent of the estimated number of people living with a severe mental disorder. Of the 39,328 people in receipt of hospital based care in 2016-17, most, 29,900, received some care on an overnight basis. The following tables provide a clinical profile of this population and the severity of their mental health at the time of admission<sup>3</sup>.

**Mean Mental Health Questionnaire (MHQ-14)<sup>4</sup> Total Scores (Mean and S.D.) for episodes of overnight in-patient care by principal Mental Health Diagnostic Groups**

<b>Principal Mental Health Diagnostic Group</b>	<b>p.</b>	<b>MHQ-14 Total Score at Admission Mean (S.D.)</b>
Schizophrenia, Schizoaffective and Other Psychotic Disorders	6.1%	34 (20)
Major Affective and Other Mood Disorders	47.0%	24 (18)
Post Traumatic and Other Stress Related Disorders	10.9%	24 (17)
Anxiety Disorders	7.1%	26 (17)
Alcohol and Other Substance Use Disorders	20.6%	34 (21)
Eating Disorders	2.6%	24 (17)
Personality Disorders	3.3%	19 (15)
Other Disorders NEC	2.6%	
Total (45,048 episodes)	100%	27 (19)

---

<sup>3</sup> Private Hospital-based Psychiatric Services 1 July 2016 to 30 June 2017 Annual Statistical Report, 23 March 2018. Private psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS)

<http://www.apha.org.au/wp-content/uploads/2018/04/PPHDRAS-Annual-Statistical-Report-for-2016-2017.pdf> Accessed 1 June 2018.

<sup>4</sup> The MHQ-14 (Mental Health Questionnaire, 14 item version) is a patient self-report measure consisting of items that address symptoms of fatigue, anxiety and depression and the impact of those symptoms on social and role functioning.

**Mean Mental Health Questionnaire (MHQ-14)<sup>4</sup> Summary and Total Scores (Mean and S.D.)  
for patients at Admission to Overnight In-patient Care compared with the General  
Population**

<b>MHQ-14 summary score</b>	<b>Patients at admission</b>	<b>General Population</b>
Vitality	26 (21)	65 (20)
Social Functioning	27 (24)	85 (23)
Role Functioning	16 (31)	83 (32)
Mental Health (anxiety and depression)	34 (21)	76 (17)
Total Score	27 (19)	75 (18)

Across all summary scores and the total score patients responses at admission to overnight in-patient care put them in the lowest fifth percentile of the general population, indicating that they have very high levels of anxiety and depressed mood accompanied by very poor social and role functioning, and very low feelings of vitality.

### **Growth and Changes Over Time**

It is vital to acknowledge the magnitude of unmet need when considering access to as well as current and future utilisation of psychiatric care and treatment; the AHIW has concluded that 54 percent of people with mental illness do not access any treatment<sup>5</sup>.

The following tables have been provided by the Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS) indicating growth over time. The key point to note is that while growth in the number of people treated has fluctuated this growth is in line growth in the Australian population.

The provision of specialist psychiatric services in the private hospital sector has expanded over the last decade. This expansion reflects a growth in demand for services as seen by the increase in the number of people treated. At the same time, between 2005-06 and 2011-12, there was a marked shift in emphasis towards ambulatory care.

---

<sup>5</sup> Australian Institute of Health and Welfare (2014), Australia's Health 2014, AIHW: Canberra

<b>Financial year</b>	<b>2005-2006</b>	<b>2011-2012</b>	<b>2016-2017</b>
Number of Hospitals	44	55	65
<ul style="list-style-type: none"> <li>• Stand-alone psychiatric hospitals</li> <li>• Psychiatric units within private general hospitals</li> </ul>	25 19	28 27	32 33
Number of designated Psychiatric Beds	1,812	2,019	3,152
Number of Patients seen	20,415	29,470	39,328
Patients in receipt of any Overnight In-patient Care	16,711 (82%)	22,645 (77%)	29,900 (76%)
Days of Overnight In-patient Care (Mean and S.D.)	30 (35)	30 (30)	30 (31)
Patients in receipt of any Ambulatory Care	9,154 (45%)	15,883 (54%)	19,321 (49%)
Days of Ambulatory Care per Patient (Mean and S.D.)	13 (19)	13 (17)	13 (16)

<b>Financial year</b>	<b>2011-2012</b>	<b>2016-2017</b>	<b>% increase</b>
Number of Patients seen	29,470	39,328	33%
AU Population Estimate	22,742,475	24,598,933	8%
Treatment rate per 100,000	130	160	23%
Persons with hospital treatment cover	10,587,828	11,318,742	7%
Treatment rate per 100,000	278	347	25%

## What is the nature of acute psychiatric care in the private hospital sector?

In 2016-17, private psychiatric hospitals treated 39,328 people

- 29,900 received overnight in-patient care
- 9,893 received both overnight in-patient and ambulatory care
- 9,428 received only ambulatory care<sup>6</sup>.

Mental health conditions are as unique as the individual experiencing them. People may encounter different issues and symptoms but the benefits of a successful therapeutic treatment program are universal. Effective treatment targets key issues such as illness/symptom management strategies, medication compliance, coping skills and relapse prevention and includes working with the patient and their family/carers to identify mental health needs, planning, monitoring and reviewing care as well as developing crisis management strategies, safety plans and goals for recovery.

Treatment and care delivered in private hospitals is provided in accordance with the *Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care*<sup>7</sup> (Mental Health Guidelines).

The intent of this paper is to outline the diversity in models of care provided in the private hospital sector. Some of the terms used including “admitted”, “same-day”, “in-patient”, “ambulatory”, “outreach” are used elsewhere with a variety of interpretations. Terminology, usage and interpretation varies across jurisdictions and contexts. This paper will not attempt to reconcile terminology and interpretations used elsewhere with those used within this paper for the purposes of distinguishing the models described. Similarly this paper has not attempted to align the models of care in use with any particular terminology used or provisions made in the regulation of private health insurance.

---

<sup>6</sup> Private Hospital-based Psychiatric Services 1 July 2016 to 30 June 2017 Annual Statistical Report, 23 March 2018. Private psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS)

<http://www.apha.org.au/wp-content/uploads/2018/04/PPHDRAS-Annual-Statistical-Report-for-2016-2017.pdf> Accessed 1 June 2018.

<sup>7</sup> Private Mental Health Alliance, *Guidelines for Determining Benefits For Private Health Insurance Purposes for Private Mental Health Care*, 2015 Edition

[http://www.health.gov.au/internet/main/publishing.nsf/content/05EB674588C31EB7CA257E28001F1BBD/\\$File/Guidelines%20for%20Determining%20Benefits%202015%20Edition-Checked.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/05EB674588C31EB7CA257E28001F1BBD/$File/Guidelines%20for%20Determining%20Benefits%202015%20Edition-Checked.pdf) Accessed 14 June 2018.

## **Assessment**

The decision about which type of care is most appropriate for the patient is made by the treating psychiatrist who undertakes a thorough assessment.

Where the treating psychiatrist makes the decision to admit the patient to a private psychiatrist hospital a comprehensive assessment of the patient is undertaken. This comprehensive assessment has components performed by the treating psychiatrist and also members of the hospital's mental health team. It is informed by information gathered from the patient and where appropriate the patient's family and carers, as well as clinician and patient rated clinical outcome measures. It may also include material provided by other medical experts, allied health professionals and health care providers. The assessment assists the treating psychiatrist and mental health team to develop the most appropriate treatment and care plan that can assist the patient in their recovery. Assessment is made of the patient's:

- current mental state and life circumstances
- mental state examination and cognitive status
- risk of harm to self or others
- family history, past mental health history and forensic history
- physical health and past medical history including medication history
- alcohol and drug use
- personal and social history
- social situation
- strength and goal

## **Treatment Planning and Implementation**

Treatment and care is directed by the patient's treating psychiatrist and informed by an ongoing assessment process.

In the event that the treating psychiatrist makes the clinical decision that the patient is in need of care beyond his/her specialist psychiatric consultations, the treating psychiatrist will direct and manage an episode of treatment and care in collaboration with the patient and a hospital's mental health treating team. The assessment assists the treating psychiatrist and mental health team to develop the patient's treatment, care planning and recovery.

Psychiatric treatment aims to:

- ameliorate symptoms,
- actively manage and respond to clinical risk
- promote social, domestic, academic and occupational functioning,
- improve quality of life, and
- promote positive mental health behaviours ie exercise, good nutrition, socialisation/community reintegration, manage substance use, meaningful/purposeful activity, promote hobbies and interests

Effective goal and recovery oriented therapeutic treatments may be delivered in a variety of care settings including overnight in-patient, ambulatory, private consultations and the community and depending on the patients individual needs therapy may be provided on an individual (one-to-one) basis, within a group or using a combination of the two.

All therapeutic treatments provide supported recovery designed to assist patients to:

- manage and improve their mental health,
- recover in a supportive safe environment,
- feel motivated about their treatment,
- share similar experiences and feel less alone,
- face personal difficulties and challenges,
- develop improved motivation, social engagement and symptom management, and
- identify early warning signs and develop strategies to prevent relapse

### **Treatment Delivery**

The treating psychiatrist continually assesses which setting of psychiatric care is safe and most appropriate for the patient and may use a combination of treatments across overnight in-patient, ambulatory, private consultation and community settings.

Therapeutic treatments are delivered by multidisciplinary teams that may include the private treating psychiatrist, psychiatry registrars, nurses, allied health professionals (psychologists, mental health occupational therapists) mental health social workers, exercise physiologists, drug and alcohol counsellors, music therapists, art therapists, diversional therapists and peer support workers. Teams are both multi and interdisciplinary in nature and may also draw on expertise from a range of other supporting clinicians and providers from pharmacists, dietitians, gym, yoga and tai chi instructors through to community support organisations.

In conjunction with specialist evidence-based therapies, some psychiatric illness may also require pharmacotherapy and/or brain stimulation procedures such as Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS). Deep Brain Stimulation (DBS) is also emerging as an effective treatment for certain psychiatric illnesses.

### **Overnight In-Patient Care**

Overnight in-patient care is a key component of a complete and comprehensive health care system. In-patients services in the private sector complement the public sector, in that, the patients treated have serious levels of mood and anxiety disorders with their severity indicated with elevated HoNOS<sup>8</sup> and MHQ-14 scores. In-patient care is managed by the treating psychiatrist, so that in-patients services are ideally part of an integrated treatment plan that both begins before the admission and continues upon discharge.

In-patient care can be seen in a stratified or progressive way. After a thorough assessment period the treating team, can decide on the optimal package of evidence-based treatments and their sequence of delivery. Since mental health presentations, even within the same disorder, are so variable, the treatment plans will be individualised. As an example, the initial goal might be to reduce agitation and the risk of deliberate self-harm and or suicide, and so a

---

<sup>8</sup> HoNOS (Health of the Nation Outcomes Scales) was developed during the early 90s by the Royal College of Psychiatrists as a measure of the health and social functioning of people with severe mental illness

patient may receive a treatment that is focussed on risk management and containment. Alternatively, a profoundly depressed patient may require strategies of behavioural activation to foster engagement and develop/boost mood. Each of these patients, who may arrive in hospital too unwell to participate in intensive psychotherapies, will then be able to transition to programs that address causes of their problems in cognitive behavioural and interpersonal areas. Furthermore, in-patient psychiatric care, will invariably involve the close management of pharmacological treatments. Often, levels and types of medication are modified or introduced/challenged with the goal of maximising outcomes and minimising side effects. In addition, other biological treatments like ECT and TMS are delivered, sometimes during an in-patient stay, which permits the careful monitoring of patients, who are assessed as being at high risk of self-harm and or suicide. These patients are also commonly at risk of deterioration in physical health and wellbeing as a result of poor self-care and nutrition.

The typical private hospital will ensure a variety of treatments to tailor services to this continuum of care, so that patients can be offered the most appropriate and least restrictive treatment option. Hence, it would not be unusual to find a breadth of treatments in any particular hospital that extend from those which are trying to settle agitated patients (e.g. Relaxation, Mindfulness), to focus concentration (e.g. Creative activities, Art Therapy), to foster behavioural activation (e.g. physical activity, walks, improving activities of daily living), to manage mood (e.g. Psychoeducation, Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT)), to manage disordered personality and relationships (e.g. Dialectical Behaviour Therapy (DBT), Distress Tolerance Skills and Interpersonal Therapy (IPT)). Sometimes these programs will be delivered to patients with a variety of diagnostic presentations and at other times they may be delivered to homogenous diagnostic groups (e.g. Post-Traumatic Stress Disorder (PTSD), eating disorders, substance use, perinatal, older persons, children and adolescents). These treatment types will be delivered in various formats, such as in open and closed groups, to individuals and couples/families, or with carers and other supporters with the patient's consent.

Furthermore, the patient should be managed with consideration to the broader context within which their mental health problem exists. Hence, any in-patient admission needs to consider the transition to possible continuing treatment following discharge. This sees the patient in the context of their family or work place and issues associated with these areas. Partners, families and other carers, need to be involved in the patient seamlessly moving from hospital to home. It is in this context that ambulatory care, a valuable service in its own right, is a key component of the comprehensive care for those patients for whom an in-patient admission has been necessary or unavoidable.

## **Ambulatory Care**

In private psychiatric hospitals ambulatory care is the term given to any therapeutic treatment intervention delivered to a patient who is not an overnight in-patient. This means that a wide diversity of specialist treatment therapies and programs are captured within this term. Ambulatory care is an effective treatment option that enables the delivery of specialised psychiatric treatment by a multidisciplinary team to patients with moderate to severe mental health conditions who are assessed by the treating psychiatrist as not requiring 24 hour in-patient care.

Although the *Mental Health Guidelines* define the minimum therapeutic contact hours for same-day treatment programs as Half Day – two and a half hours and Full Day – four and a half hours, in reality individual contractual agreements between hospitals and health insurers dictate and vary these as well as stipulating which types of same-day treatment is covered through ‘approved program’ arrangements.

Therapeutic contact modes and duration for ambulatory care is often defined by agreement between the Hospital and the Health Insurer for the purposes of determining the benefits that will be paid.

Ambulatory Care consists of same-day treatment that may be delivered as:

- A Closed Program – a structured therapeutic program for a defined number of sessions with scheduled commencement and completion dates. Like overnight in-patient care, closed group programs can be seen in a stratified or progressive way. Therapeutic content is delivered in a systemic way with knowledge, education and skills being progressively built and reinforced. Closed programs may include both individual and group therapy sessions and are generally delivered within diagnosis specific cohorts. Closed programs are a less restrictive way to provide treatment to acutely unwell patients who are assessed as not requiring 24 hour in-patient care. There may also be a clinical rationale for providing care and maintaining a patient out of an overnight in-patient environment (this could be related to diagnosis, personal circumstance, age) Examples of closed program models include:
  - Post Traumatic Stress Disorder (PTSD) – Closed programs will often be defined by occupational groupings. For example, military and emergency services personnel will often be grouped in the same cohort given occupational exposure and shared experiences. Whilst patients with PTSD due to other occupational traumatic events and injuries would be in a separate cohort. Similarly patients with a lived experience of childhood sexual abuse would be provided with an homogenous group setting to meet their specific needs and issues.
  - Cognitive Behaviour Therapy (CBT) – Mood and Affective Disorders. The defining of closed CBT groups may be based on, age, gender, diagnosis or significant life events ie pregnancy.
  - Dialectical Behaviour Therapy (DBT) – a specific type of cognitive-behavioural psychotherapy developed in the late 1980s by psychologist Marsha M. Linehan to treat patients with a borderline personality disorder. This style of therapy is best provided as a closed group.
  - Acceptance and Commitment Therapy (ACT) – Mood and Affective Disorders. The defining of closed ACT groups may be based on, age, gender, diagnosis or significant life events ie pregnancy.
  - Addictive Disorder Programs – Dependent upon the therapeutic approach may be provided as either a closed or open program. Closed groups are generally based on age, substance/addiction.

- An Open Program – an individualised therapeutic program that is designed specifically according to the patient's unique needs. The number of sessions, commencement and completion dates are flexible and planned to suit the patient's specific requirements. Open programs tend to be modular in nature and are designed to be delivered as standalone separate treatment interventions. They may include both individual and group therapy sessions and are able to cater to a wide range of diagnoses and acuity. Examples of when open programs may be beneficial include:
  - Acutely unwell patients who are assessed as not requiring 24-hour in-patient care
  - Support for patients as part of an early discharge strategy
  - Provision of continuation or maintenance Electroconvulsive Therapy (ECT)
  - Relapse prevention to allow patients to access therapeutic interventions in line with either a relapse prevention or crisis intervention plan

### **Outreach Care (including Hospital-in-the Home)**

Outreach (including Hospital-in-the-Home) care enables specialist psychiatric treatment that would normally be delivered in a hospital to be delivered in the patient's home and/or community. This model of care may be beneficial to those patients experiencing moderate to severe mental illness who have been assessed by the treating psychiatrist as not requiring 24-hour care. It allows for clinicians to undertake in-home assessment whilst providing intensive one-on-one interventions. This type of care may also assist to moderate a developed reliance on institutional care that can be a consequence of some mental health conditions.

- Community Based Care; Outreach, Hospital-in-the-home type services (type one) – one-to-one therapy delivered in the patient's home or in another community setting by an individual mental health professional or combination of mental health therapists. Outreach (Hospital-in-the-home) defined community based care may be an effective treatment option for complex and severe chronic psychiatric illnesses. It aims to substitute hospital admissions with intensive acute treatment and support in the community. Like In-patient care, Outreach services have a defined discharge point once the patient's acuity is stabilised and assessed as not requiring acute care. Typically a patient receiving this type of community based care would receive contact on a daily or very frequent basis.
- Community Based Care; Case Management, Pilot programs (type two) – one-to-one therapy delivered in the patient's home or in another community setting by an individual mental health professional or combination of therapists. Similar to 'outreach' type one care the difference with case management style services is that they are aimed at support and relapse prevention for patients with complex and severe chronic psychiatric illnesses who don't require acute care but are assessed as being at risk of deteriorating without specialist support. Patients receiving this case management style of care may receive contact at multiple weekly, fortnightly or monthly intervals. This clinical intervention aims to minimise social isolation and re-integrate the patient within the community to prevent relapse and maximise recovery.

# Efficient and effective use Private Health Insurance for people with a mental health condition

---

## Providing access to services not otherwise available

**Private health insurance currently affords people who are in an acute phase of psychiatric illness access to services that would not otherwise be available in the public sector.**

As stated in the *Mental Health Guidelines*, 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.

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 by 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

Commonly occurring mental health disorders – depression, anxiety, stress-related and substance use disorders – are experienced by an alarming 45 percent of Australians in their lifetime, according to the National Survey of Mental Health and Wellbeing. Each year, 1 in 5 adults (aged 16-85 years) experience a high prevalence mental health disorder. These high prevalence mental health disorders are a leading cause of disease burden in Australia and are important drivers of disability. Untreated, these common mental health disorders result in significant personal suffering, and individual and community costs associated with disruption to relationships, work and educational achievements, and home responsibilities. In moderate and severe forms these disorders the risk of significant self-harming behaviours and suicidality is high and hence this group of patients are associated with an increased morbidity rate

Public mental health services have historically and continue to be focused primarily on providing in-patient care to those who experience the low prevalence severe forms of mental illness and behavioural disturbances, with a significant proportion of those admitted falling under the provision of the various jurisdictional Mental Health Acts. The rising use of methamphetamines in our communities places further pressure on the public services. The 2016 National Drug Strategy Household Survey, released by the Australian Institute of Health and Welfare (AIHW), showed more users were being diagnosed with or treated for a mental illness than ever before. In the previous twelve months, 42.3 percent had been treated or

diagnosed for a mental illness compared with 29 percent in 2013<sup>9</sup>. Public mental health services work in collaboration with primary health and private sector health providers who assist individuals with mental health problems and facilitate access to specialist public and private mental health services when required.

Public and private psychiatric hospital services can be characterised as being complimentary rather than duplicative in nature, although both sectors do provide treatment across the spectrum of mental health diagnostic related groups at varying levels of frequency. Together they combine to offer balanced provision of specialised treatment and services to the wide spectrum of mental illnesses; the public in-patient units focusing generally on severe lower prevalence psychotic disorders including schizophrenia, paranoia and acute psychotic disorders whilst the private in-patient units deliver the majority of care to patients experiencing severe episodes of high prevalence disorders including depression, anxiety, eating disorders and major affective disorders.

Given this balance in the provision of mental health services and the continuing and growing pressure on public mental health services, patients who currently access their care needs through the private hospital sector would not be able to gain access to public services as an alternative. Access to hospital services for many people suffering an acute phase of a high prevalence mental health disorder may only be possible through private psychiatric hospital admission via a private psychiatrist that is self-funded or covered by private health insurance.

### **Hospital services, complementing community and home-based care**

**Community level and home-based care can be beneficial to individual patients and assist in reducing the likelihood of being readmitted to in-patient care but investment in ‘non-secondary care’ has not led to reduced expenditure in acute hospital care.**

Analysis by KPMG has shown that despite a sustained increase in per capita expenditure on primary and community based mental health since 1993, “the prevalence of mental ill-health appears to have remained relatively stable over time. This suggests that current non-secondary care expenditure is not achieving a reduction in mental ill-health.”<sup>10</sup>

This same report shows that the per capita expenditure on secondary care has remained relatively constant. The demand for acute psychiatric care is not likely to diminish in the short term. Consequently widening the scope of mental health services funded through private health insurance to include services delivered in home and community settings would

---

<sup>9</sup> Australian Institute of Health and Welfare *National Drug Strategy Household Survey (NDSHS)* <https://www.aihw.gov.au/about-our-data/our-data-collections/national-drug-strategy-household-survey> Accessed 14 June 2018.

<sup>10</sup> *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, Mental Health Australia and KPMG, May 2018 [https://mhaustralia.org/sites/default/files/docs/investing\\_to\\_save\\_may\\_2018\\_-\\_kpmg\\_mental\\_health\\_australia.pdf](https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf) Accessed 1 June 2018.

increase, not decrease the demand on insurers to meet unmet demand for community based services in addition to the demand for acute services that they are already supporting.

## **Evidence based and accredited**

### **Services covered by private health insurance need to be evidence based and consistent with Industry Standards and Mental Health Guidelines**

The importance of Accreditation in healthcare is hard to overstate. Every healthcare organisation establishes some form of internal standards and rules for operation, however; it is through the process of formal accreditation that an organisation demonstrates that it meets legislation; regulations and industry standards set by a recognised body and reviewed by an external accreditation agency. Accreditation acts as an external verification for a healthcare organisation, showing that it follows industry standards and best practices. Additionally, going through the process of Accreditation helps streamline operations, improve the quality of care and build trust with patients, clinicians and the community.

The Australian Commission for Safety and Quality in Health Care (ACSQHC) states that the primary aim of the National Safety and Quality Health Service (NSQHS) Standards is to protect the public from harm and improve the quality of health care. The ACSQHC says of the NSQHS Standards that they describe the level of care that should be provided by health service organisations and the systems that are needed to deliver such care.

The National Standards for Mental Health Services (NSMHS) are owned by the Federal Department of Health and were developed as part of the National Mental Health Strategy. The NSMHS are outcome oriented and reflect a strong values base, related to human rights, dignity and empowerment. Values essential to the provision of health care services to often vulnerable mental health patients.

The Act sets as a minimum requirement that private health insurance benefits are paid to accredited health providers. This is an important safety mechanism for patients. Accreditation to either the NSQHS Standards and/or the NSMHS should remain as a core requirement for the payment of private health insurance benefits as it provides a mechanism of independent review to verify that external industry recognised minimum quality and safety standards are being met. Further it is important to ensure that hospital-based and hospital-substitute care provided to often vulnerable mental health patients is delivered and provided within an equally evidence based and quality assured system.

## **Recognising Therapeutic Relationships and Responsibility for Risk**

### **Services that are community based need to be delivered in a way that recognises and supports existing therapeutic relationships and clear responsibilities for clinical risk**

Patients who currently access private psychiatric hospital treatment are suffering moderate to severe mental illness and are under the management and treatment of a private

psychiatrist. That private psychiatrist accepts responsibility for the ongoing care and treatment of the patient for the length of their therapeutic relationship both whilst receiving hospital based treatment and when being maintained in the community through private practice consultations. The private treating psychiatrist often takes on the role of case manager for the patient and coordinates a range of care and treatment interventions whilst overseeing the patients progress and continuing to assess the patient's mental health status, risk factors, overall treatment plan and rehabilitation.

It is vital to the patient's safety and continuity of care that there is clarity with regards to the lead clinician who undertakes and accepts the role of coordinating a comprehensive treatment plan; in terms of private psychiatric patients this may be the general practitioner or the private treating psychiatrist. For private patients who require acute hospital treatment the clinician usually undertaking this role is the private treating psychiatrist.

Community based hospital-substitution services, just like hospital-based services, for the population of patients with moderate to severe mental illness must not only recognise but support the existing therapeutic relationships that patients choose and develop with their private treating psychiatrist.

# Private Hospitals in Australia

---

## **The Australian Private Hospitals Association**

The Australian Private Hospitals Association (APHA) is the peak industry body representing the private hospital and day surgery sector. About 70 percent of overnight hospitals and half of all day surgeries in Australia are APHA members.