



Australian Health
Ministers'
Advisory Council

**National Mental Health Information Development Expert Advisory Panel
comment on the IHPA consultation paper:
Development of the Australian Mental Health Care Classification:
Public consultation paper 2, November 2015**

The Mental Health Information Development Expert Advisory Panels were established by the Department of Health to provide clinical and technical advice to the Mental Health Information Strategy Standing Committee (MHISSC) on issues and priorities that guide the development of the national mental health information agenda.

The Expert Panels comprise the National Mental Health Information Development Expert Advisory Panel (NMHIDEAP) and specialist panels brought together for specific issues or populations, such as the Child and Adolescent Mental Health Information Development Expert Advisory Panel (CAMHIDEAP).

The primary function of the panels is to provide advice on the continued implementation, use and modification of routine outcome measurement in Australia's specialist mental health services, particularly in regard to training, service and workforce development issues and advice on analysis and reporting of National Outcomes and Casemix Collection (NOCC) data to advance the understanding and application of outcomes and casemix concepts. The Expert Panels are also tasked with providing advice on emerging issues pertaining to the information development agenda in mental health, including activities that enhance the capacity of the mental health sector to improve the efficiency and effectiveness of service delivery.

NMHIDEAP acknowledges the extensive work undertaken by IHPA on the development of the Australian Mental Health Care Classification (AMHCC) and appreciates the opportunity to provide comment on the paper: *Development of the Australian Mental Health Care Classification: Public consultation paper 2, November 2015*.

NMHIDEAP members reviewed the consultation paper and have identified the following issues. Further details on child and adolescent related issues are contained in the separate submission by the CAMHIDEAP.

General

1. NMHIDEAP notes that its ability to provide specific feedback on the AMHCC is limited by the lack of sufficient publically available information regarding the data underpinning the classification. This lack of public transparency is of significant concern to the NMHIDEAP.
2. NMHIDEAP notes that the AMHCC is based upon the measures and established protocols underpinning the NOCC. However it also notes some key potential conflicts, particularly related to phase of care and silence on the need to collect measures at the start and end of

▼
**MENTAL
HEALTH,
DRUG AND
ALCOHOL
PRINCIPAL
COMMITTEE**

▲
▼
**MENTAL
HEALTH
INFORMATION
STRATEGY
STANDING
COMMITTEE**

▲
▼
**National
Mental
Health
Information
Development
Expert
Advisory
Panel**

▲

Secretariat:
Australian Mental
Health Outcomes
and Classification
Network
C/- NSW Institute of
Psychiatry
Locked Bag 7118
Parramatta BC
NSW 2124
T: 02 9840 3833
Correspondence to:
rosemary.dickson@
nswiop.nsw.edu.au

care episodes; and some features inconsistent with the *NOCC Strategic Directions Final Report*, particularly the retention of the LSP.

3. NMHIDEAP is drawing to the attention of IHPA the principles underpinning the NOCC. These include that NOCC should:
 - align to clinical good practice standards by collecting information about the consumer’s mental health and wellbeing at key points in their journey through a mental health service in accordance with the *National Standards for Mental Health Services*;
 - aim to provide both clinician and consumer perspectives (and the *NOCC Strategic Directions Final Report* proposes carer perspectives) on the extent to which services are effective in achieving improvements in a person’s mental health and wellbeing; and
 - attempt to minimise any administrative demands of the collection of this information.
4. NMHIDEAP believes that IHPA therefore has the responsibility to ensure an alignment between the AMHCC and the key underpinnings of the NOCC. Without such alignment, IHPA risks undermining the relationship between the collection of the outcomes and casemix measures and good clinical practice, which could adversely impact upon the NOCC and the AMHCC agendas. If there is to be a more substantial change, then IHPA should demonstrate the need for that change to the Mental Health, Drug and Alcohol Principal Committee.
5. NMHIDEAP notes that there is insufficient information currently available to demonstrate the need for the collection of outcome measures in the phases described in the consultation paper; or the precise rules that will be used for the practical implementation of this collection. NMHIDEAP notes that the consultation’s supplementary technical report was released in the closing days of the consultation paper response time, not allowing detailed review by the NMHIDEAP. However, preliminary inspection by several members indicates that none of the major issues have been illuminated in the brief (11 page) report. If IHPA requires a more detailed review, then this should be specifically requested. The small amount of technical information available raises serious concerns about how the development of the AMHCC has appropriately accounted for the large proportion of the empirical sample being discarded as outliers, and how this will be addressed within implementation. NMHIDEAP recommends that the more detailed technical analysis that underpins the development of the AMHCC should be made available in the public domain. This would provide the opportunity to better understand the current conceptual and analytical foundations of the AMHCC. Transparency regarding the construction of the AMHCC is imperative.
6. Given the unavailability of a more detailed technical analysis, and the insufficient time to properly review the brief consultation technical paper, NMHIDEAP believes that it does not have sufficient information to address the consultation paper questions. For example, NMHIDEAP does not have access to information that would assist them in understanding variance across the settings or age bands. As a result, NMHIDEAP cannot make comment on the adequacy of the AMHCC.
7. NMHIDEAP believes that the rules used for the practical implementation of “*Phases of Care*” will be crucial for the successful implementation of the AMHCC. Alignment of data collection

requirements of the AMHCC with the rules for *Episode of Mental Health Care* within NOCC would be fundamental to the successful implementation of the AMHCC while ensuring the sustainable collection of the NOCC. These rules underpin the publically reported national Mental Health Services Key Performance Indicator *MHS PI 1 Change in consumers' clinical outcomes*. Such alignment appears to be possible with the information provided regarding the AMHCC, but it is neither overt nor guaranteed given the lack of specific detail provided in the consultation paper. Failure to embed this alignment into the implementation of the AMHCC would enormously increase the risks and costs associated with the implementation of the AMHCC. These risks and costs include, but are not limited to, the disruption of the NOCC's reinforcement of the *National Standards for Mental Health Services* requirement for regular clinical reviews, substantial rebuilding of information systems, increased staff training and retraining, as well as the impact on NOCC data submission, analysis and reporting.

8. NMHIDEAP stresses that the introduction of the AMHCC must be accompanied by appropriate support for realignment of information systems, staff re-training, and any realignment of the NOCC collection and reporting. In addition, Australia is internationally acknowledged as a leader in routine outcome measurement in mental health. The impact of the AMHCC will require substantial evaluation to monitor any impact upon this investment in understanding the outcomes of mental health care.
9. Whilst not a fundamental reason to not proceed, it must be recognised that the collection of outcome measures for activity based funding (ABF) has the potential to impact upon the collection of these measures for other purposes. Currently the measures are collected with a focus on the actual outcomes of care for consumers. The collection of these measures for ABF could shift the focus to the amount of funding their completion may attract. This has the potential to cause a disconnect from good clinical practice, impacting upon the accuracy of the data to support clinical practice and the measurement of the outcomes of service delivery. National policies, e.g. the *National Mental Health Recovery Framework* and the *National Standards for Mental Health Services*, have highlighted the importance of information collection that supports clinical practice. Similarly, the recommendations of the *NOCC Strategic Directions Final Report* called for specific actions to enhance the clinical utility of the measures being collected. NMHIDEAP urges the development of AMHCC specific training
10. NMHIDEAP highlights that the participation of NMHIDEAP members on the IHPA Mental Health Classification Expert Reference Group ensures their expert advice is available to IHPA, but does not imply their endorsement of the AMHCC.

Phase of Care

11. Figure 1 in the consultation paper shows "*Phase of Care*" sitting below setting. This can cause confusion as to whether the "*Phase of Care*" concept can go across settings. Whilst this is a stated long term goal of IHPA, there are multiple obstacles that must be overcome if this is to become viable. At present, there is no equivalence between a phase with the same title in different settings. Therefore the classification would be communicated more clearly (both currently and for the foreseeable future) if setting was on the first level, then age, then phase.

12. *“Phase of Care”* is not currently well defined. When rating *“Phase of Care”* what period in the future is to be considered – one week, one month or 3 months? It is essential to consider the issues described above regarding alignment with NOCC, and important to test the inter-rater reliability of *“Phase of Care”* not only against a set of vignettes, but as part of service delivery. We anticipate this could result in a reduction in the number of phases considered appropriate for inclusion in an AMHCC and subsequent reduction in the number of end classes.
13. The consultation paper gives the impression that a change of *“Phase of Care”* is the main trigger for the collection of outcome measures. It should be made explicit that change of setting is a key driver that triggers the collection of outcome measures, with a change of *“Phase of Care”* the trigger only if this occurs within a setting, or if a given period of time elapses (which NOCC protocols and Mental Health Standards would suggest should be 3 months). If clinicians are left with the impression that *“Phase of Care”* is the main driver of collection, then this could be interpreted as continuing across change of settings, and would not be in accordance with mental health standards, clinical practice, nor current NOCC protocols.

The scope of NOCC and AMHCC

14. NMHIDEAP notes that the NOCC gathers a broader set of information that is required and used by mental health services, above and beyond the needs of activity based funding, most notably the collection of consumer self-reports and measures at the end of episodes of care. Therefore, any specific focus on the collection of clinician rated tools raises a serious risk of significantly impacting upon the collection of the consumer’s own perspective of their mental health and wellbeing; and the failure to mandate collection of outcome measures at the end of episodes endangers the focus upon measuring and improving the outcomes of service provision.
15. NMHIDEAP would also remind IHPA that the *NOCC Strategic Directions Final Report* makes a number of recommendations regarding the future development of NOCC that are relevant to the implementation of the AMHCC. These include:
 - a. The development in Adult and Older Persons Mental Health of both one national consumer rated measure and one national measure that captures the carer perspectives of the consumer’s mental health and wellbeing. These tools would be additions to the NOCC in the coming years and would have associated collection protocols that require consideration in the development of the AMHCC.
 - b. The inclusion of NOCC as a national minimum data set. Some initial discussion has begun towards implementation of this recommendation.
 - c. The development of a single clinician rated measure covering the domains of symptoms and functioning for adults and older persons. The intent is to use the HoNOS / HoNOS65+ as the foundation and include a measure of functioning that replaces the LSP-16 in the collection. NMHIDEAP is undertaking work to scope the development process for this new tool. NMHIDEAP therefore would urge IHPA to consider the value of using the new functioning tool as it is developed. Information gathered by a new tool about a person’s functioning, particularly sensitivity to change, will be important to consider in determining associated costings. The NMHIDEAP would suggest that IHPA re-

consider the additional explanatory value of the LSP-16 in the proposed AMHCC given the impact of its inclusion in the strategic development work outlined above.

16. The NMHIDEAP notes the deferral of the decision regarding the value of collecting the associated clinician rated measures for older and younger people due to the lack of data to draw conclusive decisions regarding their value for the AMHCC. The NMHIDEAP agrees with the need for further development of classification work for younger and older people, but notes that the continued use of these measures was noted in the *NOCC Strategic Directions Final Report* to be significantly dependent upon their inclusion within ABF. Therefore we recommend a timeframe be set for a decision regarding the use of these measures in the AMHCC to prevent indefinite ongoing collection without a clear purpose.
17. Finally, it must be underlined that one of the key messages during the implementation of NOCC was an emphasis on the use of the measures to support clinical practice. Any future communication strategy about the collection of measures as part of the AMHCC should continue to emphasise this same key purpose. This is fundamental to the sustainable implementation of the NOCC and any implementation of the AMHCC. Training to support the implementation of the AMHCC must clearly communicate the need for ABF to support clinical care and its efficient and effective development.
18. NMHIDEAP notes that the Child and Adolescent Mental Health Information Development Expert Advisory Panel is also submitting separate comment on the consultation paper.



Dr Rod McKay
Chair
National Mental Health Information Development Expert Advisory Panel
18 December 2015