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Submitted to **Australian Mental Health Care Classification - Public Consultation No. 2**
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Introduction

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Australian Mental Health Care Classification - Consultation Questions

1 Are the variables included in the draft AMHCC version 1.0 relevant to clinicians, health service managers and other stakeholders?

Yes:
Yes

No:
Yes

Comments::
The development of a new classification for specialised mental health care is an important one. Specialised services have in the past been required to fit into mainstream models to which they are not necessarily suited.

The list of variables included in the consultation paper was generally considered relevant to most stakeholders, although not all variables are relevant (or understandable) to all stakeholders. The consultation paper was insufficiently clear on the exact variables that were actually included and feedback from services indicated confusion as to what elements remained in version 1.0. It would have been more useful if these decisions were clearly outlined in the consultation paper. Additionally, many respondents were interested in a more comprehensive rationale for exclusion and inclusion of specific elements, such as the intervention code set, than what is provided.

Although conceptually relevant a number of issues and queries were raised in terms of the information provided on each of the variables.

Phase of care. Numerous issues and concerns were raised in relation to the phase of care. There remains significant overlap within the current definitions which heightens the risk that this will lead to substantial variation in interpretation and application. As phases are the basis for the classification, Queensland stakeholders have concerns that in their current form they are not fit for purpose. Further review and refinement of the definitions is critical to support a successful implementation. Additionally, it is important that further information is provided regarding how phases align to evidence based practice. For some services, it is envisaged that it would give recognition to the high flow through of clients and the fact that most clients in the acute stage are receiving a resource intensive service.

The attempt to improve definitions of phased by including expected frequency and duration of contact with services has led to greater confusion. It was unclear whether or not these statements were intended as definitional attributes of the phases or as more aspirational statements about minimum standards of care. Concerns were raised regarding what variation from the 'expectation' meant for determining and changing phases. Additionally, the justification for the inclusion of frequency of contact as a guide within the definition was absent from both the initial consultation and supplementary paper. A large proportion of the feedback indicated that the suggested frequencies did not reflect current clinical practice. Overall the definitions were not detailed enough to ensure clinicians would accurately assign Phases of Care.

The consultation paper mentioned an unknown phase of care but did not specify when this would be applicable. For example would it be a category or just what happens if someone does not assign a phase of care? If 'unknown phase ' is included as an option, or if clinicians are confused with the definitions of phase of care and therefore do not select one, the data will be difficult to interpret and utilise. This is a considerable risk given that a significant portion of data was removed from the Mental Health Costing Study analysis due to unknown phases of care.

Concerns regarding the work load and implications in the implementation of phase of care were also raised.

Mental health legal status. This concept is well understood by stakeholders from the specialised mental health sector, however the rationale of why legal status only applied to adult acute phases in the admitted setting (that is, why is it excluded from community setting) was insufficiently articulated.

Diagnosis. It is evident that diagnosis alone is not a sufficient basis for a classification, however it is considered that using diagnosis for at least inpatient episodes

of care would be useful for measuring clinical complexity.

Age group. There was diverse feedback in terms of the age groups. Whilst the three utilised were generally understood and most feedback was supportive, it was queried as to whether there had been analysis of different age groups, and whether there was a need for a further breakdown for specific areas. Further breakdown of age groups was of particular interest for child and youth stakeholders.

Clinical measures. Most stakeholders considered that the AMHCC was proposing to utilise the clinical measures in a way that differs from their current clinical use. AMHCC protocol varied substantially from the National Outcomes and Casemix Collection (NOCC) protocol, which creates a risk to the comprehensiveness, quality and utility of the information. For example, the LSP is a measure of general functioning and the rating rules require a rating of the consumer's average presentation over the past three months. However, the AMHCC requires a collection when there is a significant change in the consumer's presentation, which could happen much more frequently and application for a shorter timeframe is a contradiction to the guidelines for administration. Queensland is strongly supportive of progressing the work to identify modifications to both AMHCC and NOCC that will support better alignment between the collection requirements. The other key issues raised in relation to the clinical measures were that the:

• weighting and grouping (moderate or severe) for AMHCC differs in complex ways to how the tools are currently scored and utilised. This will have a significant impact on clinician engagement and acceptance of the AMHCC.
• reliance on total score alone rather than the importance of the individual scales e.g., a consumer may have low severity on every scale and therefore have a total of 12 (on HoNOS), compared to another individual who may rate high severity on a few scales, therefore having an overall lower score.
• description of the weightings was confusing and most respondents were unable to interpret the information provided and raised concerns that the lack of clarity hid issues and risks. For instance, there are different weightings and thresholds for acute phases in admitted and community settings, but no clear explanation or evidence of how the ratings are weighted.

Concern was also raised that whilst communication from IHPA has clearly stated that it is not the intention to increased data collection, there is significant potential that the classification rules, particularly the collection of outcomes at every phase of care change, will increase burden.

Finally, the technical supplement published just prior to closure of consultation process had more detail on the AMHCC, but overall did not provide the evidence required to have confidence that the AMHCC is fit for purpose. There was also not adequate time from the supplementary papers release for it to impact the feedback provided for the consultation paper.

2 Are there other variables that should be considered in later iterations of the AMHCC?

Yes:
Yes

No:
No

Comments::
It was unclear to many stakeholders what variables had been included in the AMHCC and there was a lack of evidence within the paper to support the inclusion or exclusion of the variables previously identified. Additionally, if exclusion was due to a lack of evidence, then Queensland considers that these variables should be reconsidered at a later date, in particular diagnosis, mental health legal status within the community (and other non-acute phases), and interventions (including considering the impact of emerging interventions such as Transcranial Magnetic Stimulation).

A range of variables that were also clinically relevant and potentially useful to the classification in establishing clinical complexity were suggested. These include: Indigenous status, culturally diverse presentations, socio economic status, interaction with justice system and corrections, child protection and family court involvement, homelessness, social and family supports, rural living location, frequent admissions and the impact of substance misuse in conjunction with mental illness.

There was a particular emphasis on co-morbidities (inclusion of secondary diagnosis to include physical health co-morbidities) as there has been an increasing portion of service delivery dedicated to the monitoring/ support of physical health issues for consumers.

It is unclear how consultation liaison services fit within this model and for outreach teams and services that support other mental health services in managing the mental health care of its population. An example may be telepsychiatry, where a metropolitan mental health service may provide telepsychiatry, conduct mental health specialist assessments and reviews with young people and their families – however this work is not attributed to the individuals providing the care, as they are considered secondary service providers, and the data is attributed to the hospital and health service in which the consumer is attached to. Stakeholders raised concerns over the lack of clarity of the impact on continual funding and progression of these contemporary best practice services.

Similar issues were raised in relation to speciality programs such as early intervention.

3 Do the final classification groups have relevance to clinicians, health service managers and other stakeholders?

Yes:
No

No:
Yes

Comments::
The consultation document acknowledges the very technical nature of the classification document, however has not provided the technical specifications to fully understand the model, and at the same time has stated the importance of a broad consultation process. It is believed that the average clinician and stakeholder

will struggle to understand the classification model as it stands and it is unclear how this will be translated into practice.

Concerns were also raised in terms of the current face validity of the model, how it aligns with National Standards for Mental Health Services and recovery principles and do not see enough evidence that it has been sufficiently developed in consultation with and understanding the needs of the different target populations, such as infant, child and adolescent population.

The definitional issues and complexity in the application of phase of care identified in response to question one are relevant to this question, but have not been repeated in full here. This issue is of significant concern as the phase of care is fundamental to the AMHCC. Most stakeholders considered that the consultation paper did not provide clarity on the proposed classification which limits its relevance.

There seems to be a large number of classes resulting from the new classification for both the admitted setting and the community setting. However, it is unlikely that these will have any clinical relevance outside specific costing modelling and applications.

The change in terminology from 'Initial Assessment' to 'Assessment only' has been acknowledged as an improvement, however it was confusing as Assessment only eliminates clients that go on to treatment, because they receive more than an assessment only. When patients are first assessed, clinicians may not know which phase of care until they have conducted an assessment and then which phase do they record? If Phase of Care is not interpreted correctly it may led to clinicians frequently updating the phase of care, or in practice patients may commonly move between phases (research showing non-linear process with period of growth and setbacks). Frequent phase of care changes will result in a significant collection burden for clinicians. The consultation paper states the majority of inpatient admissions for admitted setting are relatively short (up to seven days) and typically have one phase of care, however what about the minority of clients who will have several phases of care within a week? Completing all the assessments, multiple times in a short period is not clinically effective and is also frustrating for patients, who are repeating information.

Feedback also challenged whether Phase of Care was necessary and whether the classification could be done at the episode level. Without details of the episode analysis, the AMHCC fails to detail why Phase of Care is superior to episode as the costed unit. Although the consultation summarized the findings of analysis on comparative RIV, these results did not clarify if the episode or phase of care would be the appropriate classification unit. It was also suggested that if cost was purely location driven then Phase of Care would not be needed, rather the relationship to the resource utilisation was more useful data. The supplementary paper whilst providing further detail showed that the Coefficient of Variation (CV) and mean cost estimate analysis were not strong, although expected to improve over time.

The consultation paper notes that "the use of diagnoses to describe patient grouping has little clinical relevance when compared to other measures such as HoNOS". This statement is inaccurate and a concerning message as diagnoses remain critical to service delivery, treatment options and access to support. It is clearly recognised that diagnosis alone is an insufficient basis for classification, however it was queried whether or not a clinical classification without the inclusion of diagnosis would be able to be clinically relevant.

4 Are the priorities for the next stages of development of the AMHCC appropriate?

Yes:
Yes

No:
No

Comments::
Several areas were identified as priorities for the next stages of development of the AMHCC. Feedback was generally supportive of all areas identified in the paper, although phase of care was identified as requiring substantial work by all stakeholders. The issues are outlined in Question One of Queensland's response.

Overall feedback supported further development of the AMHCC targeting child and youth and older persons mental health care. Prioritizing the expansion of the scope of the AMHCC to be inclusive of child and youth is especially important considering recent research which identified that 1 in 7 young people will have a mental health disorder, how mental health affects someone across their lifespan, as well as the increasing aging population.

The consultation document recognises that there are drivers for child and youth services that are not clearly able to be incorporated. It is considered extremely important to focus on these with expert clinical reference groups to ensure they are captured. The implication of the wording is that these drivers are too complex to identify clear linear causal paths to fit with the model. Additionally, there is no evidence that the 0-4 cohort have been considered in this consultation paper or the modelling. There are specific service delivery drivers for this age group that must be considered, again in consultation with a specialist clinical reference group that has currency of practice.

There was also support for the priority to further explore clinical complexity and comorbidity measures. Clinical complexity and comorbidity measures were found to be useful in explaining variations in costs and therefore it would be useful to determine how they can be incorporated to ensure accurate costing. New outcome measures for services may be required to ensure complexity is appropriately captured. The main examples provided are outcome measures for infants and measures for persons within prison and detention settings.

It was recognised that Residential Mental Health Services had limited data and therefore were not able to be included in version 1.0. However, the nature of the service means there is unlikely to be significant amounts of data. This should not prohibit investigation and development of classification for these services.

The ability to capture systemic work that is undertaken by services, particularly child and youth services, should be considered for incorporation into the model. The utility of the classification for statewide services or services that provide treatment to broader catchments, such as forensic and prison mental health should also be considered.

The AMHCC consultation paper suggested that future iterations will aim to cover a broader scope of services including community-managed mental health

(CMMH) services and Non-Government Organisation (NGO) to ensure relevance for a greater range of people, domains and services. While in theory this would be a useful comparison and standardized classification, there are several considerations that need to be discussed. In Queensland, CMMH and NGOs provide different services through different models, often to a different cohort, than those provided by public mental health services. Inclusion of these services would require significant investment, in both development and implementation. The key issues related to the fact there is little to no infrastructure for the collection of the amount of data required to support a classification and there is currently no standardisation of what data is collected. The implementation of standardised data collection (including measures) requires significant service and sector development and ICT investment. This would need to be funded, particularly for smaller services.

5 Are there any other issues which should be taken into account in the next stages of development?

Yes:
Yes

No:
No

Comments::
IHPA needs to support the consistent implementation and application of business rules for recording and capturing data across jurisdictions. The current approach to business rules allows too much interpretation and local decisions for implementation, which severely limits the national comparability of data that will feed into the AMHCC. Additionally, it would be useful to have a summary of the current suggested business rules because although the consultation paper mentioned them, it did not give examples of how the business rules were revised to address the feedback provided.

It would be interesting to look at the effects that benchmarking on specific issues of cost and technical efficiency has on clinical performance. This may be something beneficial to measure in the ongoing evaluation of the AMHCC. There also needs to be recognition of the significant risks and costs associated with the early stages of implementation, including substantial impacts on workforce, clinical processes and information systems, these factors will vary depending on jurisdictions and different systems. The first consultation paper talked about administrative and operational feasibility but the second consultation paper did not address the estimated costs of implementing the new classification system. It is essential that the classification be as 'fit for purpose' as possible to reduce these risks.

The ability to capture systemic work that is undertaken by services, particularly child and youth services, should be considered for incorporation into the model.

A major concerns emphasized by several participants is the current consultation paper provides limited information to allow an objective or independent view of the technical performance of the draft AMHCC. Clarification of the processes and analysis done to achieve the results which outline the effectiveness of the proposed model would help develop confidence in an accurate and strong classification system. The consultation paper mentions that the AMHCC has undergone further scrutiny to ensure it reaches the benchmark for statistic and clinical validity. It would be useful to have access to this analysis to increase confidence and understanding in the classification. The main priority of the AMHCC should be to provide a statistically sound model that is easy for clinicians to interpret into practice and therefore the main priority for AMHCC needs to be further refinement of the Phase of Care and associated business rules/ documentation.

A number of stakeholders indicated that they found it particularly challenging to articulate informed comments on the Public Consultation Paper due to a lack of background knowledge, not provided or assumed, within the discussion paper. It was identified that understanding would have been enhanced if there had been the opportunity to consider the technical specifications supporting the proposed classification system, if further information had been provided on the different services and target population's included within the pilot and costing studies, and how the weightings were devised for the different target populations.

It is critical to clearly explain the benefits the changes will make to the delivery of services to consumers and carers in plain English.

6 Do you consent to the answers you have provided being submitted for the consultation?

Yes:
Yes