



**Mental Health Australia's submission to the  
Development of the Australian Mental Health  
Care Classification (AMHCC) - Public  
Consultation Paper 1**

**FEBRUARY 2015**

Mental Health Australia (MHA) welcomes the opportunity to comment on the consultation paper prepared by the Independent Hospital Pricing Authority (IHPA) to inform the final stage in the development of the first iteration of the Australian Mental Health Care Classification (AMHCC).

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector. It is committed to achieving better mental health for all Australians. The organisation was established in 1997 as the first independent peak body in Australia to truly represent the full spectrum of mental health stakeholders and issues. Mental Health Australia's members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

Mental Health Australia's vision is for mentally healthy people and mentally healthy communities. It aims to educate Australians on mental health issues, influence mental health reform so that government policies address all contemporary mental health issues, conduct research on mental health issues, and carry out regular consultation to represent the best interests of our members, partners and the community. These endeavours in education and policy reform are matched by our commitment to research and advocate for more innovative approaches to the provision of mental health care. In addition, the Mental Health Australia continues to focus on the human rights of people with a mental illness.

This submission has been prepared to both address the concerns of Mental Health Australia in relation to the development of the AMHCC and to inform a diverse range of members and stakeholders on some of the more technical and detailed aspects involved in building the classification.

It is recognised that building a classification for mental health care services has a number of challenges due to the long-term and often episodic nature of mental health problems. The application of a classification system to mental health care services requires the consideration of a range of issues including:

- mental health service users have diverse needs, as the course of illness for patients with the same initial diagnosis is often variable;
- patients frequently have co-existing conditions presenting an increased financial risk to service providers due to the inability of classifications to deal with patient complexity;
- services are often delivered by multiple agencies, creating complex care pathways;
- service providers often make quite different decisions regarding which treatments or interventions are most effective for patients, influencing the identification of key cost drivers; and
- informal care is very important, as for many consumers the costs of support may be determined as much by the availability of family and social support as by the diagnosis and severity of their illness.

Recognising the complexity of building the AMHCC, Mental Health Australia has provided comments and analysis, broadly around the issues raised in the IHPA consultation paper.

# The evidence base for the classification: the University of Queensland report

Mental Health Australia understands that the report from University of Queensland (UQ) consortium, commissioned by the Independent Hospital Pricing Authority (IHPA), forms the evidence base for the development of the classification. Mental Health Australia wishes to raise the issues below which were identified in the report.

## Defining mental health care services: what should be included in the classification?

The definition developed for the Care Type which sets the scope of the AMHCC excludes sections of the mental health care workforce. As the definition states a clinician is someone with specialised expertise in mental health, however this definition excludes such workers as peer workers and others, which should be considered as part of the clinical workforce.

*Placing boundaries in the definition around staffing could be considered short-sighted and excludes the of valuable mental health services.*

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The UQ report (the report) noted that mental health care delivered via consultation liaison has been consistently raised as a very important issue in defining mental health services for classification purposes. This issue was highlighted as much more important for services in the mental health field compared to many other areas of health care. The report recommended that consultation liaison care is defined as a separate episode of care in the classification system; and proposed that the Mental Health Care Type definition be extended to include specialist mental health consultation liaison services if the patient meets the criteria set out in the definition. That is, a mental health consultation liaison episode is one in which: *“the primary clinical purpose or treatment goal of the consultation liaison episode is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient’s mental disorder”*.<sup>1</sup>

Adopting this recommendation would see each mental health episode be classified as either direct care or consultation liaison. Mental health direct care is where the patient is under the care of a mental health clinician or team as the primary provider (as per the proposed Mental Health Care Type definition). Mental health consultation liaison is where the patient is under the direct care of a non-mental health clinician or team as the primary provider (and therefore a non-mental health Care Type), and a mental health clinician or team provides a consultation service for the patient.

*Mental Health Australia considers that the inclusion of this method of classification would allow greater recognition of the diverse range of mental health care services being provided across settings, such as rural and remote specific services and services provided by both government and non-*

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<sup>1</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 4

***government organisations and those sitting outside the government funding parameters.***

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The report also recommended a pathway for the inclusion of this recommendation given the number of times it was raised in stakeholder consultation. For the occur the following was requires;

- changes in the National Minimum Data Sets;
- amending the national counting rules to allow for a direct care episode and a consultation liaison episode to occur in parallel if, and only if, each is of a separate Care Type or each occurs in a different facility. A patient could therefore have one direct care episode for their primary diagnosis and Care Type, and a consultation liaison episode for other care delivered for a secondary diagnosis;
- following the development of the AMHCC a pricing framework be developed to take into account mental health consultation liaison treatment, which is significant in the mental health sector compared to other forms of health care; and
- that further work around consultation liaison should be undertaken, to ensure these types of services are adequately counted and costed.

***The AMHCC consultation paper does not address this significant recommendation. Mental Health Australia seeks clarification regarding how consultation liaison will be considered in the classification.***

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The report stated that it was generally agreed that the Mental Health Care Type should apply to community mental health services in the same way as for admitted care, and be provider agnostic. It is unclear in both the AMHCC consultation paper and the report what services are included in the term 'community mental health care services'. In reality these services may range from hospital based community care to services provided by non-government organisations (both government funded and non-government funded).

***A clear definition of what is included in community 'mental health services' is essential to understanding what services will be and will not be included in the classification.***

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As there is no widely accepted definition of 'primary mental health care' the report found that some programs provided by specialised mental health services might be considered primary mental health care depending on the definition. It was recommended that further work be carried out in this area as many jurisdictions identified certain services that may be considered primary mental health services and emphasised the importance of these services.

***Mental Health Australia recommends that further work be carried out to clarify this possible reporting discrepancy. If further work is not completed how will this affect the accuracy of the classification system?***

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The report notes that treatment for patients with a primary diagnosis of a drug or alcohol-related disorders are delivered both within and outside of specialised mental health services. Stakeholder views were mixed on whether these patients should be included in the

Mental Health Care Type, with international approaches also differing. The report advises that it is currently not feasible to include patients with primary drug or alcohol-related diagnoses within the Mental Health Care Type with existing knowledge and data collections. Changes to the data collections would require thorough consultation with the drug and alcohol sector. It was recommended that the care for these patients be classified under an alternative system, such as DRGs, until further work can be conducted in this area.

***Given that the consultation paper reports that step 4 (develop the classification system and associated infrastructure) is close to completion, has IHPA accepted the report's recommendation to pursue further work before the classification is complete?***

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Most stakeholder feedback in the report supported classifying mental health care in the emergency department (ED) under the existing ED classification rather than under a Mental Health Care Type, at least for the short term. There was strong support for reviewing the ED classification system to better capture the additional burden of treating mental disorders within the ED.

***Mental Health Australia would like to see further work undertaken to incorporate mental health care patients in the ED setting into the Mental Health Care Type. In an ideal care model it is preferable for patients with a mental disorder not to be admitted through the ED; however mental health care in the ED should be included in the classification, as the purpose of care is mental health.***

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An important recommendation in the UQ report is that mental health services not appropriately classified by a classification system, be counted and costed in a transparent way that does not establish a disincentive to providing these services. These services include the assessment and care of non-identified patients and prevention.

***The intention is to develop the AMHCC for all mental health services while being setting and provider agnostic and adopting 'the patient' approach (where all services provided to patients with a primary mental health diagnosis would be defined as being in-scope). Mental Health Australia seeks clarification as to how IHPA will identify what, if any mental health services cannot be included in the classification and reasons for their exclusion?***

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This concern is echoed by stakeholders in responses contained in Appendix 9.3 of the Stage A Final Report of the UQ study. In response to the question of what community-based mental health services should be defined as mental health services for classification purposes?

- The Royal Australian College of General Practitioners listed for inclusion - prevention and recovery programs, community based social support, employment and education support, residential rehabilitation units and step up/step down services.
- The National Mental Health Information Development Expert Advisory Panel noted concerns about significant specialist mental health activities that could be inadequately funded if not considered as part of the classification. These activities include evidence-based preventive interventions, suicide prevention (e.g. work with

families), health promotion, capacity building of non-health and other health services, training and evaluation research, telepsychiatry, forensic mental health providing consultation, children and adolescent accessing two types of care at once (e.g. patients with eating disorders accessing medical as well as specialist mental health care concurrently), evidence-based group programs, and work with special populations (e.g. forensics, Koori, homeless, refugees and out of home care children).

## Developing a typology of services beyond the broad classes in the mental health National Minimum Data Sets

The UQ report cites work undertaken to ascertain the extent of variations in jurisdictional reporting of mental health clinical services to the three patient-level NMDSs. The report noted that the way in which jurisdictions reported services may affect the nature of patient-level data available to support the new mental health classification.

Jurisdictions were asked to describe the service types used locally and to classify them according to a specifically designed service typology that was being tested with the possibility of forming a component of the AMHCC. Of note was that the work on developing this typology endeavoured to take account of the typology being developed as part of the National Mental Health Service Planning Framework (NMHSPF) where possible.

The UQ report advised that time constraints meant that only three states (Vic, NSW, and SA) provided the financial information sought. Victoria's response reported funding rather than expenditure, due to difficulty in applying the elements of the questionnaire to expenditure at the hospital level. The classification depth and level of service detail provided was variable. Some services had multiple target groups however the questionnaire design did not accommodate this diversity. Consultation liaison appeared in many of the completed questionnaires, illustrating the importance of services provided across settings and organisational boundaries, while making it clear that shared care across organisational boundaries extends beyond designated consultation liaison services. The report noted that these types of services present a challenge for the development of the new mental health classification.

***The consultation paper does not mention this service typology and if it is being considered to form a part of the AMHCC. Given the variability in the data collected and the inconsistency of service reporting across jurisdictions, it is requested that the IHPA confirm if this service typology will be used in the classification and how the inconsistencies identified might affect the data collected for the ABF MHC DSS.***

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## Mental health care cost drivers

The report specifically states that *“it is only when these building blocks are in place that it will be possible to both design and implements a new national mental health classification”*.<sup>2</sup>

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<sup>2</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 41

The report stated that *“while most of the variables identified in the literature as cost drivers are already being collected in Australia, the required building blocks to develop a new Australian national mental health classification are not in place. Much of the data (particularly the cost data) are of poor quality and other variables identified as important cost drivers, for example patient clinical ratings, are either incomplete or not collected at critical points in the overall episode of mental health care.”*<sup>3</sup>

The UQ team reported that it spent many weeks attempting to link clinical, activity and cost data at the patient level, with only limited success. The report concluded that *“ability to routinely link clinical, activity and cost data at the patient level is an essential first step in using routine data to develop a classification. Data linkage is also essential for ABF purposes. Our conclusion at the end of Stage B is that significant work is required before it will be possible to routinely link the various mental health data sets and use these data sets to develop the classification”*.<sup>4</sup>

Other issues cited in the report of concern relate to the statistical analysis undertaken to identify cost drivers amongst data items that are currently collected. Only NSW, Queensland and Victoria were able to supply data for the project in the time frame required. This limited set of data on which to base a statistical analysis could not possibly cover the full range of populations accessing mental health care services or represent the diversity of settings and providers. UQ cites time as the constraint that prevented the other states and territories for submitting data and that results can be taken as indicative only because of the poor quality of much of the data and that much of the currently collected data cannot be linked.

***Mental Health Australia recommends that the twenty eight specifically UQ report recommendations specifically designed to form the basic building blocks for the classification to function, be put in place before any further work progresses on the classification development.***

***Mental Health Australia considers it important that the outcomes of the national mental health costing study to be delivered by April 2015 are rigorously assessed to identify the level of variation in cost drivers across mental health service settings (particularly for Phase of Care and use of Mental Health Intervention Codes that are being piloted by study sites).***

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## The classification framework

The report makes a very clear recommendation that *“in addition to an episode meeting the criteria for the Mental Health Care Type, the other essential criterion is that the information required to assign an episode to a class is both collected and reported. It is recommended that the scope of the mental health classification include all episodes that meet these two criteria”*.<sup>5</sup>

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<sup>3</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 2

<sup>4</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 41

<sup>5</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 42

The report then goes on to raise the question as to how to classify episodes that fit into the Mental Health Care Type definition but do not have the required clinical information or data set. Two solutions are proposed with the preferred approach to default episodes that do not have the required mental health clinical information. Consequently the report advises that “{admitted episodes without the required data set be defaulted to the AR-DRG system, at least in the initial years. We considered the possibility that some admitted episodes might default to the AN-SNAP classification. However, if the episode lacks the required mental health information, it will also be missing the required AN-SNAP information. In relation to non-admitted care, we propose that non-admitted community and outpatient episodes be classified using the classification for other non-admitted care (currently the Tier 2 clinic list)”.<sup>6</sup>

A further challenge is highlighted by the report regarding incentives for collecting quality in mental health. The report states, “it is important to understand that the incentives for quality data collections in mental health are different than those that exist in relation to acute care. In acute care, episodes are classified by DRG and the items required to assign an episode to a DRG are coded after the episode has ended in the medical record department. Hospital management can directly influence the timing and the quality of this process. In contrast, the mental health classification to be developed will inevitably depend on clinical assessment data collected and prospectively reported by individual treating clinicians. The quality and timing of the information collected depends on clinical buy-in. In this context, hospital management practices have little influence and classic financial incentives are unlikely to be effective in changing clinical practices”.<sup>7</sup>

In conclusion the report very clearly states that “we do not believe that these default arrangements are desirable, however, there is little choice in the short term”.<sup>6</sup>

***Given the report has stated that much of the data is of poor quality and either incomplete or not collected at critical points, Mental Health Australia is concerned that the default arrangement may become chaotic as data is ‘defaulted’ to several other classifications and arrangements may not be in place to harvest this data from the other sources. It is imperative to review the variations in data collection and reporting process within the national mental health costing study currently in progress.***

***Mental Health Australia also seeks clarification as to how the data will be brought together from the varying sources and under what timeline and work program will enable this data to be collected as part of the classification?***

***The issue of clinical buy-in to collect the data accurately is also of concern and clarity is required as to what methods IHPA will be recommending to provide incentives to hospital based clinicians and what if any supports will be provided to the community and non-government sector to enable timely collection of data.***

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<sup>6</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 42

<sup>7</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 42 & 43

The consultation paper reported that the UQ proposed that the AMHCC developers allow that, for classification purposes, mental health care be bundled up to the highest level at which the package of care (or cost of the care) is predictable. However the report states that the concept of bundling only works in a funding model where the care is provided by the one health care organisation. The report gives the following example, “*Local Hospital Networks (LHNs) are the organisational entities that receive a Commonwealth contribution for public hospitals. For this reason, the LHN level is the highest level at which mental health care might be bundled for funding and other purposes. However, this is only possible in situations where all of the mental health providers in the one LHN share a common patient identifier system*”.<sup>8</sup>

***Mental Health Australia notes that there will be challenges in a hospital network even with substantial administration and data collection capacity, however further information is sought from IHPA as to how this pricing system would work across the breath of all mental health services settings including accommodating jurisdictional and demographic variables and non-government organisations?***

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## **Mental Health Costing Study**

The consultation paper notes that a key finding of the UQ report was that the costing data submitted to the National Hospital Cost Data Collection by jurisdictions for mental health services “was patchy at best”. UQ proposed that IHPA commission a one-off study or series of one-off studies to develop the AMHCC. In response to this finding IHPA engaged a consortium led by HealthConsult to undertake a six month national costing study.

***Mental Health Australia is very concerned about the absence of non-government community managed organisations within the 25 sites participating in the HealthConsult consortium study. How does IHPA propose to test the appropriateness of the new data elements in this significant section of mental health care service provision? The community mental health services included in the 25 sites appear to be only hospital affiliated, clinically managed facilities.***

***The absence of Tasmania, the Australian Capital Territory, the Northern Territory and the Victorian public sector from the in the costing study, raises the question of how IHPA proposes to test the new elements in these jurisdictions in order to produce a nationally consistent classification.***

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<sup>8</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 42

# Data to be used in the AMHCC and the Mental Health Non-Government Organisation Establishments DSS 2015

The consultation paper states that IHPA accepted UQ's recommendation that a specific data set be developed solely for the purpose of developing the classification – the ABF MHC DSS. The UQ report advised that *“the core clinical collection would continue to be the NOCC. The relevant NMDS collections would provide the relevant administrative, activity and demographic data while the national hospital cost data collection would provide the cost data. The ABF dataset needs to be specified in a form that ensures that the various datasets can be linked on a routine basis”*.<sup>9</sup>

The consultation paper explains that the ABF MHC DSS is based on data items from the existing data sets below and that, *“in order for any additional data items to be included beyond those existing and specified new items in the ABF MHC DSS, all states and territories would need to be able to collect and report them”*.<sup>10</sup>

- admitted patient care NMDS;
- admitted patient mental health care NMDS;
- community mental health care NMDS;
- mental health establishments NMDS;
- non-admitted patient DSS; and
- residential mental health care NMDS.

***Given that the intention is to develop the AMHCC for all mental health services and is service setting and provider agnostic, Mental Health Australia is concerned that the full range of mental health services provided, particularly by non-government and private organisations is not adequately represented in the ABF MHC DSS.***

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***Mental Health Australia questions why the Mental Health Non-Government Organisation Establishments DSS 2015 (MH NGOE DSS) - could not be included in the ABF MHC DSS.***

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The scope of the MH NGOE DSS is included in the service taxonomy below. These services focus on providing well-being, support and assistance to people who live with a mental illness rather than the assessment, diagnostic and treatment tasks undertaken by clinically focused services.

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<sup>9</sup> University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013, Pg 42

<sup>10</sup> Independent Hospital Pricing Authority; Development of the Australian Mental Health Care Classification – public consultation paper 1. January 2015, Pg 19

Mental Health Australia understands that the taxonomy below has been agreed to by all states and territories and Queensland and Western Australia will begin to collect this data in 2015-16.

- Counselling—face-to-face
- Counselling, support, information and referral—telephone
- Counselling, support, information and referral—online
- Self-help—online
- Group support activities
- Mutual support and self-help
- Staffed residential services
- Personalised support—linked to housing
- Personalised support—other
- Family and carer support
- Individual advocacy
- Care coordination
- Service integration infrastructure
- Education, employment and training
- Sector development and representation
- Mental health promotion
- Mental illness prevention

The UQ report also acknowledged the importance of the services provided by non-government organisations stating that *“across most states and territories non-government organisations (NGOs) provide a range of residential rehabilitation services, largely government-funded, that provide the kind of assistance and support that help many of their residents avoid the need to be admitted to hospital in the event that their mental state deteriorates”*.<sup>11</sup>

***If the criteria for inclusion in the ABF MHC DSS is that all states and territories need to be in a position to report and collect an agreed data set, why then is the non-admitted patient DSS included in the ABF MHC DSS when it is not a national minimum data set and therefore not collected routinely by all states and territories? Therefore on the basis of the inclusion of the non-admitted patient DSS in the ABF MHC DSS, Mental Health Australia wishes to understand on what basis the MH NGOE DSS is being excluded for the ABF MHC DSS?***

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The consultation paper acknowledges that the *“version to be implemented in 2016-17 is unlikely to apply to all types of mental health care service settings or providers, as data to support classification development will need to be sourced over the coming years, with data collection mechanisms built up. Part of the consultation processes and developmental work for the 2016-17 iteration will be identifying areas of focus for future work”*.<sup>12</sup>

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<sup>11</sup> University of Queensland Australia; Stage A Final Report: Defining mental health services for classification purposes: Definition and Cost Drivers for Mental Health Services project. March 2013, Pg 130

<sup>12</sup> Independent Hospital Pricing Authority; Development of the Australian Mental Health Care Classification – public consultation paper 1. January 2015, Pg 31

*Should the MH NGOE DSS not be included in the 2016-17 version of the AMHCC, will IHPA be identifying the inclusion of the MH NGOE DSS as part of its future work program for ongoing work on the AMHCC? Mental Health Australia is particularly concerned that the absence of representation of the mental health care services shown above in the initial framework design will preclude their inclusion at a later date. This concern is highlighted by the advice from the QU report which states that, “once the first version of the classification has been adopted, subsequent versions can be developed largely through the use of routinely collected data”.*

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## The link between the National Disability Insurance Scheme and the AMHCC

The consultation paper states that the scope and approach of the National Disability Insurance Scheme (NDIS) will be an important consideration in the development of the AMHCC and that attention will need to be given to how the two systems will work together.

Following the establishment of this link, the paper reports that “while the two systems are not intended to overlap, some people with a mental illness will be able to access services under the NDIS. Further to this clarification it is explained that “some of the daily living supports provided by community mental health services (for example, through adult integrated community mental health services and hospital avoidance programs), are within the scope of the AMHCC”.<sup>13</sup>

*Mental Health Australia seeks to understand that if the intent is for the two systems not to overlap, what will be the effect on funding for the supports provided by the NDIS that are identified as in-scope for the AMHCC. This lack of clarity may have unforeseen consequences for funding arrangements for mental health care services into the future.*

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## Timeline for the development of the AMHCC

The project plan for the development of the AMHCC titled the *Development of the Australian Mental Health Care Classification; September 2014* published on IHPA’s website outlines the stages and milestones required for developing the classification. The plan states that the first consultation period to be held in January and February 2015 would allow stakeholders to provide feedback on the AMHCC Framework v0.1 for input into the AMHCC Framework V1.0. However the consultation paper released for the January/February 2015 period did not provide stakeholders with the AMHCC Framework v0.1.

*Mental Health Australia recommends that IHPA’s project plan be revised to include another consultation period for stakeholders to provide feedback on the AMHC Framework v0.1 before the scheduled release in September 2015.*

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<sup>13</sup> Independent Hospital Pricing Authority; Development of the Australian Mental Health Care Classification – public consultation paper 1. January 2015, pg 16

***The project plan does acknowledge that targeted consultation will be held in June 2015 to further refine the AMHCC Framework V1.0, however without an alternation to the project timeline stakeholders will not have the opportunity to fully absorb or understand v0.1 in order to adequately engage with V1.0.***

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# Appendices

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- University of Queensland Australia; Stage A Final Report: Defining mental health services for classification purposes: Definition and Cost Drivers for Mental Health Services project. March 2013
- University of Queensland Australia; Cost Drivers and a Recommended Framework for Mental Health Classification Development: Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project Volume 1. June 2013
- Independent Hospital Pricing Authority; Development of the Australian Mental Health Care Classification – public consultation paper 1. January 2015

# Mental Health Australia



Mentally healthy people,  
mentally healthy communities

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