**Response to the Public Consultation Paper 1 – Development of the Australian Mental Health Care Classification**

The development of a separate Mental Health classification is not a high priority for Tasmania. Tasmania is on record as not supporting the need for a separate approach for mental health services and believes that the best approach is to improve the AR-DRG classification for admitted mental health and that a duplicate parallel system should not be introduced.

As Tasmania’s preferred position did not have the support of the majority, Tasmania has accepted the introduction of a mental health care type from 1 July 2015, and a new mental health data set specification, on the basis of best efforts, from 1 July 2015.

Notwithstanding this, Tasmania continues to raise concerns with IHPA’s ambitious timeline for the development of a new mental health classification and the subsequent resources and data burden imposed on states and territories.

**Specific Comments in response to the Public Consultation Paper 1**

The paper does not clarify the future of the current mental health National Minimum Data Sets (NMDS) collections together with the National Outcomes and Casemix Collection (NOCC) and whether or not the Australian Mental Health Care Classification (AMHCC) will replace these collections.

If the AMHCC collection is not a replacement for NOCC, and both collections are to run concurrently, it means there is a national requirement to report two collections, each with different collection rules reporting from one data source. These two collections appear mutually exclusive. Based on the principle of ‘single provision multiple use’ it would have seemed reasonable for the NOCC to have been adapted to meet the needs of ABF; instead of AMHCC being developed as a completely new data collection.

If jurisdictions are expected to report both NOCC and AMHCC and their collection rules are mutually exclusive, being compliant with one collection will result in non-compliance with the other. If the AMHCC takes precedence over NOCC, does that result in the NOCC being a redundant collection? If the former is the case, then do the AIHW, DOHA, IHPA and Australian Mental Health Outcomes and Classification Network (MHOCN) expect jurisdictions to continue reporting both collections beyond July 2015?

If the collection rules for NOCC and AMHCC are compatible then AMHCC represents an overlay of another set of rules on top of NOCC rules. In Tasmania’s view this is likely to create confusion and likely to detract from both collections. Tasmania’s preferred position is for single provision of Mental Health outcome measures and events with multiple uses across all relevant agencies.

Additional cost drivers that should be considered are; the socio-economic status of population groups served by mental health services. There is a significant body of research indicating increased prevalence of common mental disorders in socio-economically disadvantaged populations. Poor health recovery outcomes are also associated with these population groups.

**Mental Health ‘Phase of Care’  Community/non admitted setting**

The document states that a phase of care will be collected at each contact, a significant proportion of contacts are recorded however; the client is not present during that contact. If the client is not present, and the decision is to change their phase of care, it triggers an assessment event (case conferences are a prime example of this situation). At that point in time the clinician is potentially unable to complete an assessment and the corresponding outcome measures for the client. If the clinician is forced to provide outcome measures at this point without seeing the client, it will detract from the quality of assessment outcomes. There needs to be greater clarity on how this process will work in practice.

Perhaps ‘Phase of Care’ should be completed during ‘Face to Face’ contact with the client enabling the triggering of an assessment event. Alternatively, it should remain a part of the assessment event and not become the trigger for such an event.

Phase of Care is open to interpretation when it’s based on service contact. Depending on the clinician involved in the contact, it may result in a change to the clients ‘Phase of Care’. In a multidisciplinary team environment a client may see multiple clinicians during their treatment in the community,  clinicians from different clinical disciplines may have  a different view of the client’s ‘Phase of Care’. This could lead to multiple assessment events for a client over very short periods of time. This situation would not comply with the documents ‘principle 2’ (Clinical Meaning) or ‘principle 9’ (Administrative and operational feasibility) in developing this classification.

As previously stated, Tasmania will have difficulty in the capture and reporting of ‘phase of care’ across the various mental health services. The current hospital information systems have not been developed to easily capture this information and it will require significant resources and lead time to modify patient management systems to capture these data.