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‘Development of the AMHCC’ Project

Independent Hospital Pricing Authority

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Dear Sir/Madam

Thank you for this opportunity to respond to a number of the questions posed in the IHPA public consultation paper 1 ‘Development of the Australian Mental Health Care Classification’. This is a most important endeavor. Please find comments on the following issues:

**What are the most important factors to draw from international experiences in classifying mental health care?**

The ensuing remarks refer to the New Zealand’s mental health care case mix classification and the Ontario (Canada) System for Classification of In-patient Psychiatry (SCIPP).

*New Zealand’s mental health care case mix classification*

Collecting the demographic information of people using the specialist mental health system is important for a number of reasons, including being able to assess whether the mental health services are reaching or neglecting groups in their catchment population. The use of demographic factors, such as age, in case mix funding is merited if there is a reliable relationship to predicting costs. While possibly contentious, ‘ethnicity’ may provide valuable data if it is established that some groups are more likely to need mental health services than others. The inclusion of Length of Stay as a factor in each class of people with similar characteristics and costs is clearly related to service utilization (and expenditure) but is also susceptible to local conditions and practices.

*Ontario’s SCIPP*

SCIPP categories are based on diagnosis then ordered in clinical hierarchy according to the estimated resource intensity. Yet SCIPP explains only approximately 26% of the variability in actual per diem resource utilization for all psychiatric inpatients. This is a disappointing result. However it could be instructive to know whether resource utilization of a particular group of similar clients predicts the average resource costs of that group over time.

**What are the most important considerations in the national context?**

The above comments tie in with the observation from the developers of the MH-Classification and Service Costs project (p13) that while level of service does bear a clinically and statistically logical relationship to the person’s clinical status, this relationship between clinical factors and costs is confounded by variations in practice. If this is true then urgent efforts should be made to identify the most efficient and effective practices to guide the appropriate level of funding.

**Are there any other key considerations that should be taken into account in developing the Australian Mental Health Care Classification (AMHCC)?**

The data sets and other sources of information being used to develop the AMHCC should be examined to determine whether they are capable of delivering the requirements described in each principle for classification development. If not, it is preferable to increase the scope of the data sets rather than compromise the purposes of the classification system. A related matter is one of Health Service compliance in completing the necessary data collection. While sufficient data may be gathered to develop the AMHCC through projects and study sites, the utility of the system to benefit of people with a serious mental illness will be lost if there is subsequent poor data compliance. For example, the completion of NOCC items is still highly variable. Consideration should be given to implementing measures that improve mental health service compliance.

**Comment on the ABF Mental Health Care Data Set Specification**

I would like to mention that the inclusion of step up/step down services under ‘residential care’ may obscure their intended purpose. Some mental health residential services exist primarily to accommodate people with a serious mental illness. Other residential service types also have or access medium to longer term recovery/rehabilitation programs. Step up/step down services are typically closely linked to acute inpatient services, offer intensive short term interventions and support prior to people returning safely to their place of residence. As a service type it is more sub acute in nature rather than what is implied by ‘residential’.

**Are there any other cost drivers that should be considered in the development of the AMHCC?**

Other possible cost drivers could be:

* Events or programs that may increase mental health service utilization such as natural or man made disasters or the impact of mental health awareness programs.
* The lack of available and willing carers and families to support the person with a mental illness.
* Insufficient clinical and community managed mental health services as well as general community services to consolidate gains by the person with a mental illness and realize the goals of their care plan.

A potential cost moderator could be clients in the specialist system having access to mental health programs in the primary health system, for example, using *Better Access* via GPs.

**Are there any further considerations in relation to the proposed architecture?**

It would be useful if the duration of a service in ‘service event’ could be introduced to obtain a better sense of resource intensity.

Although not a comment about the proposed architecture of AMHCC, I would like to suggest that on the issue of NOCC measures, there is a case for using RUD ADL (or comparable) measures for adults as well as older persons, given that psychiatric disability often manifests itself in physical ways. Such an inclusion could provide information in the post acute phase as to whether psychosocial interventions are having a quantifiable impact on psychiatric disabilities.

**Which psychological interventions, if any, may be of significance in understanding the cost of care?**

The list of psychological interventions in the Mental Health Intervention Classification 1.0 – individual, group and family - contain clearly evidence based therapies, such as CBT and one or two less proven ones such as Narrative Therapy. (While there has been little outcomes based research in Narrative Therapy, its style suits the way Aboriginal and Torres Strait Islander people relate to difficulties in their personal world and to mental health issues.) It would be useful to have a more explicitly identified listing of effective and efficient interventions. This can only add to the ability of the AMHCC to reliably predict costs. It should be noted that delivering interventions such as counselling sessions in specialist mental health services can problematic due to large case loads and other work pressures. The implementation of successful psychological interventions is probably insufficient due to resource constraints in the specialist mental health system.

The AASW looks forward to learning of the outcome of this initial consultation and to contributing again in future, if needed.

Yours sincerely,

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Policy and Advocacy