**Development of the Australian Mental Health Care Classification (AMHCC)**

**IHPA Public Consultation Paper 1**

**WA Health’s Reply to the Consultation Questions**

***Question 1:*** What are the most important factors to draw from international experiences in classifying mental health care?

***WA Health’s Reply***:

HoNOS as a tool could be very useful in the financial decision making process of the need for clinical services for a particular area or population, but not for the costing a particular diagnosis or individual. Diagnosis Related Groups likewise are problematic in that they do not take into account the individual variables that patients present with, such as homelessness, lack of family/carer support/ financial hardship/ forensic history.

Overseas experience has not specifically addressed issues affecting child and adolescent mental health services (CAMHS). The impact of social factors, family functioning as well as organic/somatic co-morbidities on CAMHS services should be considered in designing the AHMCC.

***Question 2*: What are the most important considerations in the national context?**

***WA Health’s Reply***:

The AMHCC should reflect the true cost of delivering mental health services, both in inpatient and community settings. It should have clinical and financial relevance. If new data items such as phase of care and mental health intervention codes (MHIC) are required, significant investments in education, training and ICT will be required.

Difficulties with diagnosis at the early stages of mental illness are the main concern for youth. Traditional classification systems tend to lack adequate categories for young people with either at risk mental states or emerging disorders, which nevertheless have significant impact on their functioning and wellbeing by this stage.  Such persons often require specialist teams to provide care due to the specialist knowledge and skills required.  This is an opportune stage to intervene not only in terms of cost to the health system long-term, but also for the young person’s prognosis and quality of life. It is also well known that diagnostic stability is poor at this stage of illness and there are issues of stigma with premature “labelling” of young people.

Mental health services provided by various agencies need to be fully understood. The introduction of the National Disability Insurance Scheme and support packages will undoubtedly have a funding effect on public provision of mental health clinical services and non-government organisation (NGO) providers. The development of the AMHCC will assist services to better advocate for individuals and the funding for services they may require. However there may be concern about the ability to be flexible at times of increased instability.

The introduction of the AMHCC will partially drive service design unless sufficient flexibility is allowed for innovation in practice and/or model of care. Reliance on standard measures in itself may limit innovation and/or cost savings, or have the outcome of community services not providing a service due to lack of payment or resources per patient resulting in increased inpatient admissions.

***Question 3:*** Are there any other principles that should be considered in developing the AMHCC?

***WA Health’s Reply***:

The needs of statistical data collection can be different from the needs of clinicians and that this may not necessarily have clinical meaning due to the mandatory and artificial nature of the use of assessment tools as drivers for funding when not clinically indicated or relevant. There is often a mismatch between the two needs which creates a time-consuming extra workload for clinicians undertaking clerical duties rather than spending time with patients. This results in a reduction of service provision overall without a subsequent reduction in cost. Creation of systemised processes to reflect care could result in a reduction of service provision, or even more costly service provision, and pose unnecessary burden for system input by clinical staff, particularly psychiatry which is a very expensive resource.

There is variance in the subjective understanding across mental health services in regard to consistent and uniform data elements in community mental health. It is very difficult to change this. It is unsure how this would impact on using data for purposes other than funding. The data would require significant capacity for analysis for it to meet the required utility beyond activity based funding.

Principles 2 (clinical meaning) and 4 (patient/consumer based) should include statements around the importance of a systemic approach encompassing patients and their support systems.

***Question 4:*** Are there further data or other limitations of which the AMHCC should be aware?

***WA Health’s Reply***:

The Community Mental Health Care (CMHC) National Minimum Data Set (NMDS) includes ‘unknown/unregistered’ clients where service contacts provided to patients who contact MH emergency response lines and do not wish to be identified. Given that these patients do not undergo an episode of care and are 'assessment only’, clarification should be provided if they are in or out of scope.

Reliance on matching paired data (discharge from community MH and admission to MH inpatient unit and vice versa) will result in phases of care being missed and extra workload for clinicians and administrators as many patients are concurrent patients of both inpatient and outpatient. This is particularly true of patients with assertive admission as part of risk management who regularly present for overnight or 48 hour admissions as part of behaviour management.

***Question 5:*** Are there any other key considerations that should be taken into account in developing the AMHCC?

***WA Health’s Reply***:

Developmental stage, intellectual capabilities, somatic co-morbidities, and how these issues will impact on mental health care costs should also be considered.

***Question 6:*** Are there other cost drivers that should be considered in the development of the AMHCC?

***WA Health’s Reply***:

The phase of care is a linear model which does not suit patients who move more frequently between different phases and/or who are provided with services from multiple clinicians under a multi-disciplinary service provision framework. The phase of care model is likely to be suitable in an inpatient setting, but not community.

The phases of care seem adult focussed and harder to fit with children and adolescents.

* Acute and functional gains phases are inter-related/impacts on each other in a child and adolescent setting
* Intensive extended phase for children and young people can be about keeping them alive long enough to allow brain maturation.
* Reassessing the phase of care every 14 days seems a reasonable way of capturing cost drivers in the inpatient setting.

The liaison required with various service providers including NGOs to accurately decide the phase of care in multidisciplinary team management processes is a significant cost driver for community mental health.

Other cost drivers include client liaison activity, rural/remoteness and indigeneity. There are also cost variances between group and individual sessions and whether the intervention is provided by multidisciplinary teams. Travel time in country areas is a significant cost driver.

***Question 7:*** Are there any further considerations in relation to the proposed architecture?

***WA Health’s Reply***:

Whilst is it recognised that mental health data collection systems across jurisdictions are at various stages of development, data linkage capacity is essential. For example, in the IHPA Mental Health Costing Study the ability to match admitted episodes with National Outcomes and Casemix Collection (NOCC) has been problematic due to data being collected in different source systems.

Collection of new NOCC with different phases of care and collection of MHICs in addition to diagnosis is substantial data entry burden. The current WA Mental Health Information System follows the current NOCC protocol and therefore changes to the NOCC protocol will require system change, education and training.

The Community MH Care/Community Residential and NOCC submitted as part of the NMDS are structured under regions, organisations, clusters and service units. Given that the MH Care Type will now likely appear across non-specialised mental health services, a huge body of work will be required to review these 'non-specialised mental health' services and see how they fit into the organisational structures. Currently in the NMDS, the organisational structure provided for these specialised mental health services fall within the mental health organisations. There will be some difficulties trying to roll the activity to the organisational structure currently submitted in the Mental Health Establishment NMDS for these non-specialised mental health services.

***Question 8:*** Is there any further evidence that should be considered in testing the proposed architecture?

***WA Health’s Reply***:

Beginning and ending episodes of care with discharges and transfers create artificial service separations between community and inpatient as some patients are clients of both services and receive ongoing service provision from their case manager in community while an inpatient. This is in the interests of maintaining the therapeutic relationship and/or processes commenced while an outpatient and are in the best interests of the patient.

If phase of care is to be the descriptor and the number of service events per day the cost driver, then mental health care should be bundled to the highest possible level. Currently the data depicting the actual care type based on type of service event is not accurately extracted or analysed. There is an over reliance on the clinician choosing the appropriate option from drop down menus when some clinicians may have limited understanding of cost drivers.

The collection of NOCC data at the beginning and end of a transition episode from community and inpatient care along with phase of care and the associated rules does not take into account the rapid deterioration and improvement in patients’ presentation. In the Kimberley and Pilbara regions, most of the admissions to public mental health inpatient services are the result of a mental health acute emergency. From experience, very few are ‘booked’ and planned admissions for treatment. The rules around NOCC data cannot take account of these rapid changes, although phase of care can and does.

The use of NOCC data collection instruments at each phase of care can result in the overuse of this measurement tool when the number of days between phases is short. It is recommended that NOCC measures should not be the cost driver for mental health services but rather they be used only for clinical audit.

The MHIC system used in the IHPA Mental Health Costing Study does not represent the true/actual service provision. The vague description of each MHIC code creates an opportunity for clinicians’ misunderstanding or misinterpretation and consequent application of the incorrect MHIC code to a particular service event. The large volume of the MHIC codes with a very broad description compromises their clinical use. Simplifying the number of codes undermines the complexity and individualising of care. For the costing study it was necessary to develop new MHIC codes that described the service provided more accurately and assisted clinicians with the timely MHIC code allocation. However this may still not accurately represent the actual service provided and generate costing gaps.

***Question 9:*** Which psychological interventions, if any, may be of significant in understanding the cost of care?

***WA Health’s Reply***:

There is no one psychological intervention that will be significant in understanding the cost of care. The cost drivers include both psychological interventions and the tasks supporting the interventions including regular follow up, consultation/liaison with family, carers, relevant welfare organisations, school and statutory bodies.

In treatment planning, consideration is given to diagnosis and available treatment options but the outcomes rely on the individual’s ability to create the change in their life which will lead to functional gain. The capacity of the individual to maintain functional gain will depend on a range of individual psycho-social factors including age, available supports, comorbidity and social functioning. Individually-tailored rather than system prescribed interventions will always yield the best result for the patient with a resultant maximisation of resources and reduction in re-admission rates. Manualised or prescribed treatment planning may allow ABF of community mental health services but has the unintended outcome of increasing admission rates and therefore driving hospital costs higher. Therapeutic alliance with patients has as much therapeutic value as an intervention itself.

The area that weights a diagnosis and leads to none or delayed responsiveness to treatment (and thus is a huge cost driver) is social adversity. A number of risk factors around social adversity have been identified, including life events and situations (divorce and family breakup, physical, sexual and emotional abuse, homelessness), community factors (isolation, lack of support services), school context (bullying, peer rejection, inadequate behaviour management), and family factors (family violence and disharmony). These need to be reflected in classification systems and also designation of treatment interventions.

Whilst family therapy has been included as an intervention, the essential systemic work which goes beyond care coordination has not been captured. This includes mental health of parent, attitude and quality of school environment or quality of caregiving environment in residential setting. The developmental stage and intellectual capabilities of the child is also important as this impacts on how the child copes within their environment.

The creation of AMHCC has the capacity to result in prescribed treatment modalities which may not benefit the patient. The methodology for ABF calculation has been shown in the IHPA Mental Health Costing Study to miss counting many of the cost drivers outlined, including the increasing demand for clinical documentation and crisis prevention follow up. All of these will impact on the success or otherwise of patient interventions.

***Question 10:*** **Are there particular aspects or area of AMHCC that should be prioritised in its development, or aspects that should be developed at a later stage?**

***WA Health’s Reply***:

The Mental Health Costing Study does not conclude until April 2015 and it is yet to be proven through this study whether phase of care, MHIC and first episodes of care are cost drivers of mental health services. The collection of these three data items in order to report activity based on the Mental Health Data Set Specifications (MHDSS) by 1 July 2015 would be difficult even on best endeavours. WA Health suggests that the implementation of the MHDSS should be differed until the AMHCC development work has been further progressed.