

MENTAL HEALTH CARE WORKING GROUP – AUSTRALIAN MENTAL HEALTH CARE CLASSIFICATION

Western Australia (WA) would like to provide information on services provided through the Women and Newborn Health Service (WNHS) for consideration on how these services would be captured within the AMHCC.

1. Mother Baby Unit (MBU) facilities
2. Clinical Liaison Services

1. Mother Baby Unit

The MBU is a designated eight bed authorised Mental Health facility that provides acute inpatient care for women with mental health issues in the perinatal period. The MBU compliments the perinatal care provided by King Edward Memorial Hospital (KEMH) and is a 'stand-alone' facility based on site. The unit will accept an antenatal woman from 24 weeks gestation and post natal mothers with babies up to 12 months to ensure care is provided in a safe, nurturing environment with the expertise to meet the specialised psychiatric and obstetric requirements during this vulnerable period. The MBU has links with Psychological Medicine who provide psychological and psychiatric care to women attending KEMH. The MBU and KEMH provide state-wide services for high risk patients requiring tertiary care. There is a second publically funded eight bed authorised MBU in Perth with a similar model of care (but which does not accept antenatal patients) at the Fiona Stanley Hospital.

Research has shown the advantages of designated units supporting the bond and relationship between mother and baby in the high risk perinatal period at a crucial time when the brain development of babies is rapid and their capacity to form appropriate interpersonal relationships is being established. Where there are no publically funded services available in some states the mother is separated from her baby disrupting this bond with demonstrated adverse clinical and developmental outcomes for both mother and baby. Whilst the activity numbers of the units are relatively low, outcomes from the MBU have shown greater success for the mother and baby relationship, improving development of the baby and mother's and baby's health outcomes, ultimately reducing need for future health intervention, both physical and psychological.

Where there are no specialised mother baby unit facilities or no publically funded beds, the mother and baby are separated. In the ACT, NT, NSW, and QLD there are only private MBU facilities which are not authorised and not able to accept significantly unwell women who require care authorised under mental health legislation. Private facilities are not affordable for many families and in states where these are the only options, the mothers and babies are separated. There is often an unanticipated financial cost to the father or extended family who then need to provide care for the baby. When paternal or family support is not available, the state may

need to provide this support and babies in this group are often subsequently unlikely to be reunited with their mothers.

Typically babies that accompany their mother into the MBU require a range of additional care in their own right, including:

- Clinical assessment of mother infant attachment and remedial therapy to repair or enhance the relationship between mother and baby disrupted by the mother's mental illness.
- Prescription and administration of medication particularly where the baby is experiencing distress or is 'difficult to settle' as a consequence of the mother's mental illness and/or anxiety.
- Additional physical care and monitoring of baby as a consequence of exposure to the mother's medication during pregnancy. Babies born to mothers with significant mental illness may be small for dates and possibly born at an earlier gestation, requiring more intensive mothercrafting input around feeding and settling.
- Due to risk of harm by the mother in some cases, initially there will be 'all care' undertaken by nursing staff until a gradual reintroduction of the baby to mother. This allows for the safe development of the mother baby relationship in a supportive environment where mother has increasing access to her baby.
- Specialist infant mental health care provided by the psychiatrist and treating team, particularly if the baby is admitted from home due to a later presentation by mother and where they are withdrawn or displaying inappropriate behaviours as a consequence of maternal neglect or mother's disturbed behaviour before admission to the MBU.

The proposed IHPA model adequately addresses the mother's care when mothers and babies are kept together, to ensure that at all phase of care she has appropriate access to her baby, reducing her distress at separation and maintaining the mother infant interaction. However, the model is silent on the mental health and general care a baby also requires at this time. To rectify this issue the baby needs to also be recognised as a patient with their own care needs – that are linked to the mother's phase of care.

The current AR- DRG classification is problematic as a funding source in MBU's because the baby is considered a 'boarder' therefore does not attract funding for the care received.

Further, in cases where the admission of a mother is within 45 days of her delivery, there is significant impact on coding the care and subsequently accurately representing the cost of care. A significant number of mothers' admissions are allocated an "O" DRG rather than a mental health DRG which affects funding and is not reflective of the episode of care.

Whilst the proposed classification model may improve the classification for the mother it ought to also address the cost of care provided to the baby. As outlined above there is a range of care provided to these babies, which does come at an additional cost to the organisation because there is no discrete funding source for the baby.

WNHS recognises that there are few MBU facilities operating in public hospitals around Australia and is happy to work with IHPA as a pilot to explore an appropriate recognition for the costs associated with care for a baby in a MBU.

WA would also like to highlight that when women (i.e., mothers) stay in the MBU, they currently only attract the birth DRG and the loading below. Babies are considered “boarders”, so their care does not attract funding at all. Some have long length of stay and WA would welcome further discussion on how these cases will be treated under the AMHCC.

Specialist Psychiatric Age Adjustment (> 17 years, not in MDC 19 or 20)	Is in respect of a person who is aged over 17 at the time of admission, with a primary diagnosis which is not mental health-related (not in MDC 19 or 20) and has one or more Total Psychiatric Care Days recorded.	Admitted Acute Patient: 34 per cent
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2. Consultation Liaison Services

Currently a number of patients, who are admitted and discharged under a medical DRG, receive extensive psychiatric and psychological support. Limitations to source systems do create restrictions to the way these costs are reported for patients with these particular DRGs. Under the current funding model, there is no specific funding for the mental health service component of their care provided by a Consultation Liaison (CL) service. At times, when the obstetric or medical issues have been treated and resolved, it is the mental health issue that becomes the focus of care during the admission, despite the patient not being in a mental health bed. An option for consideration is for such patients to be seen as “community” mental health patients under the proposed system, despite their status as medical inpatients. That is, the general or obstetric hospital being seen as part of “the community”. The assessment of treatment as belonging to acute, functional gain, etc could still apply.

From the scope defined in the public consultation paper it seems that CL services are outside of scope for the proposed new classification model. WA’s WNHS would like to raise this cost as a large contributor to mental health services that is not reflected in current funding or costing models.