

Independent Hospital Pricing Authority
Per e-mail: submissions.ihpa@ihpa.gov.au

Women's Healthcare Australasia (WHA) and Children's Healthcare Australasia (CHA) response to the IHPA's Consultation on the draft Australian Mental Health Care Classification Version 1.0, December 2015

Thank you for the opportunity to provide comment in response to the IHPA draft Australian Mental Health Care Classification Version 1.0 Consultation Paper.

Children's Healthcare Australasia (CHA) and Women's Healthcare Australasia (WHA) is the peak body for hospitals providing maternity and women's health services across Australia. Together, these organisations represent the majority of women's and children's healthcare services in Australia.

In general, both WHA and CHA members welcome the approach proposed in the draft Australian Mental Health Care Classification (AMHCC) Version 1.0 consultation paper. The aim of the new classification to include specialised mental health care is important.

The paper itself is clear and succinct, and provides a structured approach to support the future of Mental Health service delivery in both the community and inpatient setting.

WHA & CHA suggest the following in relation to Mental Health Care Classification:

General comments

HoNOS is not used universally

CHA members noted that HoNOSCA can only be applied on children and adolescents aged between 3-18 years, and that there is still considerable inter-rater reliability issues associated with the HoNOSAC. There is no clinically validated tool that can be applied to children under the age of 3 years.

The proposed system is highly reliant on current, or increased, levels of relevant data collection. There is an additional burden in data generation & collection that might not be currently in place implied in the introduction of this classification system.

Members commented that more emphasis should be placed on the importance and impact of patient based factors. The implications of working with blended and separated families, kinship carers or other care providers, and care of children & adolescents within the child protection system as well as the impact of mental health legal status in the ambulatory care setting cannot be underestimated in relation to cost and time.

Costing of Child & Adolescent mental health care

Our members suggest that a Child and Adolescent Mental Health expert be appointed to the Mental Health Classification Expert Reference Group. Members have also offered to become a part of a future C&AMH costing study.

They are also keen for the initial costing of C&AMH to be reinstated. The impact of reduced funding of C&AMH DRGs has been serious (as demonstrated in the WA context). Ultimately consumers suffer and the state will absorb an 'increased' financial cost in the health and other sectors moving forward.

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

1.1 1.1 Level 1 – setting

WHA & CHA are concerned that the split of settings into admitted and community branches is oversimplified. It is not clear how outreach, day program, and hospital-diversion based services will be classified under this system.

1.2 1.2 Level 2 – mental health phase of care

It is believed that the average clinician or stakeholder would struggle to understand the classification model as it stands, and it was unclear how this will be translated into practice. Because this is a newly developed classification system the AMHCC would benefit from the development of worked examples and case studies to guide clinicians in decision making when assigning a particular phase of care to a patient. It is acknowledged that the phase of care is defined in the consultation paper however guidelines to accompany those phases would assist clinicians in assigning the relevant/correct phase of care.

1.3 1.3 Level 3 – age group

WHA & CHA members recommend that the 0-17 age group be reconsidered. The nature of assessment, treatment and support provided to adolescents is significantly different to that provided to younger children. Many Child & Adolescent Mental Health services divide care up between age groups serving the separate need of 0-12 year olds and 13-21 year olds. We recommend this some age break-up.

WHA members also noted that the numbers represented in the statistical breakdown (Public Consultation Paper 2 – Supplement) for the over-65 age group reflects reasonably low numbers of people across this age group. Older persons mental health represents a large and growing portion of our mental health sector service delivery. We ask if there should be some further analysis of data to confirm classifications prior to settling on a classification system for this group.

1.4 1.4 Level 4 – mental health legal status and Level 5 – HoNOS complexity

Mental health legal status and HoNOS complexity are not adequate measures of complexity for children and adolescents.

It is unclear how HoNOSCA) outcomes inter-rater reliability will be addressed and operationalised across teams, services and jurisdictions, to ensure it is consistent. Unclear of the HoNOSCA complexity ratings and the impact this focus may have on teams and services, especially if funding or costs are associated.

1.5 1.5 Level 6 – LSP-16 complexity

It is not logical to include the LSP-16 as a measure of complexity for the 18 – 64 year old age group but no equivalent measure included for 0-17 year olds. Please refer response to Consultation Question 2 for recommendations from CAMHS regarding the need for additional complexity variables.

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

Psychosocial complexity is not adequately captured in the current iteration of the model. Of particular concern is the lack of attention to the impact of social care services (most notably the Department of Child Protection and Family Support) on length of stay (LOS).

Regarding the below statement:

“The FIHS and CGAS were tested in relation to consumers in the 0-17 years age group. Due to low sample size there was insufficient evidence to support the inclusion of either as a variable at this stage”.

CHA members are of the view that low sample size is not an adequate reason to exclude these variables. With the Strength and Difficulties Questionnaire (SDQ), CGAS and FIHS all excluded from the list of variables, the model provides no method of capturing psychosocial complexity for children and adolescents. It does not make sense to use the LSP-16 as a measure of complexity for the 18–64 year old age group and provide no equivalent measure for children and adolescents.

The SDQ is also the only consumer and carer rated measure. This is important as it provides a basis of comparison to clinician rated outcome measures, with their risk of bias.

International Classification of Disease 10 (ICD 10) codes also ought to be considered as potential variables that would allow for improved measurement of psychosocial complexity. For example, Z codes could be considering for recording 'Factors influencing health status and contact with health services'.

Our members also wish to note that the addition of any of these variables to the model would encourage better recording and reporting of outcome measurements amongst mental health clinicians.

Regarding the below statement:

“Responses to the January 2015 consultation paper sought consideration of a broader range of variables in the AMHCC in relation to child and adolescent mental health care. These included, but were not limited to, the interface between mental health care services and other government agencies, the impact of the mental health of primary carers and other social considerations. IHPA considers these issues as important to take into consideration and will undertake further consultation with the child and adolescent mental health care sector over the coming months. However, it is important to note that not all of these variables are suitable for inclusion in a classification system which seeks to explain the costs of service delivery by the mental health sector, rather than the total economic cost of individuals' illness over time”.

Feedback already provided noted difficulties in capturing the cost of treatment when considering the child as an individual, rather than a child dependant on the quality of their caregiving environment and other social ecology factors. There is considerable effort and cost in effectively intervening to improve this. Throughout the paper, there is a conceptual overemphasis on social support required, rather than evidence based treatments to enhance relationships, and commitment to time consuming collaborative interagency work. The purpose of considering the interface between mental health care services and other government agencies, the impact of the mental health of primary carers, and other social considerations in the model is not to fund to services for the “total economic cost of individuals' illness over time”, but rather to assist in the development of loadings that would see each patient receive a level of funding that is commensurate with their complexity and length of stay (LOS). The paediatric loading, which has been eroded each year for the major mental health DRGs does not capture the costs of this.

Members indicated that Mental Health Status and legal status in the community is an indicator of complexity – this does not appear to be incorporated in the current models (just in the inpatient setting). The legal status of a child in the context of child protection issues and family court involvement are significant drivers of resource utilisation as well as mental health act status.

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

Recent episodes of care across five years would seem to be a good addition to the classification. This could be a useful measure in a setting where there is a rotating door for admission (e.g. detention centres).

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

We note that the Mental Health Costing Study was entirely hospital-based. In the previous study, there was only one C&AMHS inpatient site used, which was partially closed for a period of the study. As a result, CHA recommends that the involvement of both community and at least four hospital-based child and adolescent mental health services be made a priority in the next stage of development of the AMHCC. A number of CHA members are willing to act as pilot sites to assist in developing the classification.

The document makes some very good points about the distinction between adult mental health services and child and youth mental health services. For example, C&AMH services involvement with family, patient, teachers, community resourcing, cultural support etc. this is quite a complex area to design into the classification. It is not clear from the discussion document how much C&AMH service consultation has been undertaken in the pilot and costing study and how they will be engaged for future consultations.

There is no evidence that the 0-4 year old 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.

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

5.1 Therapeutic interventions

Regarding the below statement:

“Mental health interventions relate to selected mental interventions provided to consumers under four categories: assessment and review interventions, therapeutic interventions, emergency interventions and service coordination interventions. It was captured using the Mental Health Intervention Classification (MHIC). The MHIC was designed by the Australian Institute for Health and Welfare in 2013, but has not been routinely captured in admitted data sets to date.

In analysis of the MHCS data, the only intervention that was found to be significant in explaining variation of costs was electro-convulsive therapy (ECT).”

Our members are of the view that ‘therapeutic interventions’ is a particularly broad category that ignores the significant difference in costs associated with different types of ‘therapeutic interventions’. For example, the cost associated with providing both individual and family therapy to a child is vastly different to the cost associated with providing individual therapy on its own.

The AMHCC offers no equivalent to the procedural coding system used in general medicine. An inpatient stay is treated as a single ‘service event’, despite the fact that a stay as short as one night is an intensive period of assessment, treatment and support that may involve any number of separate procedures/therapeutic interventions.

Our members are of the view that ‘therapeutic interventions’ ought to be divided into subcategories to reflect the various types of therapies provided by mental health clinicians (including risk assessment, family and individual therapy etc.)

1.6 5.2 Weighted HoNOS score thresholds

Regarding Appendix B on page 32 of the consultation paper “Weighted HoNOS score threshold for ‘high complexity,’” CHA members are of the view that these score thresholds should be

reviewed. Currently, the threshold for 'Acute' for a 0-17 year old admitted patient is lower than the threshold for 'Acute' for a 0-17 year old community patient which is counterintuitive. The table indicates that a patient should be more 'well' when discharged from an inpatient unit than when discharged from the community setting.

We also consider that the 'Consolidating gain' score for Community patients is too high. Member services note that a score of 23 is considered clinically significant.

Finally, we are of the view that it is not appropriate to use absolute HoNOS scores to assist with developing a costing measure. The use of absolute scores is appropriate for clinical decision making only.

It would be useful if there was a Child and Adolescent Mental Health expert on the Mental Health Classification Expert Reference Group.

Thank you for considering our submission.

Yours sincerely,

Julie Hale

Julie Hale
Deputy Chief Executive Officer
Women's Healthcare Australasia & Children's Healthcare Australasia

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