Private Mental Health Consumer
Carer Network (Australia) Limited
engage, empower, enable choice in private mental health

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SUBMISSION

Fifth National Mental Health Plan

1 Introduction

We thank the Department of Health for the opportunity to provide input into the consultation of the Fifth National Mental Health Plan.

The *Private Mental Health Consumer Carer Network (Australia)* (hereafter Network) represents Australians who have private health insurance or who receive their treatment and care from private or office based settings for their mental illnesses or disorders and also represent their carers**.** As our title implies, the Network is the representative voice for consumers and carers in private mental health settings. We are highly informed about consumer and carer concerns and the operations of private providers.

The Network is committed to working with the Australian Government and relevant others in addressing the needs of people with a mental illness including their family or carers.

2 Private Sector

The Network notes in the very beginning of the Draft Consultation Document Pg 3, '*that the Fifth Plan sets out a national approach for collaborative government effort over the next five years*' and that '*these actions set the direction for change and provide a foundation for longer term system reform*'

Simply by this narrow definition, a large number of consumers and families and other carers are omitted from this very important Fifth Plan. It is also noted that the Network has commented on the Third, Fourth and now the Fifth Plan, that private sector services have been omitted completely. By private sector services we mean:

- Private hospitals with psychiatric beds
- General Practitioners, psychiatrists, psychologists, mental health nurses in office based practice
- Other allied health practitioners in office based practice

This sector provides approximately 70% of all mental health services delivered within Australia.

3 Private Psychiatric Hospital sector

Noted below are some key indicators with more detailed dissemination of the private psychiatric hospital sector *1. Key Statistics regarding Private Hospital-based Psychiatric Services* and *2. Comparison of the*

casemix of Public and Private hospital-based specialised Psychiatric Services appearing as Appendix 1 have been provided by the Private Psychiatric Hospitals – Centralised Data Management Service for the periods 08-09, 09-10, 10-11, 11-12, 12-13, 13-14. Noted below are some important demographics for the private sector.

- 63 private psychiatric hospitals
- Approximately 2600 inpatient beds
- 20-22% of the Australian Mental Health Workforce
- Treats in excess of 34,000 patients per annum in the private psychiatric hospitals only. (This figure would be far exceeded by those in treatment from office based practices)
- Approximately 16 private hospitals currently provide:
    - Community services (former trials known as 'Hospital in the Home')
    - Mental Health Nurse Incentive Program

4 Office Based Psychiatrist sector

In terms of psychiatrist statistical data, the following key findings are from the ABS data on the use of MBS subsidised mental health-related services in 2011 which was published on 24 March 2016. This includes detailed data on psychiatrists and patients' use of MBS mental health services in 2011.

Key findings include:

- 1.5 million people, 296,400 people or 1.4% of the total saw psychiatrists in 2011 and the average number of consultations was 7.1.

- Of all people who had at least one MBS subsidised consultation with a Psychiatrist in 2011, more than half (56.9%) also had at least one prescription filled for antidepressant medications in 2011, one-third (33.4%) also had at least one mental health-related consultation with a GP, and 31.2% also had at least one prescription filled for antipsychotic medications. Around one in five (19.3%) saw a Psychiatrist only, with no other MBS or PBS subsidised mental health-related treatment in 2011.

In addition the AIHW published 2014-15 data on Medicare-subsided mental health related services in April 2016. This includes some further useful statistics, particularly of note (in terms of increasing demand/role of the private sector in delivering mental health services):

- The total number of Medicare-subsidised mental health-related services increased from 7.7 million services in 2010–11 to 9.8 million services in 2014–15, translating to an average annual increase of 6.0% over the 5-year period to. From 2010–11 to 2014–15, clinical psychologist services had the highest average annual increase (10%), followed by GP services (8.2%) and services by other allied mental health services (7.8%). The number of subsidised psychiatrist and other psychology services increased at a lower rate over the same period (average annual increase of 3.5% and 3.1% respectively).

5 Office based Psychologist sector

Data from the Australian Psychological Society shows that of their members, at least 10,000 are delivering psychology services in private practice. Key findings also include:

- Psychologists delivered 4,710,921sessions of psychological services in the 2015 calendar year.
- Psychological therapy is also being delivered in private practice through other funding sources eg.
    - Primary Health Networks
    - Workcover
    - Department of Veterans Affairs
    - Victims of Crime

- Client self-funded through their health insurance fund however there is no current data on extent of this work.

6 Other Office Based Allied Health Professionals

Data made available to the Network shows that Occupational Therapists and Social Workers provided a further 324,760 sessions in the 2015 calendar year.

We do not have data which would define access to mental health nurses, but the Network believes this would be in excess of Occupational Therapists and Social Workers.

7 General Practitioners

The Network also knows that a great deal of people access GPs for their mental health issues. Many rely on their GPs usually under extended visits, because they cannot access other mental health services.

The data for 2011 released this year from the Australian Bureau of Statistics shows that 1, 244, 900 people in 2011 or 5.7% of the total for an average of 1.8 consultations each saw their GPs for mental health issues. This data can be obtained through the same link as above namely ABS data on the use of MBS subsidised mental health-related services in 2011 which was published on 24 March 2016.

The data provided to the Network shows that a large number of individuals - 1.5 million people (7.2% of all Australians) used at least one MBS subsidised mental health-related service in 2011. These are the latest figures available from the ABS.

As with the previous national mental health plans, private sector consumers and their families and other carers feel omitted, abandoned, invalidated, with their mental illnesses not considered acute or important enough to be included within any national initiatives relating to mental health.

As a Network we continue to advocate for inclusion at the beginning of any initiative and regarding this Fifth Plan, this would have been involvement in the writing group. We believe we are objective, sensible and understand the complexities across the interface between the public and private mental health system. We would urge our inclusion within any future initiatives. We have demonstrated skill sets and very experienced state coordinators and staff who we believe would value add to any mental health initiative in the future.

8 Integration – public/private interface

We know from our members that many source treatment from office based clinical services but rely on the public mental health sector for inpatient admissions and community case management. It would seem that this would be the best of all worlds, however there are significant difficulties and it would have been important to include this aspect within this Fifth National Mental Health Plan. We do note that this was an aspect of the Second National Mental Health Plan (partnerships in service reform and delivery) where there were 3 national demonstration projects with the true interface being provided by the Melbourne Clinic and St Vincents Hospital sites. We have in the past heard from consumers and families that they were devastated that this was a demonstration project only and was not implemented on an ongoing basis.

9 Priority Areas

Priority Area 1: Integrated regional planning and service delivery

Summary of actions:

2. Governments will work with Primary Health Networks and Local Health Networks to implement integrated planning and service delivery at the regional level.

PHNs will need to work with private hospitals and office based practices and this needs involvement and accountability within the Fifth Plan as well as other service delivery models.

Priority Area 2: Coordinated treatment and supports for people with severe and complex mental illness

Aim: An integrated and sustainable *service system* that provides the right amount of *tailored clinical* and community supports.

Again this must include office based practice particularly when we talk about tailored clinical supports.

Summary of actions:

3. Governments will support coordinated service delivery for people with severe and complex mental illness through the development of national guidelines.

Any national guidelines must include office based practice through the Royal Australian and New Zealand College of Psychiatrists and the private psychiatric hospital sector. Any national guidelines must be as applicable to the private sector as any other sector in order to maintain high quality, effective, cost efficient services of which the Commonwealth Government is the sole payer by way of Medicare for office based practices.

4. Refers to monitoring and reporting to health ministers on emerging health and other related policy issues that may arise because of the National Disability Insurance Scheme. People that have health insurance paid for them ie partners, children to age 23/25, parents etc provided they meet the criteria for the NDIS as far as the Network understands will be eligible to receive services under that scheme. If this is correct, then the private sector must be included not only within this Fifth Plan but also any discussions or plans for the NDIS.

The data collection of the previously mentioned Australian Private Psychiatric Hospitals Centralised Data Management Services can provide substantive data which shows via outcome measure scores that the private hospital sector does indeed cater for those with severe and complex mental illness. Though less so with the low prevalent disorders but a high percentage of the high prevalence disorders as Appendix 1 shows.

5. PHNs and LHN will work with health and social service agencies operating in their regions to develop region-wide arrangements to ensure coordinated treatment and community support for people with severe and complex mental illness.

Again, many people with severe and complex mental illness are seen by private office based practitioners mostly psychiatrists and clinical psychologists. This is where many are referred to for their expertise, management including medications, secondary assessments etc. This sector offers consistent practitioner involvement, rather than a rotating registrar system or fly in fly out consultant psychiatrists to regional settings.

The office based practitioners through the RANZCP ,Australian Psychological Society and the Australian College of Mental Health Nurses must be involved within this action.

Priority area 3. Suicide prevention

People do not discriminate whether they are part of the public or private mental health sectors, people suicide across the community. Suicide also happens to people within communities who may not have ever had support

from specialised mental health services or practitioners and we understand that a focus for the Fifth Plan is also directed to these people.

The private psychiatric hospital sector do not keep discreet records or know of suicides unless this occurs within an inpatient unit. We know of some private psychiatric hospitals where an attempt has been made, then refuses to readmit that person to the hospital again. Due to the sector referral processes, once the person leaves the private hospital, apart from a follow up telephone call from most hospitals, does not keep contact with them unless they are part of a community care program. Rather consumers are discharged into the care of the private psychiatrists. One would expect that the psychiatrist would become aware of this information via police or the coroner's office which often as we understand, requires a response or report to be provided.

However the Network believes that work should be undertaken in this area to identify a better way of capturing this crucial information and also to identify those at risk of suicide. Coroners' courts do not provide the type of information for early intervention that would be useful for private hospitals to understand.

It will be crucial for Governments to work with the private hospital and office based practitioners through their organisations to determine what and how that crucial follow up care can or should be provided for people who have attempted or are at risk of suicide.

The Government must work together with the private sector to develop and implement the same or similar data collections that relate to suicide and suicide attempts. How will consumers be safe guarded by any Government initiatives around this crucial area just because they are in the private sector.

We must be confident that data collection will strengthen the evidence base and improve the quality of care just as importantly in the private mental health sector as anywhere else.

Priority Area 4: Aboriginal and Torres Strait Islander mental health and suicide prevention.

This is an area that the Network strongly supports but has little capacity or understanding of the unique challenges for ATSI peoples. There is much to do to improve the understandings or more importantly the misunderstandings of white Australians toward ATSI peoples. The suicide rate for young indigenous youth is too high, physical health issues are poorly addressed, so the Network strongly supports this Priority area as a direct and robust requirement to influence policies both federal and state to improve the well being of indigenous people.

Priority Area 5: Physical health of people living with mental health issues.

The physical health of people with mental illness is a national priority and it is frightening how the life span is so significantly reduced for people with mental illness and this is so wherever a person received their treatment, support and care. We know that many people are not taken seriously when describing physical health symptoms especially on presentation to emergency departments, with many being attributed to the mental illness when in fact there is a serious and potentially life threatening underlying physical condition.

This issue must be relevant to the private sector. If consumers are seeing a psychiatrist for example in private practice, there is little if any discussion around physical health issues rather a suggestion about contacting the GP. There seems to be a reluctance to be involved in physical health monitoring by some psychiatrists who are doctors with a lot of years going through general medicine as part of their training. They would be best to advise on side effects of psychotropic medications. We recommend this be raised with the Royal Australian and New Zealand College of Psychiatrists who have done a lot of work in this area and have a very good publication around this specific issue.

Summary of actions:

16. Any guidelines developed by governments for the use by health services and health professionals must also be directed to and include the private hospital sector and office based practice.

17. Systems are developed for monitoring progress. Again the systems must incorporate the private hospital sector which would be the easiest part of the private mental health sector to implement given there are 63 private hospitals with psychiatric beds which currently forward data to the APPHs Centralised Data Management Service. We strongly recommend discussion with Mr Allen Morris-Yates, Director allen.yates@pmha-cdms.com.au - 0417 268 386

18. As above, it will be essential to the wellbeing and life expectancy that the national reporting via the above means is undertaken.

Priority Area 6: Stigma and discrimination reduction

One of the roles of government and organisations such as our Network is to work with the community and the workforce to reduce stigma and discrimination of people living with mental illness and their families.

Summary of actions:

As a peak consumer and carer advocacy organisation, the Network is well placed to work with governments and the health workforce.

The Network has just completed a project called *Consumers and Carers as Educators Project* which combines the lived experience of two consumers, a carer, a psychiatrist and a GP via online or face to face workshop applications to educate health professionals about the key issue of collaboration, communication and cooperation between treating health professionals. This is currently on the Network's website www.pmhccn.com.au Resources tab, online training. We are very pleased to advise that we have acquired Continuing Professional Development (CPD) point allocation from the Royal Australian and New Zealand College of Psychiatrists for their fellows and trainees. It has been uploaded onto the RANZCP's Learning Management System and will be promoted to all their members across Australia and New Zealand. This is a first for both a consumer and carer organisation to have direct, significant and long term input into the education and training of the psychiatric workforce from a consumer and carer perspective and has been widely acclaimed. We are also currently seeking the same CPD point allocation from the Australian Psychological Society, the Royal Australian College of General Practitioners and the Australian College of Mental Health Nurses.

This initiative will go a long way to educating practitioners and reducing stigma and discrimination.

Priority Area 7: Safety and quality in mental health care

Currently the private sector through the APPHs Centralised Data Management System routinely collects data from private psychiatric hospitals which is reported to it. The collection process is focussed on a number of measures, these being the clinical outcome measure in HoNOS and the consumer self reporting measure the MHQ 14. More recently the CDMS is collecting a Patients Experience of Care measure of consumers perspectives of the services they receive. The equivalent in the public system is the 'YES' tool. Reports are provided to the private hospitals routinely on a quarterly basis and annually to the Australian Government.

Such reporting has occurred since 2000 with the results detailed via the Annual Report which results are made publicly available in a transparent manner. Given that this data is available, these must be included in a far more prominent manner as is currently ie through the annual National Mental Health Report, rather than just a page or two. Given the numbers of people treated in the private

psychiatric hospital sector which are significant, (see Appendix 1) surely these are important statistics which describe consumer outcomes and other data.

Summary of Actions:

21. Governments will develop a national mental health safety and quality framework and this must include the private hospital sector. People receiving treatment, care and support must be equally entitled to the highest quality of care in the safest environment around Australia.

22. Governments will work with the ACSQHC to amend the National Standards for Mental Health Services (NSMHS) to better reflect their intent and interface with the National Safety and Quality Health Service Standards.

    The Network holds grave concerns that the National Safety and Quality Standards will replace the National Standards for Mental Health Services in the near future. There are a number of standards in particular Standard 7 Carers, Standard 10, Access, Support, Treatment and the Recovery standard. The Network knows that accreditation against the mental health standards was a requirement for a number of years under the National Funding Agreements with the States and Territories however we understand that this is not the current case, rather that the jurisdictions can opt for this process which is voluntary.

    The private hospital sector has never fully engaged in accreditation against the national mental health standards with around just 4-6 of the 63 private psychiatric hospitals being accredited over time against them.

    There is much emphasis on the National Safety and Quality Standards and all health services/organisations are required to undergo accreditation against these. There is therefore a much greater awareness and acceptance of these and the national mental health standards seem to take a much lesser presence. We acknowledge that there is a linkage tool with an excel spreadsheet which is supposed to capture the missing criterion.

    We would recommend that the National Standards for Mental Health Services remain and be strengthened in light of the drivers of the National Safety and Quality Standards, currently the Australian Commission on Safety and Quality in Healthcare. The national mental health standards are very important to consumers and carers and will continue to be so irrespective of the review and implementation in 2019 of the revised National Safety and Quality Standards. There is no current body to promote and drive the national mental health standards as there is for the Australian Commission on Safety and Quality in Healthcare does for their standards. The Network therefore recommends that an entity be established or require a dedicated function of the ACSQHC to oversight the accreditation of both public and private mental health services against the national mental health standards.

24. Governments agree on a national statement of priorities to guide mental health information developments over the next 10 years.

    This is critical information which should be made available to all. We believe that information about community services, diagnoses, side effects, etc are not readily available in office based practices. The Network strongly recommends that any information must also be distributed to office based practices.

26. Governments will undertake work to improve consistency across jurisdictions in policy underpinning mental health legislation.

People who receive their treatment from office based practices or who are admitted to private psychiatric hospitals are equally committed to involuntary treatment. Queensland and South Australia are the only states currently which can admit involuntary patients under mental health legislation.

As with any involuntary status, choice is taken from the consumer and/or their families. This has an even greater impact on consumers and their families from the private sector. If people are admitted to a private psychiatric hospital and then deteriorate or become behaviourally aggressive, the practice mostly is to transfer them to a public hospital. This has enormous consequences with the transfer processes themselves, and a greater understanding and policy directions must take account of this fact.

Monitoring and reporting on reform progress

The Network is well placed to provide direct input to both state but especially federal government initiatives and policies. We are a very active peak consumer and carer systemic advocacy organisation, established for the long haul and have just recently become a company limited by guarantee. We have a very stable record of consistent and productive advocacy by way of 47 Submissions, invitations to appear before 10 parliamentary inquiry committees etc however the Network is almost always overlooked.

We are working for change but that requires a much better understanding and better inclusion of private sector services by organisations such as Mental Health Australia even though the organisations involved in private mental health care are member organisations. Governments must also understand the interface that the private sector has with public mental health services and must include the practitioner, private hospital and our Network at the beginning of initiatives especially given the large number of people ie 7.2% or - 1.5 million people. It is important to note that whilst these are the latest figures from the ABS it covers only the 2011 year. It is very likely that these figures are now much higher.

We are trying to overcome this by becoming increasingly active in promoting the Network wherever we can. We also have around 1,000 members who are consulted via our established State Advisory Forums which meet with grass roots consumers and their families on a regular six monthly basis.

This provides the Network with an opportunity to understand and monitor the issues and needs of our members in a consistent and strong manner. We believe we should have been included within the writing group of the development of the third, fourth and particularly this fifth plan.

We have a good understanding of the experiences and outcomes from a qualitative perspective of our members and actively seek to raise systemic issues nationally.

Summary of actions:

27. Governments will implement a set of national reform and system performance measure to monitor whether there is any difference in mental health reform.

    Given that opportunities for the involvement in the development and writing of the fifth plan we are seeking membership of any committees/working groups/advisory groups established to define national policies and reforms and any system performance measures.

29. Governments will work to ensure that progress and reform are monitored in all parts of the mental health service system.

    As mentioned throughout this Submission the private sector is significant, with a large number of people being affected with 70% of all mental health services delivered by private

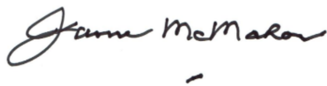
practice, private hospital and private allied health practitioners. 22% of the mental health workforce is currently employed within the private hospital sector alone.

Governments must work with the private sector through a number of channels. These would be:

Royal Australian and New Zealand College of Psychiatrists	)	
Australian Psychological Society	)	
Australian Private Hospitals Association	)	
APPH - Centralise Data Management Service	)	All these organisations must be
Private Mental Health Consumer Carer Network (Australia)	)	consulted at the very beginning
Australian College of Mental Health Nurses	)	of any national initiative
Australian Association of Social Works		
Occupation Therapy Australia		

We would be pleased to provide further clarification to any points made within this Submission. Please contact me in the first instance either by phone or email to: jmcmahon@senet.com.au

Yours faithfully,



Ms Janne McMahon OAM
Chair and Executive Officer
8th December, 2016

Appendix 1:

1. Key Statistics regarding Private Hospital-based Psychiatric Services

	08-09	09-10	10-11	11-12	12-13	13-14
Service utilisation and charges						
Persons admitted	24,348	26,673	27,729	29,470	31,846	33,673
as a proportion of the Insured Population	0.304%	0.326%	0.329%	0.339%	0.357%	0.370%
Overnight Inpatient days		601,275	624,376	673,154	720,849	762,863
Sameday admissions		194,170	159,449	190,311	202,822	223,753
Total charges		$342M			$476M	

The proportion of the privately insured population in receipt of spcecialised hospital-based psychiatric services has remained relativley constant over the period covered by the available statitsics. Similarly, after adjustment for CPI increases, the real cost per episode of care has shown only very slight increases of 1.6% from 2005-06 to 2009-10 and 0.6% from 2009-10 to 2012-13. Specifically, with respect to charges per episode of Overnight Inpatient Care, in 2005-06 the average total charge per episode was $8,650 rising to $10,290 in 2009-10 and $12,646 in 2012-13. When later figures are adjusted to 05-06 dollars assuming a constant non-farm GDP inflation of %4, the average total charge per episode in 2009-10 is $8,790 and in 2012-13 is $8,850.

Payment source (statistics for 2012-2013)		
Health Insurance Funds	88.3%	The majority of people whose care was paid for by DVA, DoD, Workcover authorities and other third party payers suffered from Post-traumatic stress disorder.
Public sector payers (DVA, DoD, and State Health Departments)	7.1%	
Workcover and Other Payers n.e.c	4.2%	
Self-insured	0.4%	

	08-09	09-10	10-11	11-12	12-13	13-14
Demographic profile						
Females as % of all patients	64%	64%	65%	64%	64%	64%
Age (average in years) of all patients	46	46	46	46	46	46
Older persons (65+) as % of all patients	12%	13%	13%	13%	13%	14%
Diagnostic profile						
Schizophrenia, Schizoaffective and Other Psychotic Disorders	8%	8%	7%	7%	7%	7%
Major Affective and Other Mood Disorders	51%	49%	48%	47%	48%	46%
Post Traumatic and Other Stress-related Disorders	11%	9%	9%	9%	10%	10%
Anxiety Disorders	7%	7%	7%	7%	7%	7%
Alcohol and Other Major Substance Use Disorders	16%	18%	22%	21%	20%	23%
Eating Disorders	3%	3%	3%	3%	3%	3%
Other	4%	6%	4%	6%	5%	4%
Comorbidity						
No major psychiatric comorbidity		75%				
with Alcohol or Other Major Substance Use Disorder		15%				
with Personality Disorder		12%				
with Both		3%				

The overall clinical profile of people admitted to private hospital-based psychiatric services, as represented by both the demographic and diagnostic profiles recorded at each episode of care, has remained relatively constant over the period. The only noticeable change was an increase, between 2008-09 and 2010-11, in the proportion of episodes where the principal diagnosis was an Alcohol or other substance use disorder. Overall, it is estimated that that diagnosis was also identified as a secondary cause of the episode of care in 15% of cases. In almost 50% of cases, the current episode of care had been preceded by an earlier admission at some time in the previous 12 months.With respect to admissions to overnight inpatient care, on average, in 47% of such admissions, the person had had a previous admission to overnight inpatient care at some time in the preceding 12 months.

Self-assessed Clinical profiles and outcomes (MHQ-14 statistics for 2013-2014)

	Mental Health	Social Functioning	Role Functioning
General Population (ABS, 1995)	76	85	83
Overnight Inpatients at Admission	34	27	15
... at Discharge	60	59	59
Change (effect size)	1.23	1.32	1.42

When compared against the general population the average patient, at admission to overnight inpatient care, is in the bottom 5% of the population with respect to their mental health, social functioning and role functioning.

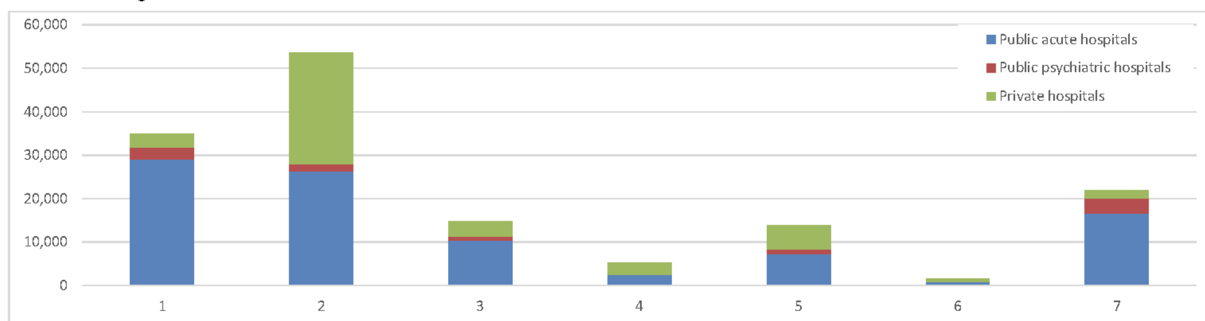
Clinician-assessed outcomes (HoNOS statistics for 2013-2014)	
Significant improvement	73%
No change	24%
Significant deterioration	3%

As indicated by both patient self-reports and clinician ratings, the majority of patients have markedly good outcomes, particularly with respect to their capacity to re-engage in their social and other roles.

2. Comparison of the casemix of Public and Private hospital-based specialised Psychiatric Services

Separations from Overnight Inpatient Care by Sector/Hospital Type in 2012-13 (from AIHW)

Separations from Private hospitals account for approximately 30% of ALL separations from specialised psychiatric overnight inpatient care for adults; separations from Public psychiatric hospitals account for a further 6%, whilst separations from Public acute hospitals account for the remaining 64%.



1 - Schizophrenia, Schizoaffective and Other Psychotic Disorders
2 - Major Affective and Other Mood Disorders
3 - Post Traumatic and Other Stress-related Disorders
4 - Anxiety Disorders
5 - Alcohol and Other Major Substance Use Disorders
6 - Eating Disorders
7 - Other

Involuntary admissions by Hospital Type	Public acute hospitals	Public psychiatric hospitals	Private hospitals
	41.5%	43.1%	0.4%

Note: The statistics provided in this second section are for ALL separations from specialised, hospital-based, psychiaric care, regardless of whether those services were publicly funded, payed for by health insurers or other third-party payers, or payed for by the individual person in receipt of care.

For further information regarding the statistics presented here, please contact the Director of the Private Mental Health Alliance's Centralised Data Management Service, Allen Morris-Yates, at allen.yates@pmha-cdms.com.au or on 0417 268 386.