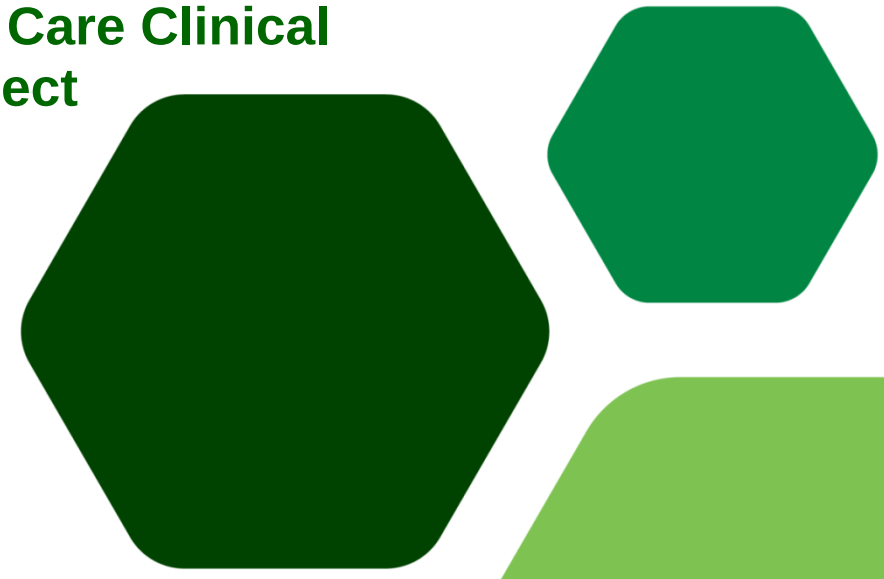
Independent Hospital Pricing Authority

Mental Health Phase of Care Clinical Refinement Project

Report on analysis, findings and recommendations of the Mental Health Phase of Care Clinical Refinement Project

November 2019



IHPA

Mental Health Phase of Care Clinical Refinement Project – Report on analysis, findings and recommendations of the Mental Health Phase of Care Clinical Refinement Project – November 2019

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Acknowledgments

This is a report of the Project to review and refine the Mental Health Phase of Care. The Project was undertaken by six clinical advisors (CAs) on behalf of IHPA.

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This report was authored and prepared by Stephen Mirfin, Karen McAlear, Graeme Sanders, Lee Mickle and Dr Stephen Fenner on behalf of IHPA. The authors wish to gratefully acknowledge the support and advice of the individuals and organisations who contributed to the Project.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

ABF	Activity Based Funding
AMHCC	Australian Mental Health Care Classification
CAs	Clinical Advisors
HoNOS	Health of Nation Outcome Scale
IHPA	Independent Hospital Pricing Authority
IRR	Inter-Rater Reliability
LSP-16	Life Skills Profile
MH-CASC	Mental Health Classification and Service Cost
MHCS	Mental Health Costing Study
MHFoC	Mental Health Focus of Care
MHPoC	Mental Health Phase of Care
MHWG	Mental Health Working Group
NHRA	National Health Reform Agreement
NOCC	National Outcomes and Casemix Collection

Executive Summary

This report outlines the key methods, analysis, findings and outcomes of the Mental Health Phase of Care Clinical Refinement Project.

The Mental Health Phase of Care (MHPoC) is an activity unit representing the intended care to be provided alongside the primary goal of care within the episode of care. The MHPoC is part of the Australian Mental Health Care Classification (AMHCC), the new classification developed by IHPA for pricing public hospital mental health services in Australia.

The Refinement Project commenced in November 2017, after completion of the Inter-Rater Reliability (IRR), which noted in conclusion a poor to fair reliability of the MHPoC. Such variation affects the ability for IHPA to consistently collect and distinguish phases of care within episodes, cost and price mental health information for Activity Based Funding (ABF) purposes. Consequently, IHPA brought together a team of six mental healthcare clinicians to review and refine the phase of care to improve the reliability of clinical assessment and reporting.

The findings in this report are based on evidence gathered from a representative number of mental health clinicians in various services (both inpatient and ambulatory) across the Australian jurisdictions. Sites were nominated by the jurisdictions to participate in the Project so that the CAs working with IHPA could speak with mental health care clinicians through interviews and focus groups. In addition, a review of the concepts in the MHPoC was undertaken by several of the advisors working on the Project as information from the interviews and focus groups pointed towards key themes. There was agreement from clinicians interviewed and those who attended the focus groups that the MHPoC is an appropriate way to assess and represent the activity described as phase of care intended to be provided to the consumer. Clinicians emphasised a desire to make the MHPoC work.

A key finding of the Project was that the phases were separating patients by anticipated outcomes (e.g. functional gain, consolidating gain) rather than the type of intended care that would better reflect resource needs (e.g. acute care, care for an extended period). These internal validity issues were being compounded by clinical confusion relating to the naming conventions and what the phases of care should represent and how each should be defined. The theme that emerged from the concept analysis, interviews and focus groups suggested that phases needed to be more consistently aligned with each other and in their emphasis on describing the phase of intended care to be provided as opposed to outcome expected of the consumer. Alignment to type of care provided would reduce the overlap and provide a system for clinicians to assess their patient's needs more intuitively.

The findings of this report indicate that reliability between clinicians in identifying the most appropriate phase consistently remains poor relative to the requirements of the AMHCC. The findings are consistent with the IRR published in April 2017.

As a result of these findings, the CAs sought to realign the phases towards describing a type of care in the first instance rather than focus further on consumer characteristics or outcome of care. It is anticipated that this approach to refinement has resulted in an increase in the clarity, and reduction in the ambiguity of the current definitions. Options 1 and 2 outlined in this report provide flexibility to jurisdictions who, following consultation feedback at the MHWG, have expressed a diversity of views. Jurisdictions can see the benefit in both options and there is agreement amongst the CAs that further testing be performed on these options prior to implementation of a preferred choice.

The refined MHPoC names and definitions are described in Table 1 and 2. This Project proposes that assessment only be re-defined as a data item, for data collection purpose, rather than a phase.

Table 1: Summary of Refined MHPoC (Option 1)

Phase name	Primary goals of care
Acute Mental Health Phase of Care	The primary goals of care are intended to reduce high levels of distress, manage complex symptoms, closely monitor and reduce immediate risk.
Subacute Mental Health Phase of Care	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to mitigate or prevent relapse into acute mental health ('stepping up in care'). ***or*** The primary goals of care are to restabilise recovery and promote a return to previously observed function. To increase independence and social/vocational integration via a program of skills acquisition ('stepping down in care').
Non-acute Mental Health Phase of Care	The primary goals of care include supporting ongoing independence, quality of life and functional stability, that consolidates recovery and assists community integration.
Assessment Only Data Item	The goal is to obtain information, including collateral information where possible, in order to determine the consumer complexity and need for intervention.

Table 2: Summary of Refined MHPoC (Option 2)

Phase name	Primary goals of care
Acute Mental Health Phase of Care	The primary goals of care are intended to reduce high levels of distress, manage complex symptoms, closely monitor and reduce immediate risk.
Subacute Mental Health Phase of Care	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to mitigate or prevent relapse into acute mental health (‘stepping up in care’).
Rehabilitation and Recovery Mental Health Phase of Care	The primary goals of care are to restabilise recovery and promote a return to previously observed function. To increase independence and social/vocational integration via a program of skills acquisition (‘stepping down in care’).
Non-acute Mental Health Phase of Care	The primary goals of care include supporting ongoing independence, quality of life and functional stability, that consolidates recovery and assists community integration.
Assessment Only Data Item	The goal is to obtain information, including collateral information where possible, in order to determine the consumer complexity and need for intervention.

The following recommendations are made from the review and Refinement Project:

- That IHPA consult with jurisdictions on Options 1 and 2 of the proposed refinement to the MHPoC.
- That testing is completed on the preferred option, with a jurisdiction, prior to adopting new phase definitions.
- That IHPA consider undertaking an impact assessment as part of work required in order to adopt the refined phases.
- That the impact assessment considers all aspects of this report including the possible redistribution of consumers into new phases.
- That IHPA work with jurisdictions to redefine assessment only and develop business rules which support it as a data item rather than a phase.
- That in the longer term a further IRR study is undertaken to assess the reliability.
- IHPA consider the development of standardised MHPoC content for training purposes for use across jurisdictions.

1. Introduction

This report sets out the findings of the review and refinement of the MHPoC Clinical Refinement Project. The Project began in November 2017 and was completed in March 2019.

1.1 Independent Hospital Pricing Authority

IHPA was established as part of the implementation of the National Health Reform Agreement (NHRA) 2011. Under the NHRA, the Council of Australian Governments unanimously agreed to the establishment of ABF as the primary funding methodology for public hospitals throughout Australia. The aim of a national ABF system is to improve the efficiency and transparency in the delivery and funding of Australian public hospital services.

IHPA has several determinative functions as specified by the NHRA. IHPA's primary role is to determine the National Efficient Price and National Efficient Cost for public hospital services. One of the key functions to achieving pricing is to review and update classifications (both new and existing) on which a pricing model can be based for specific services and service domains.

1.2 Patient classification system and mental health care services

Patient (or activity) classification systems aim to provide the health care sector with a nationally consistent method of classifying all types of patients and consumers, their treatment and associated costs, resulting in improved management, measurement and funding. These classification systems categorise patients and consumers based on similar diagnostic, clinical, demographic and therapeutic attributes.

The patient classification systems developed are comprised of categories (or codes) that provide clinically meaningful ways of relating the types of patients and consumers treated by a hospital to the resources required. Implementation of activity classification systems allows hospital and health service provider output to be measured, which forms crucial data for policies on funding, budgeting and setting costs.

As part of the implementation of ABF for mental health care, IHPA developed the AMHCC. The AMHCC is a clinically relevant classification that explains resource consumption (costs) at the patient level. The AMHCC requires the collection of a clinician-rated measure of the prospective goal of care called the MHPoC. The MHPoC describes the type and intensity of care expected for a patient. It is worth highlighting that for the purpose of this report and in keeping with contemporary use of language within the field of mental health, the term patient will be replaced with the term consumer.

An important objective in developing the AHMCC was to provide a classification system that could be used across settings where services are provided for mental health care.

The AMHCC Version 1.0 was implemented on a national best endeavours basis[1] from 1 July 2016.

The variables needed to determine each end class in the AMHCC are:

- Setting;
- MHPoC (clinician-rated measure of the prospective goal of care);
- Age group;
- Mental health legal status (in the admitted, acute mental health phase of care and for 18 - 64 year olds only); and
- Outcome measure scores (Health of the Nation Outcomes Scale [HoNOS[2]] for all settings and age groups and Abbreviated Life Skills Profile [LSP-16] for adults and older persons in the community setting).

Figure 1 presents the structure of the AMHCC Version 1.0. There are a total of 45 classes in the admitted setting branch, including 16 end classes where an unknown MHPoC or HoNOS score is reported. In the community setting branch of the AMHCC, there are 46 classes, including 15 end classes resulting from unknown mental health phase of care or unknown HoNOS scores. The classification currently groups Unknown LSP-16 scores with Moderate LSP-16 scores.

[1] A Health sector National Best Endeavours Data Set (NBEDS) is a metadata set that is not mandated for national collection but there is a commitment to provide data nationally on a best endeavours basis (MeTEOR, AIHW).

[2] The Health of the Nation Outcome Scales (HoNOS) is a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning for those in the 18 - 64 years old age group. Information about the HoNOS can be obtained from the Royal College of Psychiatrists (from Australian Mental Health Outcomes and Classification Network).

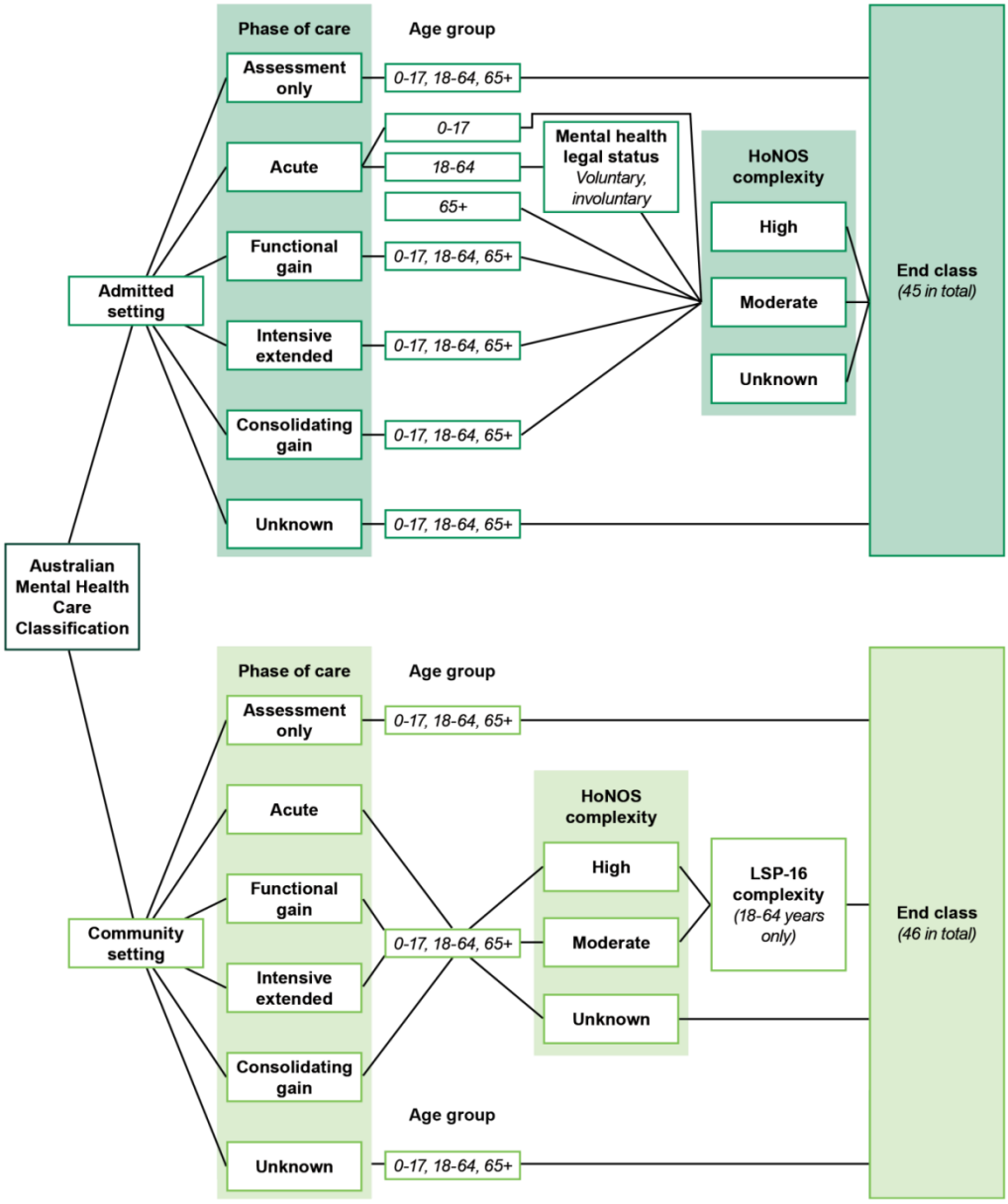

Figure 1: Structure of the AMHCC

1.3 Review and refinement of the mental health phase of care

The MHPoC Clinical Refinement Project was undertaken as a result of the IRR study, reported in April 2017, which highlighted poor to fair clinician IRR and a recommendation for the ongoing refinement of the MHPoC. One of the main conclusions from the IRR study was the observation that “based on the data collected during the study, the analysis of the Kappa statistic indicated that currently the level of agreement between respondents is borderline between poor and fair” (Coombs, 2017 p. 6). Therefore, the MHPoC Clinical Refinement Project sought to understand the nature and reason for poor IRR and correct this through a refinement process by speaking directly with clinicians working in services across Australia and age groups.

The objective of the Project was to review and refine the existing MHPoC activity unit to:

- Increase the clarity and reduce the ambiguity of the current definitions of the MHPoC along with testing the validity of these phases across child and adolescent, adult, and older person mental health;
- Support improved consistency in the national application of MHPoC across consumer groups and service settings through the identification principles underpinning the completion of the phases and other supporting materials;
- Ensure the MHPoC has clinical meaning and reflects current models of care and service provision.

1.4 Governance

The Project was commissioned by IHPA in 2017. Six CAs with a broad range of mental healthcare professional backgrounds undertook the study for IHPA.

IHPA's MHWG oversaw progress of the refinement and endorsed the direction for refinement. The MHWG advises IHPA on matters relevant to mental health care and includes representatives from all jurisdictions, mental health clinicians and mental health peak bodies. The CAs reported findings to IHPA and the MHWG during the Project lifecycle.

Progress of the Project was also discussed at the Clinical Advisory Committee and the Jurisdictional Advisory Committee.

1.5 Related reports

The MHPoC Clinical Refinement Project built on four previous Projects undertaken by IHPA under the guidance of the MHWG to develop the mental health care classification, including:

- Development of the AMHCC;
- Mental Health Costing Study (MHCS);
- Public Consultation papers;
- IRR study of mental health phase of care,

Table 3 lists the relevant Project reports relating to the development of the Phase of Care concept and the AMHCC.

Table 3: Related Project reports and documentation

Document	Description and IHPA website link
Definitions and cost drivers for mental health services project (2013)	Prepared by The University of Queensland for IHPA to assist the development and specification of a mental health classification system. Available at: https://www.ihpa.gov.au/publications/definitions-and-cost-drivers-mental-health-services-project
Mental Health Costing Study Final Report (Jan-December 2014) (reported 2016)	The Mental Health Costing Study aimed to produce a robust consumer level data set that is representative of mental health services provided in Australia. Available at: https://www.ihpa.gov.au/publications/mental-health-costing-study
Development of the AMHCC Consultation Paper 1 (January 2015)	This is the first in a series of public consultation papers to inform the development of the first iteration of the AMHCC. It followed on from consultations undertaken by the University of Queensland (UQ) in the early stages of this project and targeted consultation undertaken by IHPA through the AMHCC Mental Health Costing Study. Available at: https://www.ihpa.gov.au/publications/development-australian-mental-health-care-classification-amhcc-consultation-paper
AMHCC - Public Consultation No. 2 (November 2015)	This is the second public consultation paper to inform the development of the AMHCC. Available at: https://www.ihpa.gov.au/consultation/australian-mental-health-care-classification-public-consultation-no-2
AMHCC User Manual (2016)	This document provides background to the development of the new classification, explains the data elements and collection protocols, reporting requirements, and how the data are grouped. Available at: https://www.ihpa.gov.au/publications/amhcc-user-manual
Mental Health Phase of Care Guide (2016)	The purpose of this document is to provide the definitions, guide for use and guiding principles for the application of the new concept of the mental health phase of care that forms part of the AMHCC. This document provides practical guidance on how to assess the mental health phase of care for a consumer Available at: https://www.ihpa.gov.au/publications/mental-health-phase-care-guide
Inter-Rater Reliability Study Final Report (2017)	This document provides information relating to the IRR study including a test of the inter-rater reliability of the mental health phase of care instrument, gathered information about clinicians' views of the mental health phase of care. Available at: https://www.ihpa.gov.au/publications/mental-health-phase-care-inter-rater-reliability-irr-study-final-report

2. Background

The original work to develop a concept that defined the phase or stage of illness or care came from the Mental Health Classification and Service Cost Study (MH-CASC). This was the first time a casemix classification has been developed for mental health care (Buckingham, Burgess, Solomon, Pirkis, & Eagar, 1998a) . During this study a concept was developed that aimed to capture some information regarding the stage of the consumers' illness as this was an important funding consideration.

Consultation during the Project planning stages indicated that the concept had strong credibility with clinicians as a vehicle for defining 'bundled episodes' that crossed treatment settings. Clinicians argued that some concept like Mental Health Focus of Care (MHFoC) was integral to the definition of mental health episodes, as it brings together two key concepts – that patients' needs change over time as they move between stages of a mental illness, and the focus of treatment (and associated resource use) changes accordingly. Clinicians also argued that the clinical focus is not dependent on treatment setting (Buckingham, Burgess, Solomon, Pirkis, & Eagar, 1998b p. 204).

2.1 Mental health phase of care

The MHPoC is both a data item and an activity unit. The phase of care needs to be captured prospectively, rather than as retrospective assessment, defined by patient characteristics and associated goals of care ('patient journey') rather than solely by the physical location of treatment (e.g. acute unit, rehabilitation unit) or the treating clinical team (e.g. acute team, rehabilitation team). This results in the phase of care being allocated in a way that is setting agnostic, so that regardless of where the care is provided the MHPoC can be allocated.

A new MHPoC begins either when a consumer commences an episode of care or when the consumer's primary goal of care changes in an existing episode of care. The episode of care is defined as the period between the commencement and completion of care characterised by the mental health care type. An episode of care may have multiple MHPoC instances. The consumer's mental health care needs may change as they move between different phases of an episode and accordingly, the goal of care and the need for resources may change.

The MHPoC[3] is currently defined as:

> The prospective primary goal of treatment within the episode of care in terms of the recognised phases of mental health care. Whilst it is recognised that there may be aspects of each mental health phase of care represented in the consumer's mental health plan, the mental health phase of care is intended to identify the main goal or aim that will underpin the next period of care.

[3] Australian Institute of Health and Welfare. (2019). *Mental health phase of care* (Glossary item). Retrieved 2 April 2019 from http://meteor.aihw.gov.au/content/index.phtml/itemId/682464

The MHPoC is independent of both the treatment setting and the designation of the treating service and does not reflect service unit type.

There are currently five phases of mental health care. The classification also provides for 'unknown phase':

1 Acute
2 Functional gain
3 Intensive extended
4 Consolidating gain
5 Assessment only

2.2 Development of the Mental Health Phase of Care

The MHPoC concept was developed in 2012, through a Project commissioned by IHPA as part of the National Health Reform agenda.

An initial review of the cost drivers in mental health (Whiteford et al., 2013) identified that for costing purposes the focus of care did not adequately provide the level of granularity that would be necessary for costing in mental health. In the final report the authors wrote:

> For illustrative purposes only, they may include an Acute Phase, a Rehabilitation Phase, a Relapse Prevention and Consolidation Phase and potentially others. These Mental Health Phases will replace or complement the current Focus of Care data item (Eagar et al., 2013, p. 44).

Following this conceptual work, a MHCS was undertaken where a number of clinical data items were collected including a new data item of MHPoC. In this costing study, clinicians expressed confusion in relation to what was required to be captured, and the frequency with which the MHPoC was to be reviewed, updated and recorded.

The MHPoC is being introduced across public sector mental health services in all service settings and across all age groups. It is a concept that underpins AMHCC Version 1.0, the classification system to support ABF for mental health services in Australia.

2.3 Inter-Rater Reliability study

The IRR study (Coombs, 2017) provided IHPA with the opportunity to test the reliability of clinician allocation of consumers to the MHPoC. The study found fair to poor IRR and concluded that the MHPoC required further refinement. Key to this conclusion was that:

- Level of agreement between clinicians was borderline between poor and fair according to analysis with a Kappa statistic model.
- This model suggested a higher level of agreement for the 'acute' and 'assessment only' MHPoC.
- The other three mental health phases, functional gain, consolidating gain and intensive extended were less robust.

The author of the IRR observed, having engaged with clinicians across Australia, that “mental health phases of care may be more difficult to rate given the complexity of the presentation of consumers, the confounding nature of clinical expectation and resource availability and the current mental health phase of care definitions” (Coombs, 2017, p.45).

This study resulted in the creation of the MHPoC Clinical Refinement Project to identify the cause of the poor IRR outlined. Many of the recommendations and the conclusions of the IRR study were considered as part of this Project.

3. Methods for review and refinement

3.1 Overview

The Project was conducted using several methods to obtain information from clinicians across Australia representing different services and age groups of people seeking mental health care. In order to facilitate the interviews and focus groups, nominations were sought across jurisdictions from mental health services.

The purpose of using a mixed methods approach was to understand in greater detail the cause of the poor IRR and how the MHPoC concept could be refined to improve consistency in allocation and reporting. The review work was subsequently undertaken in parallel stages. Given there were six CAs reviewing the MHPoC, the interviews, focus groups and conceptual analysis were undertaken in parallel by a combination of the Project team. Using this information and the expertise of the CAs, the MHPoC was subsequently refined.

The main steps taken to review and refine the MHPoC are listed below and outlined in Figure 2.

- Pre-review, undertaken by the six CAs of the MHPoC, and discussions with key stakeholders
- A clinical review by the six CAs of the MHPoC
- Analysis of the review outcomes to identify issues with MHPoC
- A clinical refinement process

Several approaches to reviewing the MHPoC were adopted including interviews, focus groups, targeted stakeholder interviews, and a review of the literature. The Project was a qualitative review, designed to understand what the origin of poor IRR might be.

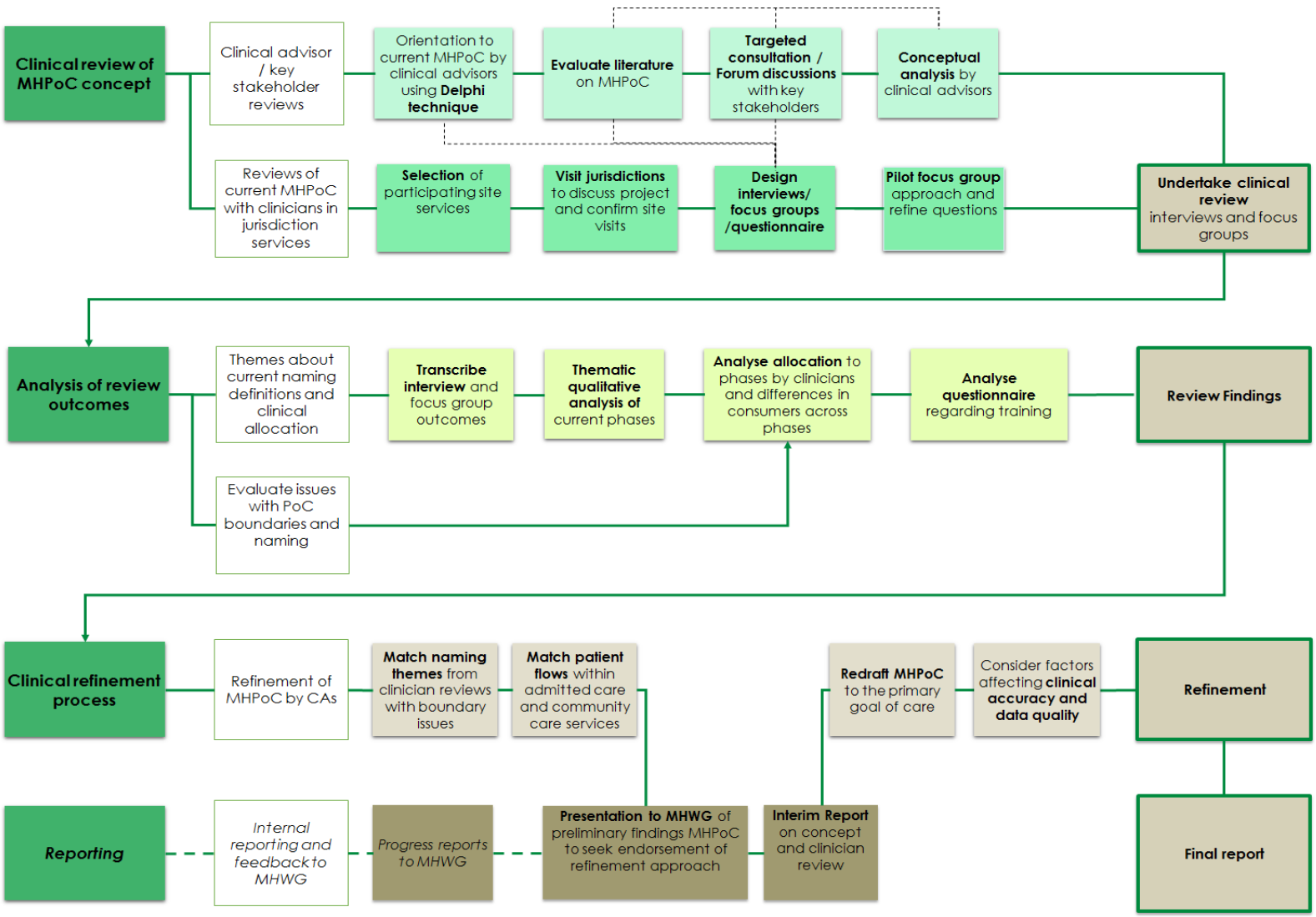

Figure 2: MHPoC review and refinement process

3.2 Pre-review investigations and stakeholder discussions

3.2.1 Site selection and jurisdiction visits

In order to facilitate focus groups and interviews, nominations were sought across jurisdictions from mental health services. Nominated sites asked clinicians to partake in the Project from a wide range of mental health specialties including ambulatory, inpatient, child and adolescent and older persons mental health care. A list of sites visited is provided in Appendix 1.

Following the selection process, CAs attended a series of meetings with each jurisdiction. These meetings allowed the CAs to engage with a wide variety of clinical and non-clinical staff including staff from technical areas such as data and information system management, performance reporting, health funding and policy branches.

The consultative meetings explored the main approach to the implementation of the MHPoC in jurisdictions, resources used and challenges for implementation and exploration of specific issues. Potential risks and impediments to the MHPoC review process for a jurisdiction were discussed.

3.2.2 Orientation to phase of care using Delphi technique

As part of the Project initiation process, the CAs participated in an online Delphi process. The Delphi technique is a qualitative approach that is used to gain consensus through expert opinion on a real world problem (McPherson, 2018).

The Delphi process orientated members of the CAs with an understanding of the MHPoC by encouraging a close and deep reading of the current MHPoC definitions and the underlying constructs associated with each MHPoC. The Delphi process was completed prior to the undertaking of interviews, focus groups and the conceptual analysis as detailed later in this report. The Delphi process provided an opportunity for the group to consider questions that may be used in interview and the broader questionnaire of mental health professionals that became part of the focus groups.

3.2.3 Targeted Consultation and Forum Discussions

In preparation for the review work, input was sought from key stakeholders who had previously engaged in either the original MH-CASC study or who had been approached because of their expertise in the clinical field of mental health. The CAs and representatives from IHPA undertook interviews with stakeholders who had approached the Project team offering to provide further background to the development of the classification. The background included offers to clarify or provide insights beneficial to the Project following clinician interview, conceptual analysis and literature review. These consultations included engagement with members of IHPA's MHWG, researchers from the Definition and Cost Drivers for Mental Health Services Project, members of professional bodies representing various clinical specialities, special interest groups and consumer and carer consultants.

The Project team used the opportunity to engage with these stakeholders who offered a different perspective on the MHPoC to the predominant clinical engagement with clinicians in jurisdiction health services. A workshop was undertaken within the first two months of the Project where members from the carer and consumer forum attended in order to gather feedback on the usability and language in the current MHPoC. A further presentation by CAs was held with consumers and carers at a national forum seeking their views on the MHPoC.

3.3 Clinical review of the Mental Health Phase of Care

3.3.1 Interviews

Semi-structured interviews were conducted with clinicians from the nominated services. The reason a semi-structured approach was used, as opposed to asking the same set of identically worded questions without deviation, was because the CAs wanted to explore the answers of clinicians further. The semi-structured interview enables the interviewer to explore the understanding of study participants of a specific topic providing validity to the process (Crookes & Davies, 2004). The semi-structured approach is flexible and dynamic, interviewing via face-to-face encounters with participants in an effort to understand their perspective and interpretations (Taylor, Bogdan, & DeVault, 2015) of mental health care perspectives.

Over time, the interviews followed a more in-depth, less structured approach. The approach was more iterative by clarifying issues as they arose and was undertaken to reduce bias in terms of the CAs themselves bringing any preconceived ideas to the interviews (Fontana & Frey, 2000). Questions are shown in Appendix 2.

Clinicians participating in the interviews signed a consent form to participate and for the interviews to be recorded. No clinicians refused to sign a consent. There were two occasions where the recording device failed to capture the interviews and notes were made and included for thematic analyses.

All interviews were transcribed from which the indications (data points) to identify the views of participants about the MHPoC outlined in Section 4 were analysed.

3.3.2 Focus Groups

In addition to the interviews, focus groups were the second key mode of MHPoC review and were held at sites with practicing clinicians to provide insight to how clinicians were allocating consumers to the MHPoC at specific services. A focus group offers a dynamic forum for expert engagement “because participants are influencing and influenced by others”(Krueger & Casey, 2000).

Focus groups allowed the CAs to interact with different groups as well as observe the interaction between group members (Rosenthal, 2016) as they discussed and problem solved issues they had experienced with using the MHPoC in practice. In addition, focus groups can promote the participation of reluctant interviewees or those who feel that they have nothing to contribute (Crookes & Davies, 2004 p.11). Focus groups were also popular for those clinicians with particularly heavy schedules on the day the CAs conducted site visits but wished to participate in some way.

Approximately 15% of focus group participants were unable to stay for the full one-and-a-half-hour discussion due to clinical duties and responsibilities. The initial focus groups were structured while later focus groups became semi-structured and more exploratory and confirmatory. The structured focus groups began with an introduction and overview of the MHPoC Clinical Refinement Project along with instructions on the activities that would be completed during the one-and-a-half-hour session. Four initial focus groups were undertaken and viewed as pilots to test that the approach would support the Project aims. In these initial focus groups, participants were asked a series of questions and asked to write their responses on post it notes.

Although the structured approach yielded useful information, it was too restrictive and a flexible and iterative approach with practicing mental health clinicians was preferred. Following a review of the initial pilot, the questions were changed, and a semi-structured format adopted. Subsequently, the focus groups format sought clarification of issues as they were raised by clinicians, as well as testing themes that arose from interviews. Later in the Project, the focus groups provided an opportunity to test possible modifications to the MHPoC. Not all focus groups were transcribed because of the quality of recording multiple participants, but the audio recordings of all focus groups were reviewed, and a CA transcribed pertinent material making it available for thematic analysis.

Participants in focus groups signed a consent form to participate and for questionnaire outcomes to be reported. Please see Appendix 3 for a copy of the survey questionnaire provided to participants of this Project.

3.3.3 Questionnaire

A structured questionnaire was provided to participants attending the focus groups and interviews. The purpose of the questionnaire was to follow-up with clinicians on the impact of current training programs and to understand, in addition to proposed refinement to the phases, how training would likely improve IRR of the MHPoC. The questionnaire also provided the Project with an overview from the clinician’s perspective of the applicability of the existing phase to the clinical case load.

The specific aims of the questionnaire were to understand clinicians’ views on how training in the MHPoC should be undertaken, whether the MHPoC in its current form describes the kinds of consumers being seen by the respondent and if the number of phases adequately described consumers seen in contemporary clinical practice.

Respondents were provided with 13 statements that they either strongly agreed, agreed, disagreed, strongly disagreed, or neither agreed nor disagreed with. The survey questionnaire (Appendix 3) included demographic information such as service setting, discipline and the age group of consumers with which the respondents primarily worked and a section for open ended responses. The written comments were included to overcome the possibility that some participants may not say what they really think in open discussion (Dilshad & Latif, 2013).

There were two sources of information related to training from the Phase of Care Questionnaire. A series of survey questions, Questions 1-4, and written training comments. The four training questions requested participants to rate their agreement with training approaches:

- Face-to-face training;
- Use of real-life clinical vignettes;
- Training delivered online; and
- Phase of Care in isolation of other tools.

Results are summarised in this report as they relate to the key training outcomes.

Training materials were made available to the Project team from New South Wales, Queensland and Western Australia. Some variance in emphasis on training was highlighted as part of the evaluation.

3.3.4 Concept analysis

A concept analysis is a structured process that involves a close reading of the text. Several CAs undertook the concept analysis of the MHPoC following feedback and early analysis of transcripts taken from the interview and focus group process.

This process aimed to clarify all concepts contained within the MHPoC, distinguishing concept characteristics to identify mutually exclusive categories (Castro, 2016) with a focus on ensuring these categories meet the intended purpose as part of the AMHCC.

The analysis was an iterative process that involved delineation, comparison, clarification, correction and identification (Morse, 1995) of the values in the MHPoC. The work relied on the literature about the phase of care including the IRR study.

3.4 Thematic grouping and coding method

Thematic analysis was undertaken using the transcribed interviews and the information collated from the focus groups and the questionnaire. The information from these three sources was coded using constant comparative analysis (Glaser & Strauss, 1967) which is an inductive method in which codes are developed directly from the information transcribed rather than fitting the data into pre-existing codes. The groupings were used to relate what clinicians understood the phases to represent.

Figure 3 shows the process followed from source information to presentation of the themes relating to MHPoC and how the evidence was collated for refinement of the MHPoC.

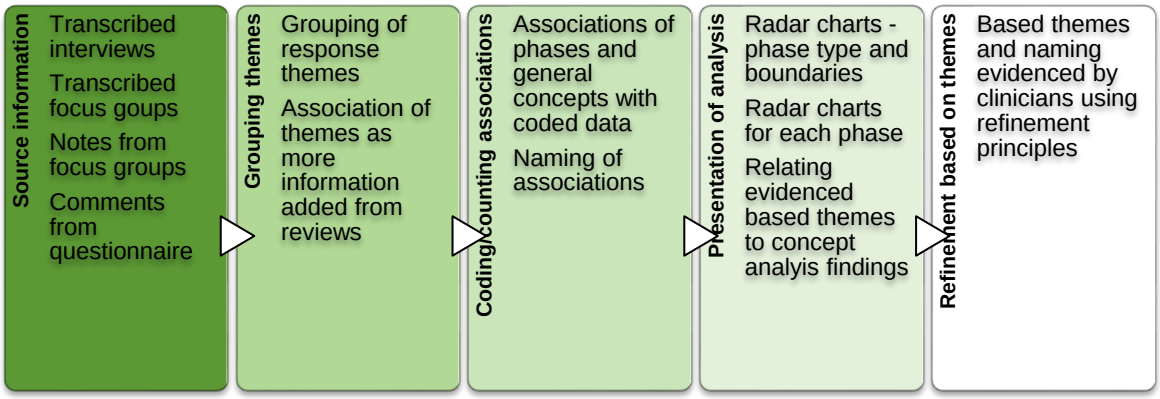

Figure 3: Thematic process for reporting clinical outcomes

Source information: Themes were identified, initially in NVIVO software and subsequently using Microsoft Excel to reflect clinicians' way of thinking about the phases, their meaning in clinical practice and relationship to the consumer and care delivery. The formulation and identification of key themes was complex due to the nature of the semi-structured interviews, yet the core standardised questions helped form the major groupings.

Grouping themes: Each theme that emerged during the review of transcripts was coded and elements of transcripts were associated with these themes in order to group and count text of a similar theme. Concurrently, each section of transcribed information (phrase or sentence) was closely compared to those following to identify underlying concepts or codes. Codes were then compared, and similar codes grouped into themes.

In the examples below, the theme correlates the clinician's interpretation of a phase (acute) with what the clinician thinks the phase is trying to describe.

Example 1: Acute care

Theme 1 *"Acute is a lot of inability to kind of make rational decisions and understand the consequences of those decisions, so like very poor judgement and insight. Often, a very clouded opinion or understanding of what they need in terms of treatment … it's deterioration of both mental and physical health, but the physical health seems to be a consequence of the mental health deterioration".* ***Theme 2*** *The acute phase would be quite short with us, and* ***Theme 3*** *then it goes into intensive extended.*

Where the types of themes that emerged were…

Theme 1 the clinician understood acute as defining the consumer presentation only;

Theme 2 the acute phase is short in length; and

Theme 3 the clinician had built a relationship with acute and intensive extended.

Example 2: Functional gain

Theme 1 *So what they have gained - "functional gain", I see it as more as they are gaining it, as in the process of gaining, consolidating is that they've understood - "functional gain"* ***Theme 2*** *is that they are in the process of adding more and more, the skills and strategies'.*

Where…

Theme 1 demonstrates the clinician has understood Functional Gain to describe the process or outcome of gaining function; and

Theme 2 that the consumer is able to build and add more skills and strategies.

As the Project progressed, more themes emerged from the interviews and further codes were generated and grouped together. In both the examples above, the themes generated related the phase to a type of 'something' (care, presentation, environment) to information that indicated phase definition and to lengths of time associated with phases. In the second example relating to the phase 'functional gain', a picture emerged over time suggesting some relationship between functional gain and the extent of skills building with the person above and beyond baseline. Variations in the number of themes reported related to whether a clinician thought about an association and expressed it. The thematic analysis was limited to only those associations that clearly identified a relationship with a phase, collection or training.

Coding and counting associations: Codes were generated for themes. Each instance of an association, such as relating functional gain and an outcome type, counted towards the total counts observed in the results. For example, for functional gain, many associations were found such as **FGO10,** where **FG** relates to the phase, **O** relates to the outcome of a consumer and the numerical count of **10** indicates the number of instances clinicians observed of that theme (10 instances).

Similar coding was applied for other themes relating how phases relate to a consumer presentation. For example, in **ACA02**, the **AC** is acute (phase), **A** is the acute (presentation) and **02** being the instance count again. Codes were grouped by phase and theme. The acute phase of care was often related to other presentations including a recovering presentation such as in the code **ACR03,** where the **R** denotes recovering.

The naming convention for the themed codes was consistently applied so that phase was described first, followed by the variable and then the occurrence. The variables were defined as themes emerged with the most common variables relating to the overall meaning behind a statement relating to outcome, care or consumer presentation. Other variables included how the phases related to ambulatory/inpatient, phase relating to other phase and phase relating to consumer clinical state (stable, deteriorating, recovering, acute).

Presentation of thematic analysis: Many of the findings in Section 4 are presented using radar graphs. Radar graphs were selected to show the overall or association in clinical thinking when clinicians explored the phases, what they mean and how they are applied. Radar graphs are useful in illustrating complex relationship information much like the clinical perspective on the association between a phase and the consumer presentation.

Refinement based on themes: the thematic analyses and how these related to the concept of MHPoC (concept analysis) underpinned the refinement process with the principles outlined in the following section.

4. Review findings

This section presents the main findings of the thematic analysis from the clinical review. High level themes relating to the clinicians fundamental understanding of the MHPoC, how these are interpreted and differences in consumer care allocation to a phase of care were observed during the analysis of interview, focus group transcripts and notes.

There were 64 interviews transcribed as part of the MHPoC Project review process alongside a series of 29 focus groups. 255 clinicians in total were either interviewed or took part in a focus group.

Included in this section are the findings of the training review component of the questionnaire and responses by clinicians about how often they report a change in phase. These findings, along with the work undertaken during the conceptual analysis are discussed in Section 5.

255 questionnaires about training were completed, both as part of the focus group and interview process (see Appendix 3). Most questionnaires were completed by nurses, 54.9%, while psychologists, social workers, occupational therapists and medical practitioners also contributed. Nearly 10% of questionnaires were completed by non-clinical, managerial or unknown professional designation. Most respondents had between 1 to 10 years of experience in mental health, 34.5%. 56.9% of respondents had previous training in the MHPoC, meaning that 43.1% had no previous MHPoC training. 54.4% reported working in community care and 29.8% worked in inpatient care.

Most respondents worked with adults, 53.7%, 12.9% worked with children and adolescents and 9.8% with older persons. 14.1% of respondents reported working across all age groups.

4.1 Phase of care representation

Clinicians almost uniformly recognised that consumers move through stages or phases of care and described these phases or stages variously as relating to:

- The illness or clinical presentation of the consumer;
- The phase or stage of care being provided, the care environment or care outcome; or
- A combination of the two.

Breaking these distinctions down further, the following grouped themes were representative of the comments made by clinicians in respect to what the MHPoC phases represented for them in their practices:

a. That the phases primarily represent a **type of service** or characteristics of a service – clinicians placed greater emphasis on phases relating to service or type of service offered within a jurisdiction.
b. That the phases primarily represent the **clinical aspect of a consumer's presentation** or **outcome related to the phase** and consumer presentation – clinicians placed greater emphasis on phases relating to the attributes (such as symptom, distress level) that a consumer presents with and what the outcome should be within the phase.
c. That the phase primarily represents the **type of care** that should be provide to the consumer – clinicians placed greater emphasis on the type of care to be provided in a more generic sense.
d. That the clinician agreed that consumers moved through phases or stages but **could not sufficiently nor consistently describe** what the phases represented to either service, type of care, consumer presentation nor any other related clinical domain of mental health.

The way clinicians associated the phases of care varied according to which phase of care a clinician recommends for a consumer[4]. The radar graph in Figure 4[5] shows the association between the type of phase (assessment only, acute, functional gain, consolidating gain, intensive extended) according to clinician's understanding of the purpose of a phase, the consumer presentation, the environment (or setting), the consumer outcome or the service/care type.

[4] These specific findings were possible to collate by phase because of the structured questions (see Appendix 2) adopted about each phase in the semi-structured interviews and focus groups.

[5] The radar graph in Figure 4 displays the level of association between a phase of care and a type of service, environment, outcome. Where a clinician in interview indicated this association, a code was developed to identify and count the association. A count is only recorded once per interview or focus group per phase to type. Therefore, these counts are unique instances of association by the clinician.

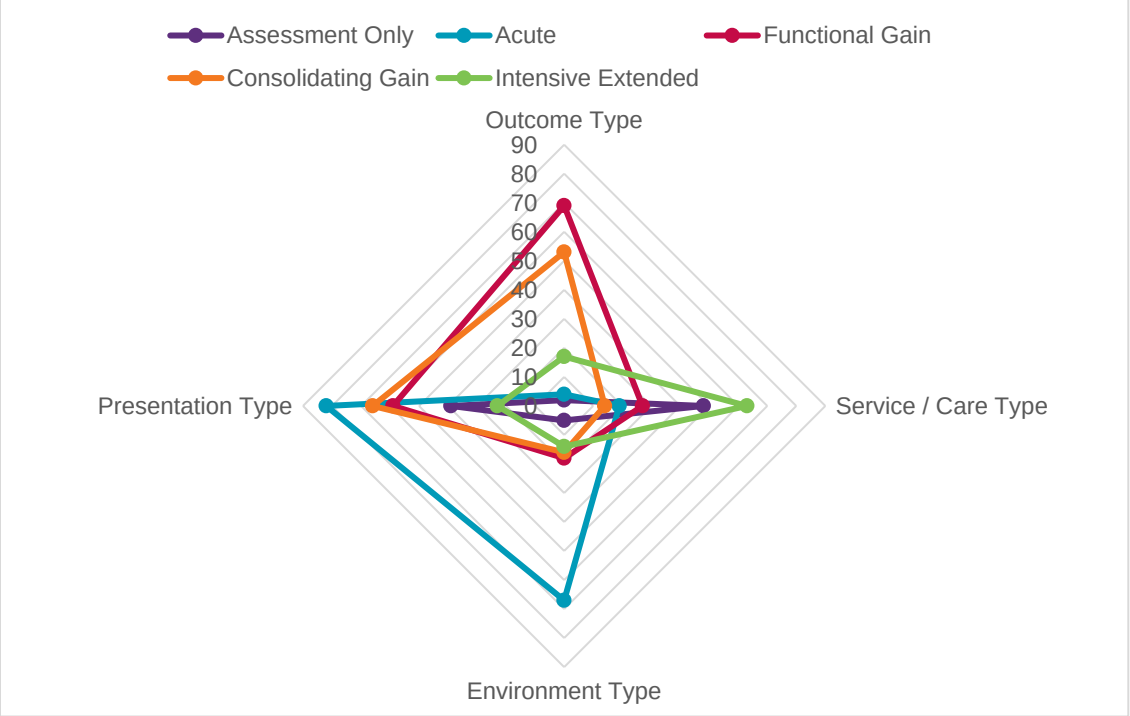

Figure 4: Phase to type (phase purpose)

There was a mixing of association between the phases and what they represented to clinicians. There were 69 unique responses reported by clinicians that indicated that they associate functional gain as a type of outcome of the care intended or that the phase is a means to describe the outcome of the consumer. Consolidating gain had a similarly high response rate of 53 unique associations relating the phase to consumer outcome. Clinicians did not associate acute to outcome type (4 associations) but there was some association with the intensive extended phase as representing the consumer outcome (17 associations).

Clinicians strongly associated the acute phase of care with the presentation of the consumer (n=82). Phases consolidating gain (n=66) and functional gain (n=59) were also correlated by clinicians with the consumer presentation.

Intensive extended was reported by clinicians as being closely associated with the service they work at or the care type (n=63), as well as acute (n=19). Acute was also observed to have a strong relationship with environment type or setting (n=67).

To clinicians, the phases represented many different aspects including the consumer presentation, the care or the outcome anticipated for the consumer. There was little indication that phases are consistently understood as relating to one of these classification types. In many cases, there was overlap in association between phases such as functional gain and consolidating gain being highly associated with outcome. Clinicians associated the acute phase three classification types of presentation, environment and service.

4.2 Consumer presentation and phase overlap

A second key finding from the Project was that clinicians associate the phases of care with the stability of the consumer presentation. The radar graph in Figure 5 shows the responses from clinicians according to four presentation categories defined as stable, acute, deteriorating and recovering presentations[6].

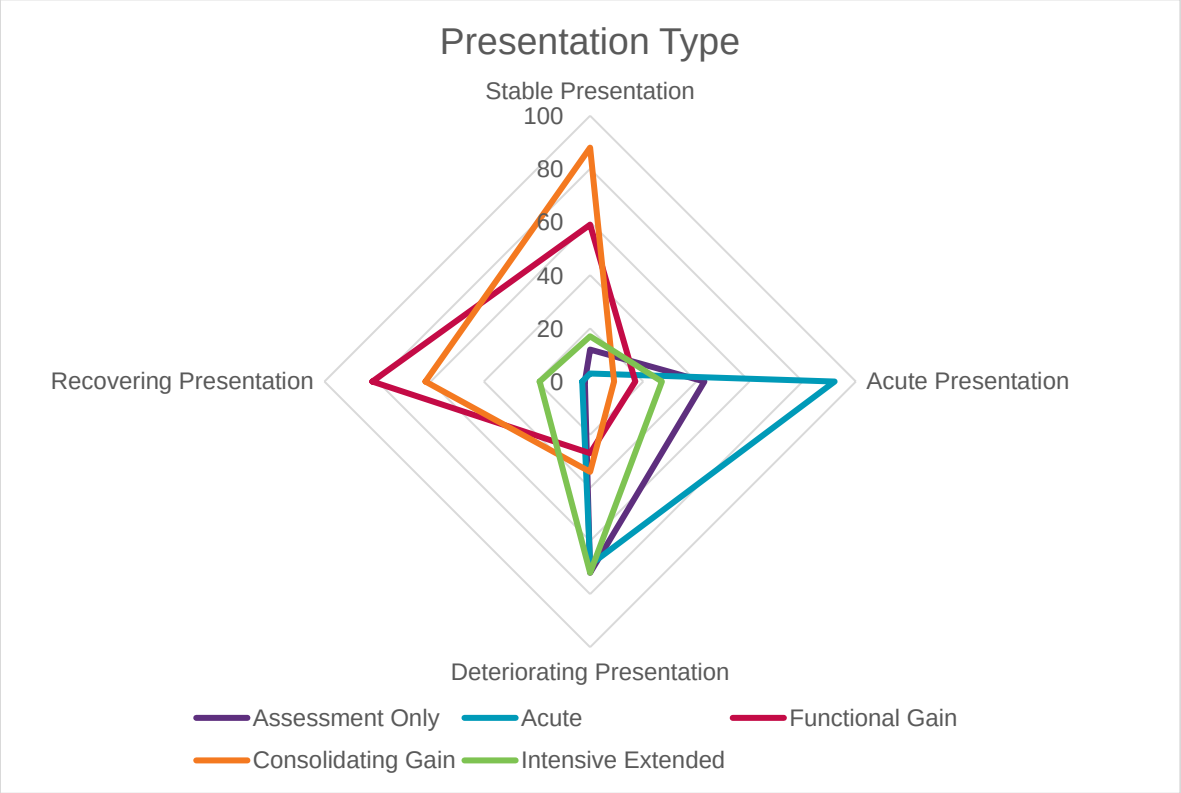

Figure 5: Boundary overlap (stability of presentation to phase)

As shown in Figure 5, the clinicians associated the acute phase with an acute or deteriorating presentation of the consumer. Clinicians associate the intensive extended phase with people who present in a deteriorating state.

Functional gain was associated with people in a recovering stage and people who are stable. Consolidating gain was mostly associated with people who are stable in their

[6] A stable clinical presentation is defined as one where the consumer is clinically stable in their presentation either as a result of sustained treatment and intervention or, where discharge from a service is being considered, or the consumer no longer requires intervention to keep them stable in presentation.

A deteriorating presentation is where the consumer presentation is worsening and likely to continue to worsen without further intervention from the clinical service.

A recovering presentation includes situations where the consumer has experienced deterioration at some point, and which is now improving or recovering. This could be applicable in pre (acute avoidance) or post-acute presentations.

An acute presentation includes those consumers whose presentation has become the most clinically unstable resulting in an increased risk, increase in symptom and which requires a substantial increase in resource in order to move the consumer towards recovery.

presentation. These and associated findings are explored in greater detail below in relation to each phase.

4.3 Results by phase

4.3.1 Acute

Acute was the most consistently described phase by clinicians according to its relationship with consumer presentation, the environment the consumer was treated within, or the service the consumer received.

The following themes generated from data gathered in interview and focus group participation (see Figure 6):

- That clinicians held the strongest association between acute and the presentation of the consumer (n=82).
- The next strongest association clinicians held was with acute and the inpatient setting (n=67).
- Clinicians stated an association with acute and the nature or level of care being provided in terms of the consumer presentation (n=19). This association differs from the environmental association in that the clinician spoke more generally of care rather than a strong association with inpatient environments.

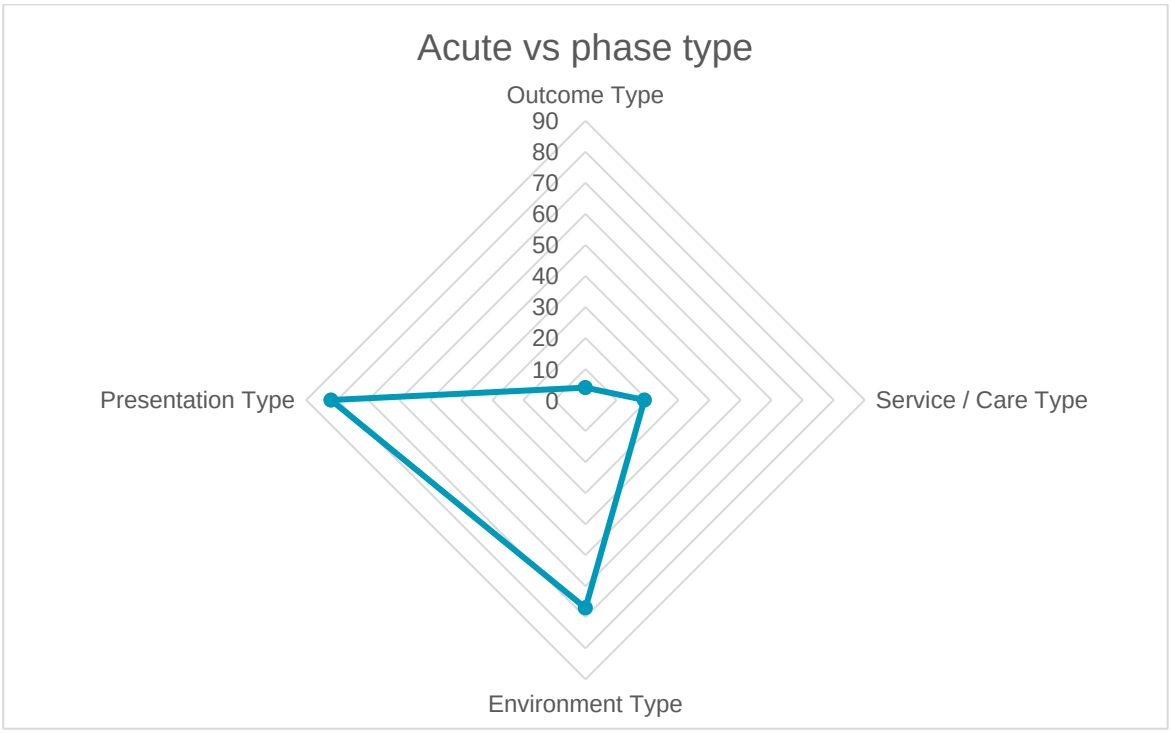

Figure 6: Acute phase association

The association between acute as an environment and presentation was affected by the relationship between acute and other phases. For example, clinicians expressed that in some instances they would move consumers into functional gain or intensive extended to express recovery or a step down whilst still an inpatient. In these instances, it was the

presentation and not the environment that was considered to define the phase. If the clinician held the view that the presentation represented acute there appeared to be more likelihood that, business rules permitting, the clinician would also move the consumer into a ‘step down’ phase irrespective of the consumer still being admitted. Similarly, the opposite was more likely to be true for a clinician who viewed acute as relating primarily to the environment.

Clinicians reported that, in relation to function, acute phase was most related to the return of this function of the consumer where this was explored in the interview or transcript process as shown in Figure 7. There were 53 instances where clinicians associated this type of clinical thinking, 28 instances where clinicians indicated an association between acute and preventing deterioration or relapse prevention, and 16 associations with maintenance of function.

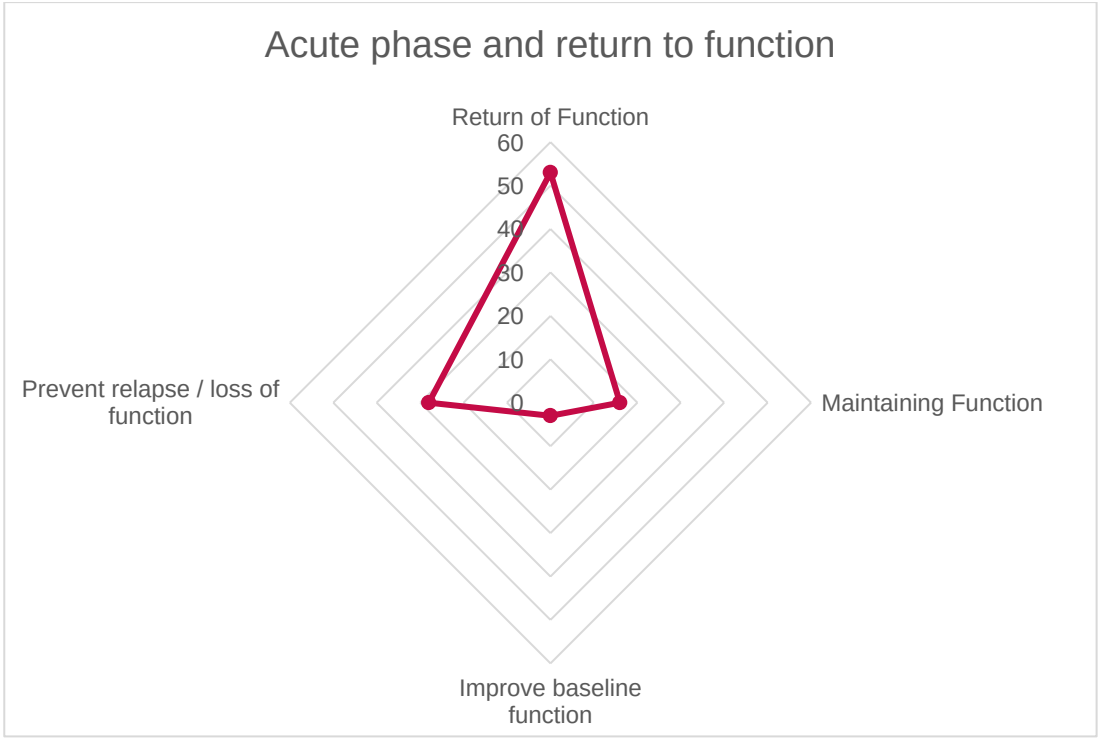

Figure 7: Association of acute phase with return to function of the consumer

In the graph shown in Figure 8, acute phase and functional gain phases are overlaid. The acute phase was indicated by clinicians as having a stronger association (n=53) with a return of function than functional gain (n=27). Similar associations relating to preventing deterioration or relapse were found when comparing for acute (n=28) and functional gain (n=25).

Some clinicians stated that the most function for a person is returned within the inpatient environment as part of an acute episode, although not all clinicians were able to articulate this level of reasoning for the association.

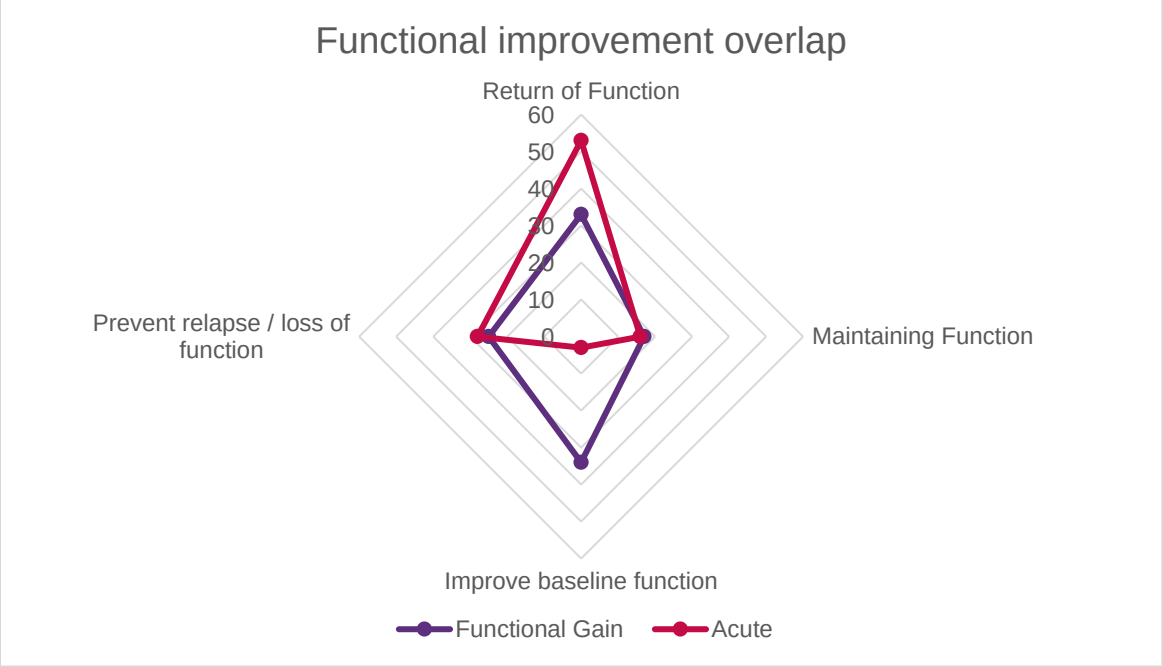

Figure 8: Overlap of acute and functional gain in functional improvement

4.3.2 Functional gain

Respondents to interview and focus groups provided various interpretations of functional gain and its use as a phase in clinical practice. Clinicians considered many aspects of the consumer, the care and the environment when describing the meaning or purpose of functional gain.

The following themes generated from data gathered in interview and focus group participation indicate the following:

- Clinicians expressed a strong relationship between both functional gain and consolidating gain in addition to the nonlinear relationship all phases share (n=34).
- There were 19 instances where clinicians expressed that no additional relationship exists between functional gain and consolidating gain.
- Clinicians associated functional gain with a reduction in symptom (n=29) and with acuity of illness (n=17).
- In 82 instances, clinicians identified recovery more globally as a key aspect of the acute phase. However, the degree to which recovery had already taken place, prior to phase allocation, appeared largely subjective and difficult for many clinicians to consistently quantify.
- Clinicians reported (n=27) that functional gain represented a more relapse preventative nature of care.

When exploring themes related to a consumers return of function:

- Clinicians associated this phase with a return to baseline or pre-morbid function (n=33).
- There were 14 additional instances identified where clinicians associated this phase with skills building in addition to baseline function.

- There were 27 instances of association between functional gain and the provision of a service or care to the consumer.
- Some clinicians felt that the level of service or care was more intensive than intensive extended and consolidating gain if the consumer was placed in functional gain during an inpatient stay (n=13).

The radar graph below in Figure 9 (re-presented from Figure 4) illustrates the clinicians' associations with functional gain as a type of outcome and a presentation type more so than service or environment type. When clinicians described the presentation of the consumer, they also described the outcome (return of function) they anticipate achieving in many respects. There is large overlap in clinical thinking about the relationship between these two aspects of presentation and outcome and this reinforces the view that clinicians may largely view this phase in terms of the consumer presentation and the anticipation of an outcome desired by the treating clinician.

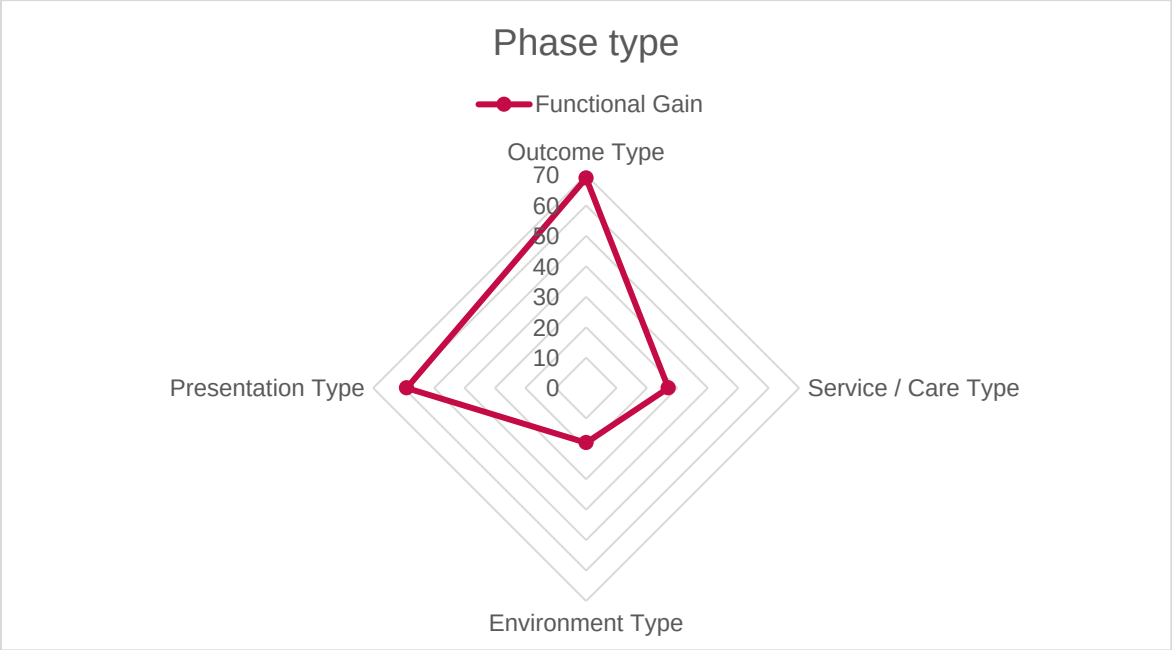

Figure 9: Association of functional gain with type of phase

The extent to which the degree of function is returned from a clinician's perspective was explored as function featured prominently in the interviews and focus groups due to its reference in a number of phases. The most common themes referenced when exploring function included a return or maintenance of function, functional improvement above baseline and the prevention of deterioration or relapse that would result in a loss of function.

In isolation, functional gain was found to have the strongest association by clinicians with improving all types of function, baseline function (n=34), preventing deterioration (n=25), and maintaining function (n=17) even though the acute phase reported higher indications of people gaining function in that phase (see Figure 8).

Figure 10 shows the overlay of consolidating gain with functional gain with regards to functional improvement expected in those phases. There is some general overlap in

association between the two phases. Clinicians appear to display the most overlapping association of these phases with improvement to baseline function (n=34) for functional gain and consolidating gain (n=21).

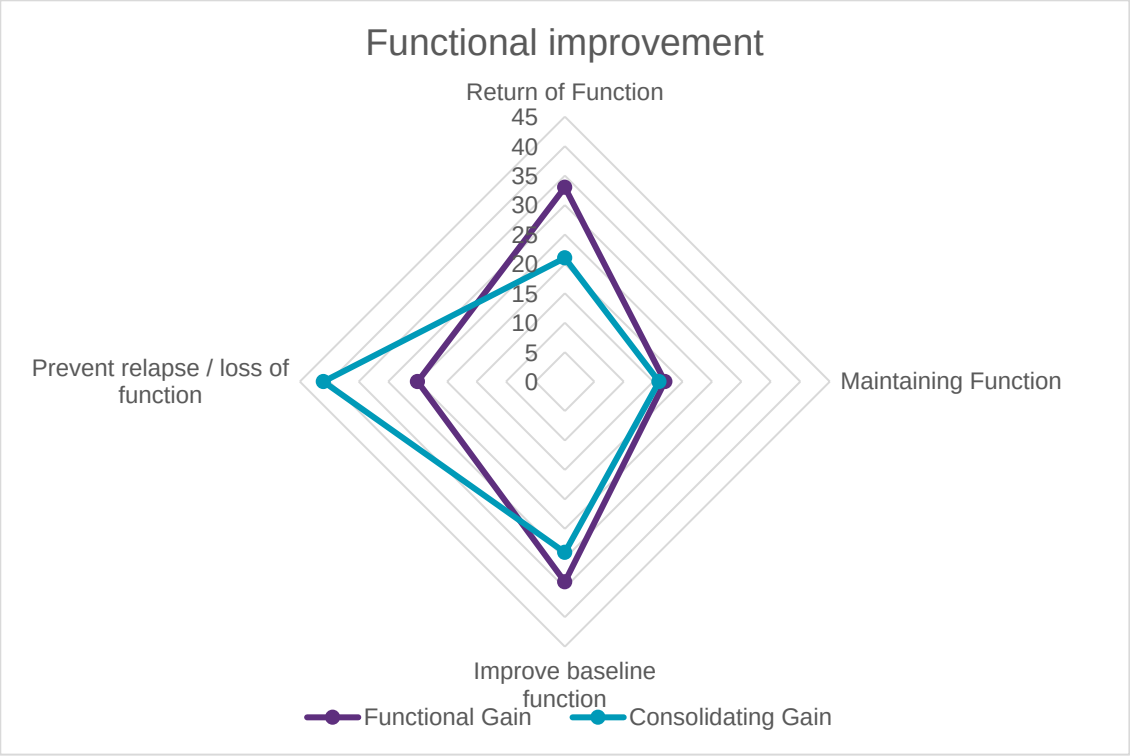

Figure 10: Association of functional improvement expected in consumers for functional and consolidating gain

Similarly, when consolidating gain was compared with intensive extended, clinicians showed similarity in association between these two phases and prevention/deterioration aspects of the consumer/clinical relationship. Figure 11 illustrates this overlap alongside a similar overlap between intensive extended (n=37) and functional gain (n=33) in the return of a consumers function to baseline.

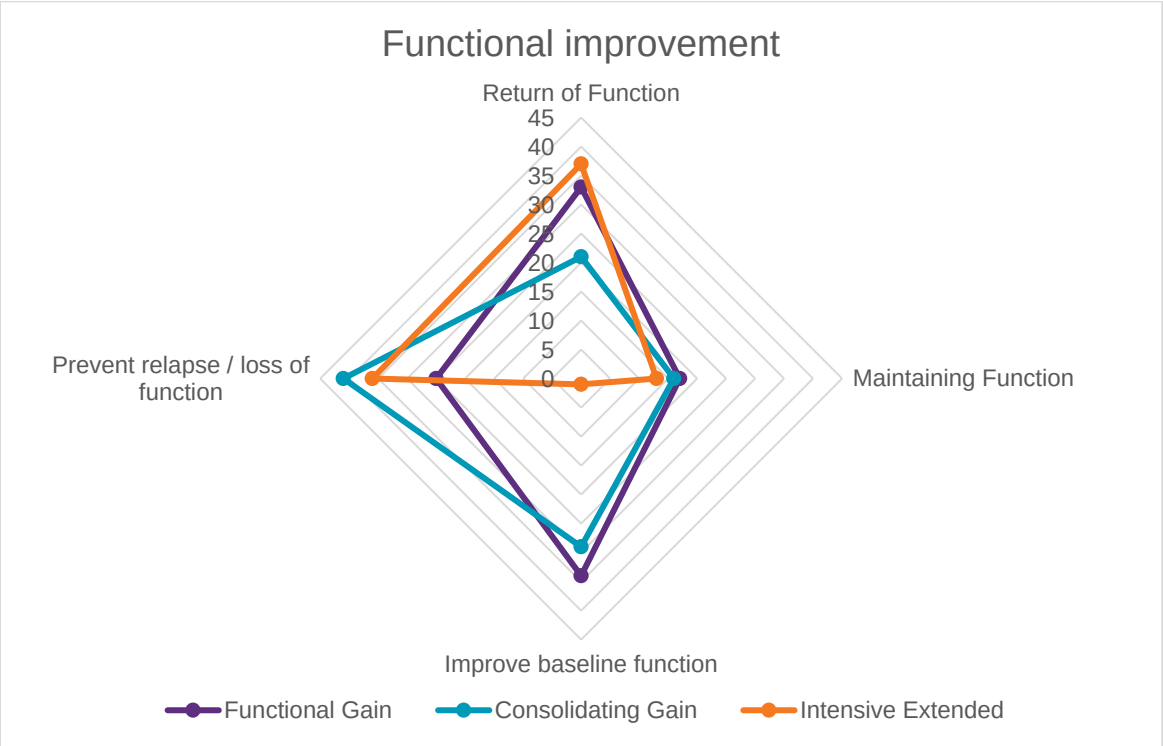

Figure 11: Association of functional improvement expected in consumers for functional and consolidating gain and intensive extended

4.3.3 Intensive extended

Responses indicated that intensive extended, from a clinician's perspective, is associated with the service the consumer requires in the first instance (n=63) and presentation of the consumer in the second instance (n=23). The following observations were made by clinicians:

- Clinicians initially described consumers within this phase as requiring complex or intensive support but many felt that the support offered was not extended or indefinite in length.
- Many clinicians appeared to place emphasis on the intensive (n=19) rather than extended component of the label, with some clinicians rejecting the capacity to provide both intensive and extended therapies or support within the community setting (n=7).
- Some clinicians described intensive extended as acute in the community or similar (n=17). Clinicians also understood that intensive extended may be used within inpatient settings for consumers who may be unwell but not have reached locally defined 'peak' acuity (n=7).

Figure 12 illustrates that clinicians view this phase as having the strongest relationship with consumers who are experiencing a deterioration in presentation (n=72). The acute phase has marginally less association with deterioration presentation type (n=69) but substantially more relationship with acute presentation. Both acute and intensive extended held strong association amongst clinicians with a consumer who is deteriorating.

Similarly, intensive extended appears to have a relatively large number of associations with being preventative (preventing loss of function) with associations noted 36 with acute (n=28) the next closest phase. Both intensive extended (n=37) and acute (n=53) appear to have close relationship with return of function and similarly minor relationship with maintaining function. Neither of these phases appear to have a clinical association with improving baseline function (see Figure 13).

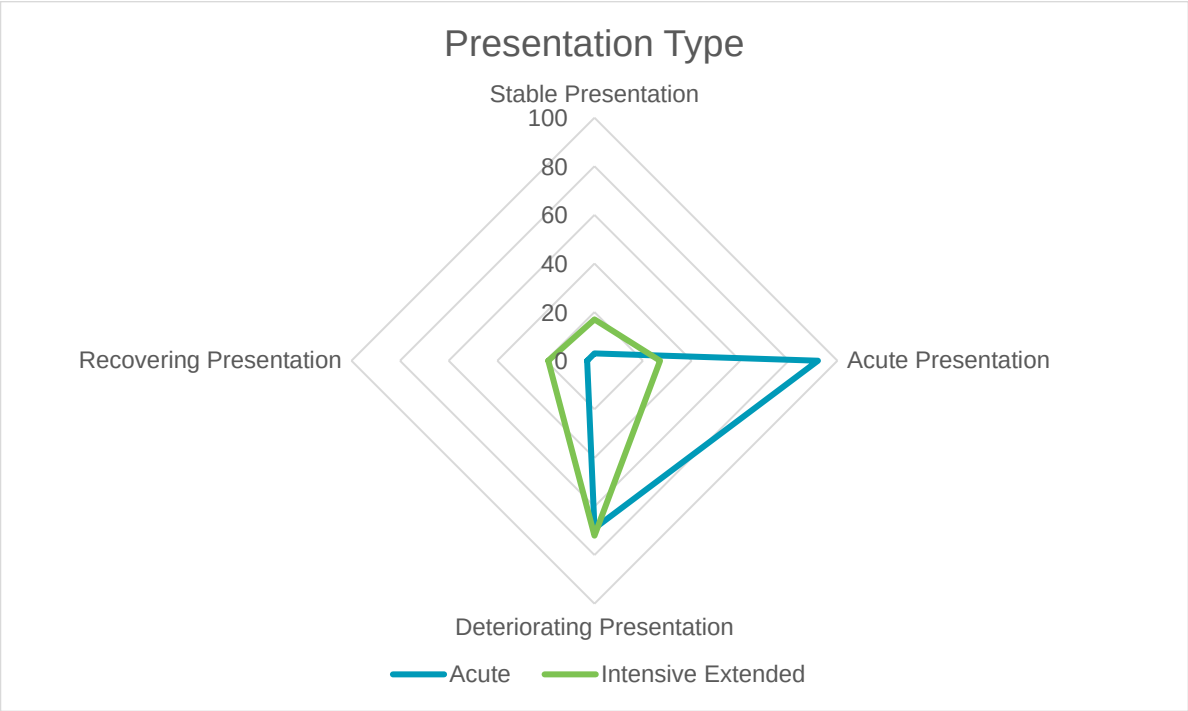

Figure 12: Association and overlap of intensive extended and acute phases for consumer deterioration

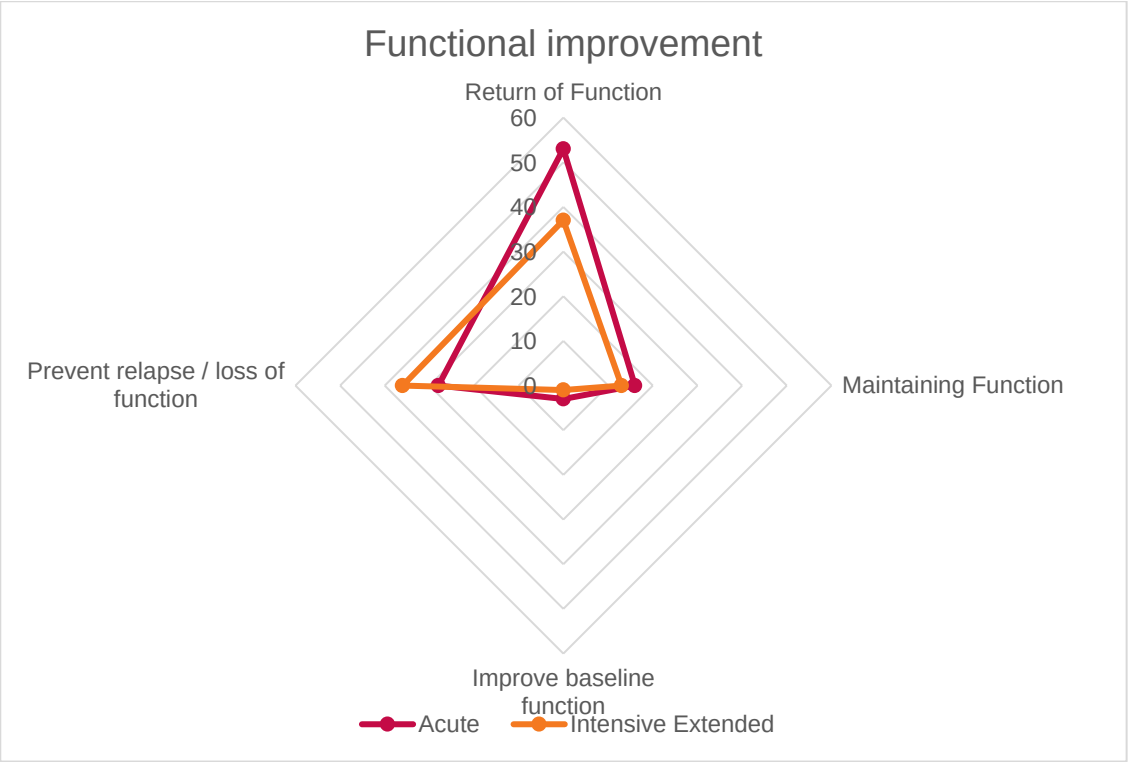

Figure 13: Association and overlap of intensive extended and acute phases and functionality of consumer

Intensive extended appeared to have the most association (n=63) with being a phase representing service/care type being provided to the consumer rather than relating to outcome, environment or presentation. This may be unsurprising given intensive (the intensity of service provision) and extended (length of service provision) make up the phase label itself.

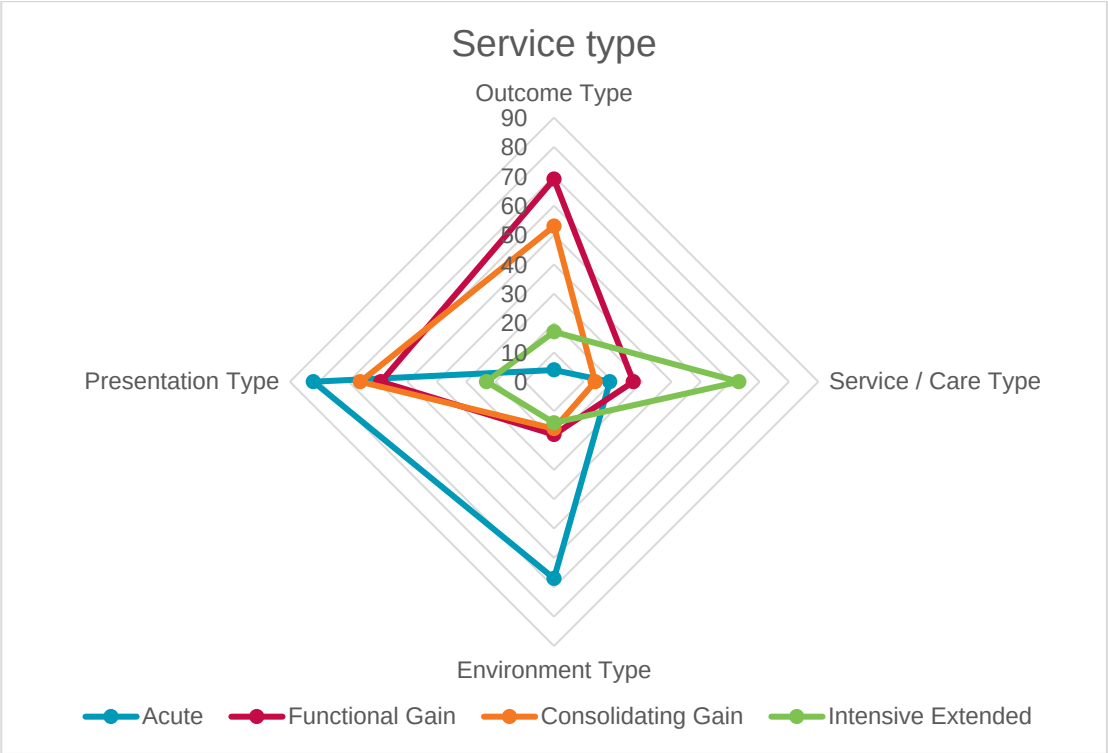

Figure 14: Association with service and intensive extended

4.3.4 Consolidating gain

Respondents to interview and focus groups provided various interpretations of consolidating gain and its use as a phase in clinical practice. Clinicians considered many aspects of the consumer, the care and the environment when describing the meaning or purpose of this phase.

The themes generated from data gathered in interview and focus group participation indicate the following:

- Some clinicians expressed a specific relationship between both functional gain and consolidating gain in addition to the nonlinear relationship all phases share (n=34).
- In terms of the clinical presentation of the consumer there were 88 instances of association between this phase and a stable clinical presentation.
- This was followed by a recovering presentation (n=62).

Many clinicians referenced previous usage of the term maintenance in discussion about this phase.

- There were 71 instances where this was discussed or identified in focus groups, with 63 indications where clinicians preferred maintenance as an alternative phase.
- Of those responses, 33 clinicians mentioned the language was easier to understand.
- Clinicians indicated that maintenance had more meaningful relationship with clinical practice and language understood by clinicians (n=21).

Information provided by clinicians indicated that consolidating gain was largely being associated with:

- An outcome type (n=53) or presentation type (n=66) as opposed to service or environment type.
- In 16 instances, clinicians indicated that consolidating gain was used within the team for consumers who were being planned for discharge.

Many of these responses indicated that this population of consumers were markedly different to the 'classic' maintenance care, where people still required ongoing treatment and support. Discharge planning was described as much more administrative in focus than active clinical treatment.

The following radar graph (Figure 15) highlights the close relationship between functional gain and consolidating gain where overlap in association between these two phases and presentation/outcome is evident.

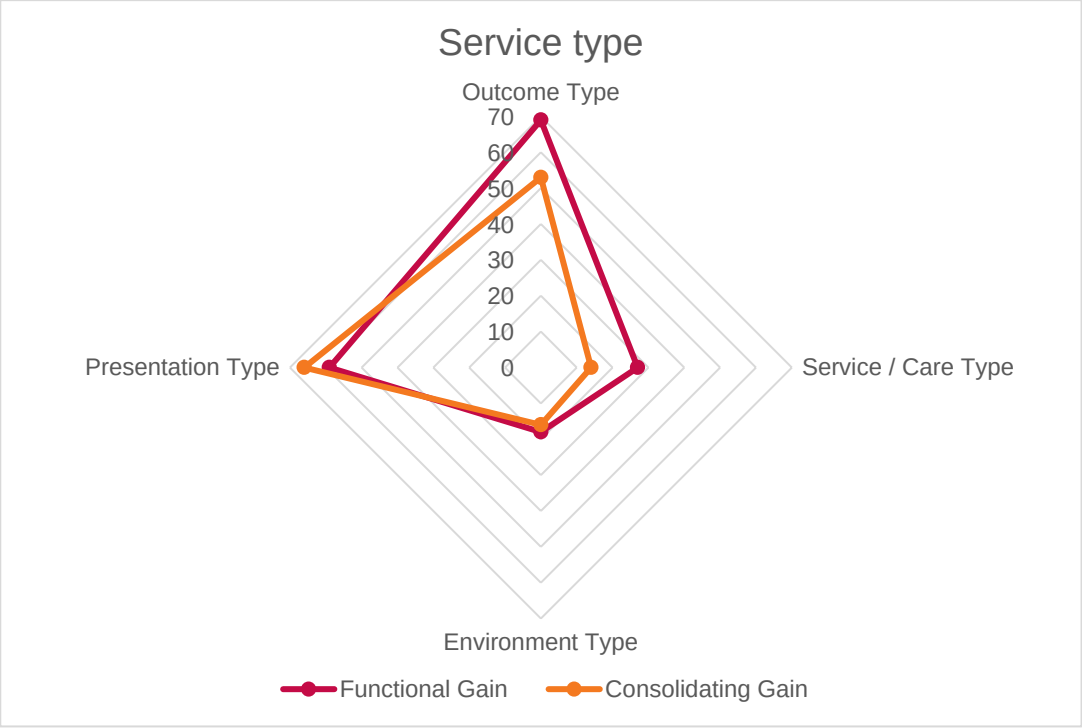

Figure 15: Association with service allocation for functional and consolidating gain

As indicated in the section of the report detailing functional gain and Figure 9, the key difference between these two phases appears to be in the greater emphasis on preventing functional decline as opposed to functional gain which holds stronger clinical association with returning function to baseline. Both phases appear to hold close to equal association with maintaining function (16 and 17 associations respectively).

Clinicians stated that consolidating gain and functional gain relate strongly to a consumers recovering and stable presentation. Similarly, both phases appear to lack association by the clinician with an acute or deteriorating presentation.

Consolidating gain is differentiated slightly by its higher association with stable presentation (n=88) whereas functional gain has stronger association with recovering presentations (n=59) – see Figure 16.

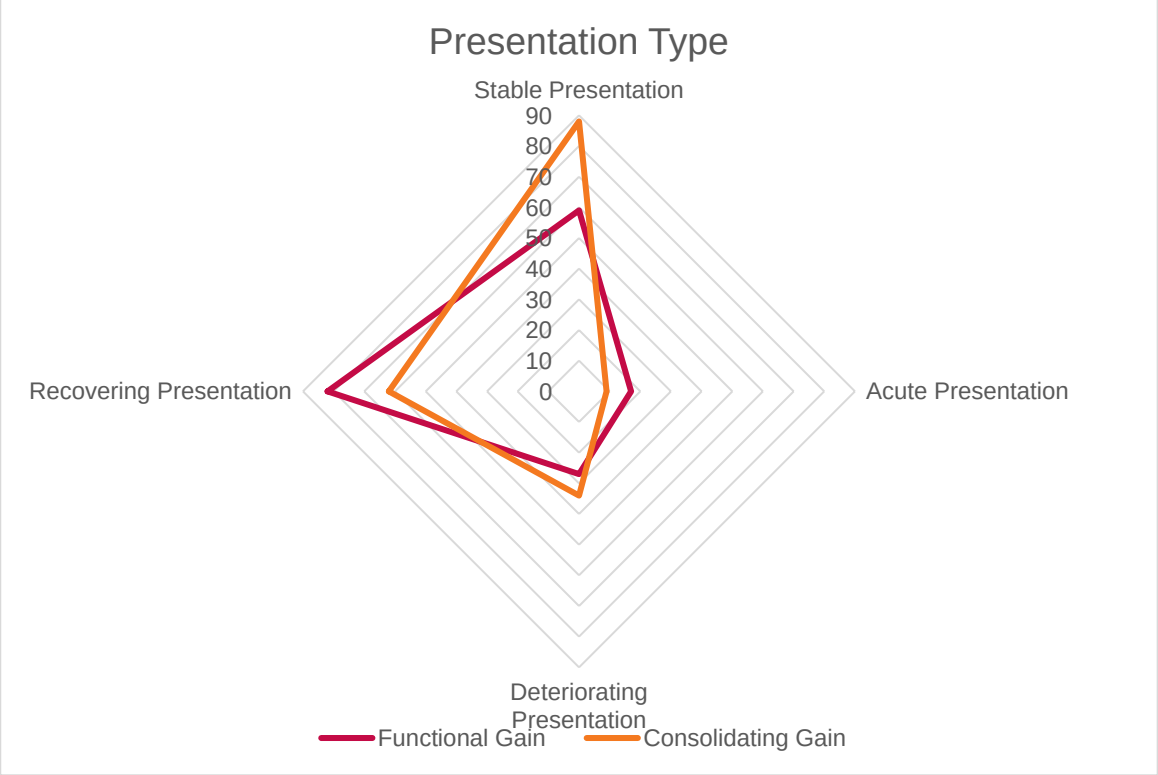

Figure 16: Association and overlap of functional gain and consolidating gain phases and functionality of consumer

4.3.5 Assessment only

Assessment only was considered a time limited activity rather than a traditional phase of care. This appeared to be consistently understood by clinicians as a result of the very specific rule set that governs its use. The Clinical Refinement Project therefore provided less focus on the refinement of this phase as a result.

The assessment category in the AMHCC is designed to indicate a consumer exiting from health services where no service (following assessment) is being provided by the jurisdiction. There is strong reason to suggest therefore that this phase should be provided with a different designation rather than be described as a phase of care.

Figure 17 illustrates the relationship between presentation and service type that would be expected of the assessment only category.

Given that assessment only is essentially a service activity, often required as a result of clinical presentation changes in the consumer, both these data items would suggest a sound clinical understanding of assessment only purpose.

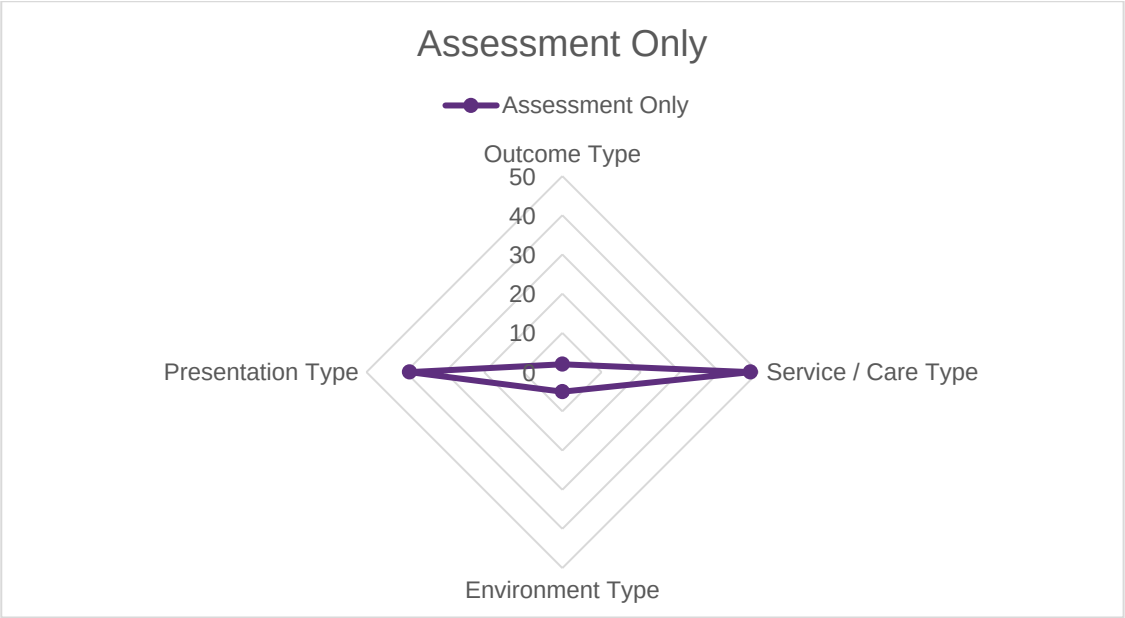

Figure 17: Association with service allocation for Assessment only

Similarly, Figure 18 illustrates the type of clinical presentation that might be expected of a consumer requiring assessment. This is once more in keeping with the clinical nature of an assessment service.

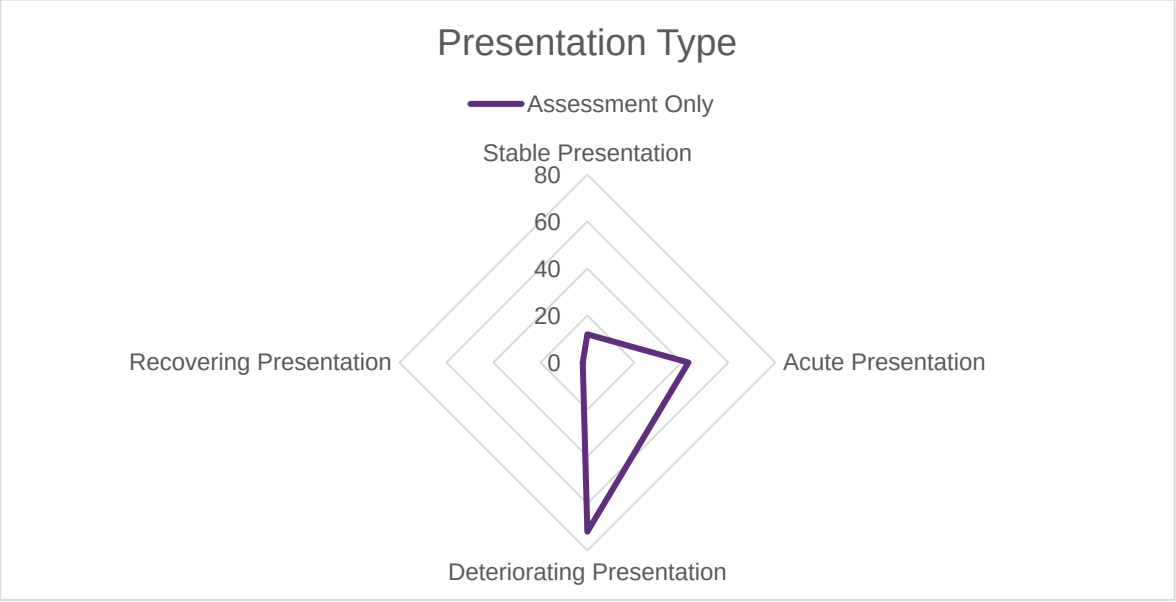

Figure 18: Association assessment only and functionality of consumer

4.4 Clinical setting and impact on phase selection

Figure 19 represents the responses from clinicians who reported that they are influenced by whether the person is an inpatient or being treated in and ambulatory setting. A degree of association between acute (high association), functional gain (moderate association) and intensive extended (low association) was found.

Except for assessment only, consolidating gain appears to be the only phase with little to no association with inpatient environments and with the strongest relationship in ambulatory setting.

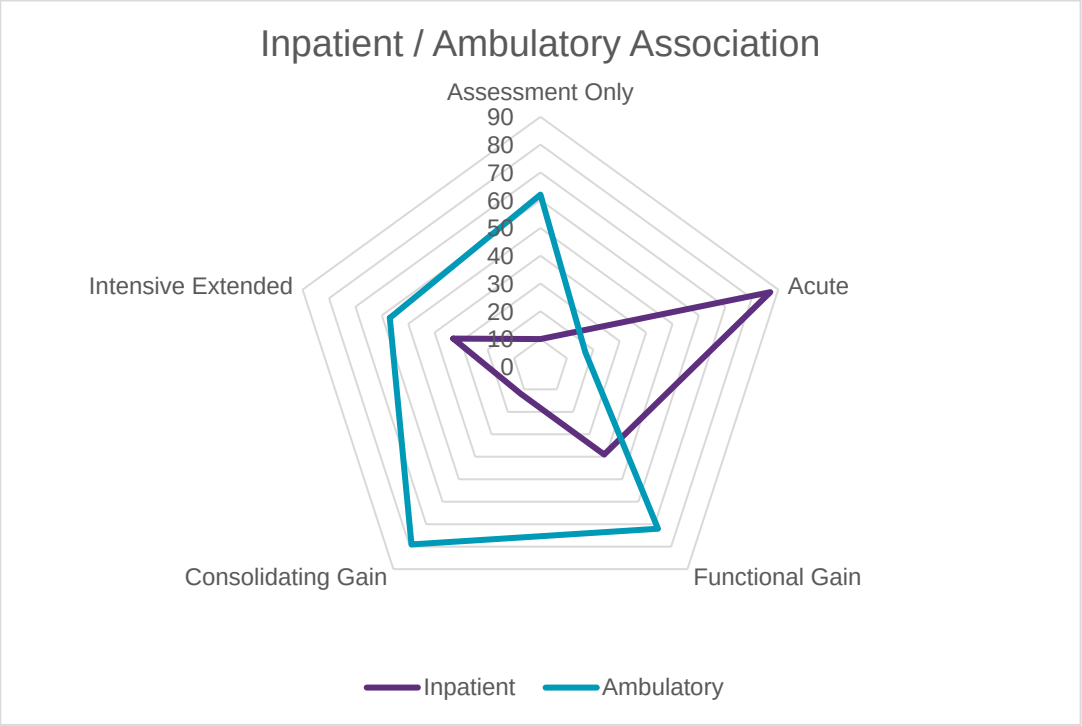

Figure 19: Inpatient and ambulatory phase association

Many clinicians, when discussing acute, described either the presentation or the care and environment. The way in which clinicians decided on acute would also impact how other phases featured in relationship to inpatient environments.

4.5 Frequency of reporting phase changes

Clinicians raised the burden of recording the phase of care for reporting to the ABF Mental Health Care National Best Endeavours Dataset for use in the AMHCC. The issue was not related to the service, setting or specifically to a jurisdiction.

Clinicians in jurisdictions who have implemented the MHPoC indicated that they either collect the MHPoC, HoNOS and LSP-16 data items according to strict diarised National Outcomes Casemix Collection (NOCC) protocols, or were flexible in their approach in order to capture these data items according to ad-hoc times required of the MHPoC. NOCC has appropriate protocols to enable completely flexible ad-hoc data capture according to the needs of MHPoC. However, Figure 20 shows the percentage of the respondents in Queensland, New South Wales and Western Australia who stated they followed diarised rather than ad-hoc NOCC protocols. The responses in each state ranged from 24 to 40. In Queensland, 88% of clinicians who raised this as an issue stated they did not always report MHPoC by AMHCC requirements, 93% from Western Australia and 96% from New South Wales mentioned similar reporting behaviour.

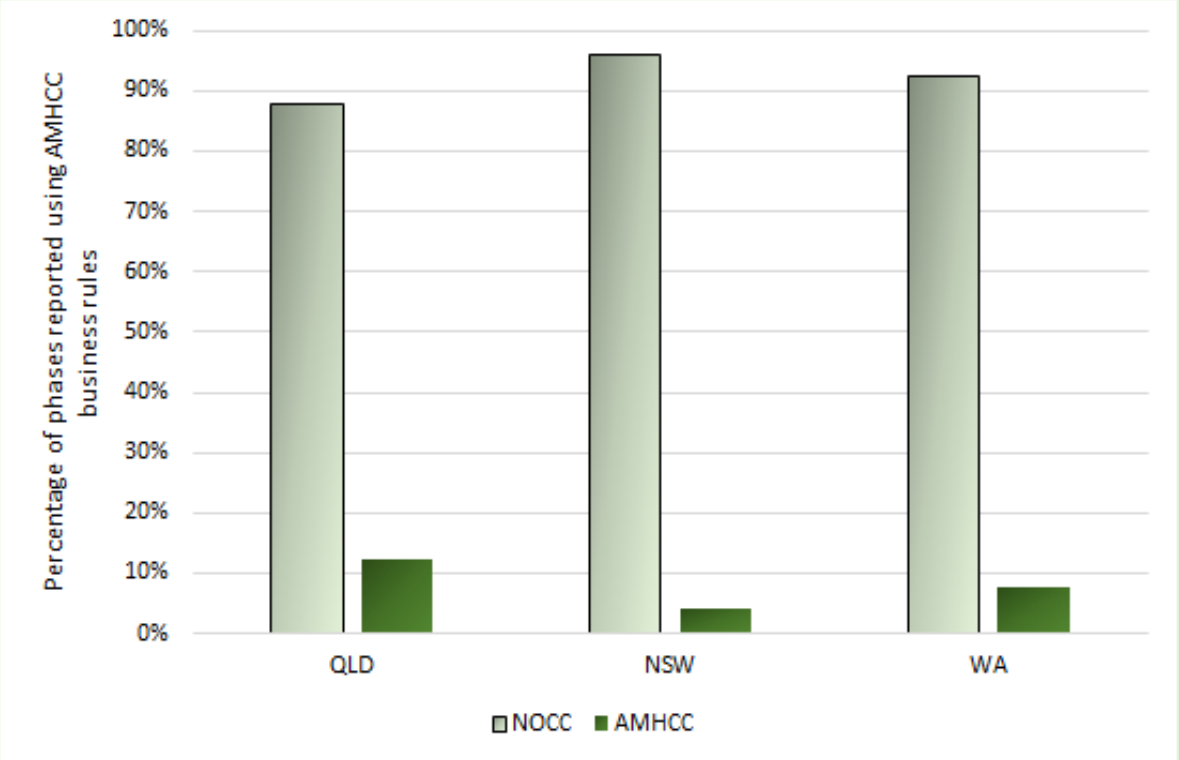

Figure 20: Drivers for data collection diarised NOCC vs AD-HOC AMHCC

The diarising of MHPoC changes has the potential to disrupt the relationship between reflecting live changes to the consumer's presentation and the change in phase. If a consumer deteriorates in presentation but only receives a phase change once they reach an inpatient environment, then there is potential that changes of phase reflecting increasing complexity prior to acute may have been omitted from the episode of care. The implications for these reporting patterns are explored in greater detail within section 5.4 clinical documentation process.

4.6 Training of clinicians

Over 200 survey questionnaires about training were completed, both as part of the focus group and interview process (see Appendix 3). Most questionnaires were completed by nurses, 54.9%, while psychologists, social workers, occupational therapists and medical practitioners also contributed. Nearly 10% of questionnaires were completed by non-clinical, managerial or unknown professional designation. Most respondents had between 1 to 10 years of experience in mental health, 34.5%. 56.9% of respondents had previous training in the MHPoC, meaning that 43.1% had no previous MHPoC training. 54.4% reported working in community care and 29.8% worked in inpatient care.

Respondents worked with adults 53.7%, 12.9% worked with children and adolescents and 9.8% with older persons. 14.1% of respondents reported working across all age groups.

Some clinicians indicated their MHPoC training may have occurred as early as 2014 as a participant in the costing study or later in the IRR study and was prior to the rollout in 2016. For some of these people it did not result in any ongoing collection or current use of the MHPoC.

The findings from the questionnaire provided to clinicians about training and the MHPoC concept indicated the following:

- Most respondents agreed or strongly agreed that the MHPoC categories describe some of the consumers that they worked with.
- Most respondents were more ambivalent about the number of phases of care neither agreeing nor disagreeing that there needed to more than five phases or less than five phases.
- They were marginally more positive that the MHPoC as currently defined reflected contemporary practice.

Overall, respondents agreed that a face-to-face approach to training would be best and this training should include real life clinical examples. Respondents were more ambivalent about online training, with 30% of respondents agreeing that online training would be useful and 30% disagreeing.

Table 4 shows the level of agreement/disagreement for the 4 training questions clinicians indicated a preference for. Relatively similar cross jurisdictional variation in understanding were observed throughout irrespective of the materials used by a jurisdiction.

Table 4: Clinician responses regarding MHPoC training programs

Questions 1 and 2	**Percentage agreement**
Q1. Face to face workshops would be the best approach to training in the mental health phase of care	82%
Q2. It is essential that mental health phase of care training includes real life clinical examples	89%
Questions 3 and 4	**Percentage disagreement**
Q3. I think the mental health phase of care training could be adequately delivered online as a self-directed package	40%
Q4. The mental health phase of care is best done in isolation from training in other measures	41%

The brief evaluation of training materials related to the MHPoC was considered an important aspect of the Project. Emphasis was placed variously on the relationship between outcomes, ABF, key performance indicators and the clinical utility of the MHPoC. Some referred to broader ABF developments and the AMHCC without providing too much technical detail or focus on the overarching function and purpose of the MHPoC within the AMHCC.

5. Discussion of findings

Data gathered as part of the analysis indicated that, as currently designed, the phases are not consistent in the way that they separate the population of consumers. As a splitting variable of the AMHCC, the MHPoC should separate consumers into discreet populations and these populations should be separated using a consistent set of rules. This set of rules is the design and configuration of the phases themselves and it is this design which may result in poor IRR.

The phases, which individually appear to describe different aspects of either the consumer, the care, the environment, the outcome or a combination, affect both the internal consistency of the MHPoC itself and impede the ability of clinicians to make decisions that are based on a consistent understanding of what exactly the phases represent.

Many clinicians stated that they had a sound grasp or understanding of the MHPoC in clinical practice. However, as the analysis of data indicates, there is variance in clinical understanding of the phases which is similar in outcome to the IRR. Where the IRR indicated poor reliability, the data gathered during this Project indicates that clinicians have different perceptions about both what the phases mean and how to apply them in practice. Clinicians, when describing what they understand phases to mean, provide descriptions which both overlap with other phase descriptions and the purpose of those phases by way of the primary goal of care.

5.1 Design of Mental Health Phase of Care

The phases themselves were meant to represent a population of consumers who were stratified by a particular care status. The current phases do not contain sufficiently comparable attributes or elements and therefore may encourage uneven or inconsistent stratification of consumers. Each population of consumers, represented by a phase, should have some relationship to the other populations represented by a phase alongside an appropriate way in which the populations are filtered consistently into the phases. This filtering process should be suggestive of care being provided (hence phase of care) according to general population needs.

The original cost drivers and recommendation for mental health classification development study (University of Queensland, 2013) and subsequent costing study (Mental Health Costing Study, 2016) provided example of how the MHPoC may help to derive cost across these sub episodic periods by understanding the complexity and resource intensity of providing care and, via HoNOS and LSP-16, the consumers complexity.

Exploring the design of the MHPoC in its current configuration allowed the Project team to identify if the purpose is intuitive to understand and clearly and consistently communicated to clinicians given the outcome of the IRR study and thematic analysis of data provided by interviews and focus groups.

The Project worked on the development of different ways of presenting the MHPoC and within focus groups and interviews these were generally positively endorsed. However, the systematic use and evaluation of these materials has not been a part of this Project and their impact on reliability not tested. These may be useful training aids but for routine clinical practice the simplification of the presentation of the MHPoC concept and its underlying constructs are paramount. Clinicians repeatedly told the Project team that the MHPoC should be simple and easy to use.

As with previous work, the notion of a MHPoC had strong credibility with clinicians. They recognised that phase of care existed and that at different times over the consumers' journey there is variation in the type and amount of work necessary to meet the consumer's needs.

While there is clearly a lot of work and effort occurring to support the consistent application of the MHPoC in practice, many of the people who were interviewed described being confident that with continued effort the consistent application of the MHPoC can be achieved. Although this confidence is tempered by concerns that the necessary training and inclusion of the MHPoC into routine business practice will not occur, the current Project has identified that in practice a complex set of inter-related factors impact on the consistent application of the MHPoC in practice. As has been noted, study participants were after more detailed explanation of the components of the different categories and guidelines for category allocation. While this may increase IRR the ability for this to be routinely used in clinical practice would be a significant challenge.

5.1.1 Phase of care structure

In representing care complexity, the phase acts as a population grouper of consumers who all share similar care and resource needs. Similarly, the primary goal of care represents the main anticipated outcome or outcomes expected when providing the care represented by the phase. If the phase represents the type of care being provided and the outcome reflects success in delivering that care then the description of care being provided in each phase (frequency of contact, indicative phase length, interventions) are the activities that achieve the outcome of the phase. This logical and intuitive hierarchy was derived from analysis of the original Cost Drivers and a Recommended Framework for Mental Health Classification Development (University of Queensland, 2013), which offered a proposed guide to the development of the classification through observation of the way in which the phases are described and structured presently.

Figure 21 represents the typical hierarchy of the MHPoC in describing the phase at the highest level (phase label acute for example) before moving down to the primary goals of care meant to be achieved by the phase. Lastly, the final layer is the more detailed layer of information which described in various ways a description of service activity, intensity, environment, phase length, intervention types.

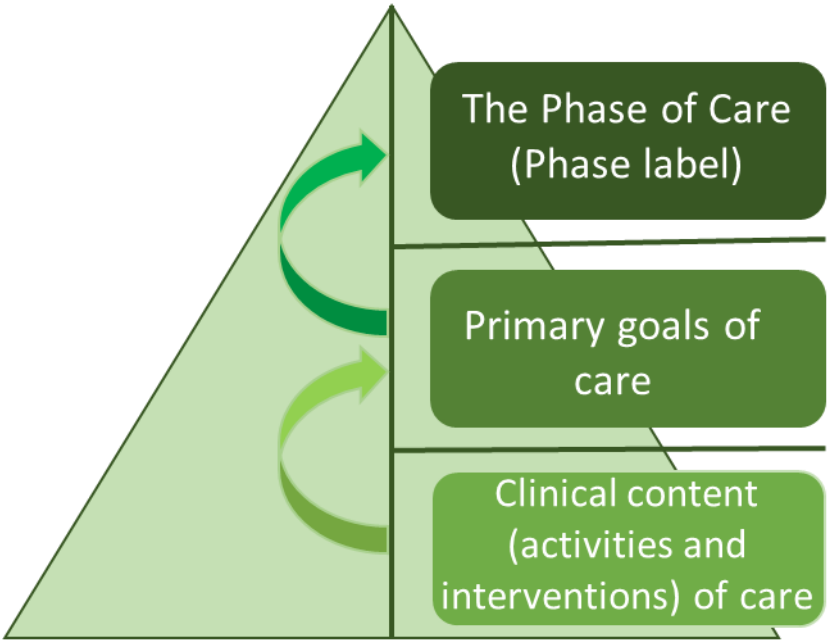

Figure 21: MHPoC hierarchy determined from review

Though not explicitly stated, this structure appears to be a fair representation of the original intention of the phases of care. At the present time, for some of the phases, if this hierarchy is applied there is an overlap in these layers for example where some phases represent the primary goal or goals of care in the first instance e.g. functional gain, which some clinicians identified as the key outcome or objective of the phase. In this example functional gain occupied both the top tier of the hierarchy and describes the primary outcome or experience of the consumer gaining function. However, there appears to also be a more nuanced problem with the way clinicians understand phases.

5.1.2 Representation of the phases

Clinicians when interviewed as part of the Project expressed various degrees of understanding with respect to what each of the phases represented. Many clinicians stated that they understood the concept of each phase of care but when comparing the responses provided to what they considered the phases represented, offered competing or alternative views to those of their local and cross jurisdictional colleagues.

While the MHPoC is meant to be setting and service agnostic this is a challenge given that clinicians are so influenced by the structure of services and the clinicians already established roles within teams. This makes it a challenge for clinicians to separate out their role or the role of the team within which they work from the primary goal of care for individual consumers as described by the MHPoC.

Clinicians were keen to reinforce their understanding of the phase of care and appetite for its use in clinical practice but, in a manner like the IRR study, provided enough variation in understanding of what each phase represents as to pose further questions as to why the MHPoC facilitates such variance in the first place.

The following are an example of the combination of interpretations made by clinicians as part of the interview and focus group process:

Acute: can relate to the consumer presentation (acuity of illness), the care environment (acute inpatient unit). Acute is unlikely, however, to relate to the outcome of the consumer but may infer a complex consumer.

Functional gain: can relate to the consumer outcome (to gain function) but is unlikely to relate to the environment or be care related. Functional gain appears to describe the result/outcome (gained) or an aspect of the recovery journey itself (gaining) and may therefore infer a consumer who is or has improved in function.

Consolidating gain: can relate to the consumer outcome (to consolidate gain) but does not make explicit the nature of gain. Consolidating may relate to a service activity (to consolidate a position of recovery). Consolidating gain may suggest a relationship with functional gain as the subsequent phase (to consolidate gains in function).

Intensive extended: can relate to the intensity of service or care delivery (intensive service or care) and length of time to deliver the service (extended service or care) but is unlikely to be an outcome of the consumer or an aspect of the consumers' presentation. Intensive extended may however indicate or infer a complex consumer.

Assessment only: can relate to an activity of assessment. This is unlikely to relate to consumer presentation but may relate to service activity in the use of assessment and provide defined limitations of the phase due to 'only'.

Typical comments gathered via the interview process illustrate some of the possible source of confusion in response:

"Functional gain is suggesting psychosocial, but even then, consolidating gain has got optimised functioning and promote recovery with community integration in it" **SW Adult Ambulatory 05**

"I think it's the word. See the word intensive stopped me from using it for the middle group (functional gain) but the word extended stopped me from using it for the first group (acute)… So, I just stuck with functional gain and then probably consolidating gain… I probably have only used the two" **RN Adult Ambulatory 05**

5.1.3 Overlapping boundaries

In isolation, how phases are understood and described by clinicians is less problematic until the relationship between one phase and another was drawn out in discussion at the interviews or focus groups. The perceived or understood relationships between the phases generated inconsistency in the application of the phases across the continuum of care. There must be a relationship between the phases for the classification to operate and separate populations. However, this relationship must be consistently understood and applied by clinicians across the phases without inviting in the opportunity for local or fixed interpretations based on assumptions. Varied interpretations were observed irrespective of the clinical specialty (child and adolescent mental health, adult and older persons mental health) and the jurisdictions previous exposure to or length of time taken to implement the MHPoC and familiarise it with its staffing base.

The IRR study highlighted a high degree of irregularity in the way clinicians apply the phase functional gain to a consumer when given a clinical scenario with the study which noted that this phase suffered the lower IRR of all the phases. Clinicians who were interviewed as part of this Project appeared to consistently describe two major understandings amongst other less significant aspects of their understanding of the phases. When talking about the phases more broadly clinicians described:

- A part of the consumers' stage of illness and how this related to the phase.
- The type of care being provided and how this related to the phase.

Clinicians also talked about these two points interchangeably with different emphasis provided for each depending on the phase being discussed or the clinicians understanding of the importance of either in discussion. What became apparent when looking at the themes is that clinicians provided overlap in understanding related to the consumer, the care and the phase. For example, when clinicians talked about consolidating gain they often used two types of language:

- The first in talking about and describing a low-grade service type required of the consumer in order to maintain their current clinical presentation and or to prevent relapse.
- The second in talking about the consumers' typical presentation which requires either of the above aspects of care to be provided.

This highlights a challenge for the IRR in relation to consolidating gain as the needs of a consumer who is clinically stable as a result of low-level clinical input are different from those of consumers who require much more assertive clinical activity in order to prevent a relapse from the consumer's perspective. The current definition of consolidating gain shows a number of elements at play:

> **Consolidating gain:** The primary goal is to maintain the level of functioning, or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the consumer has stabilised and functions relatively independently. Consolidating gain may also be known as maintenance.

In the current definition, consolidating gain expects to represent:

- The maintaining of function or consolidation of gains.
- Improvement of functioning during recovery.
- Minimise deterioration or prevention of relapse where the consumer is stable and functions independently.

The data indicates that from the clinician's perspective knowing where to draw the line between these distinctions of what creates a boundary for this phase is difficult. Each phase, in order to be successful in describing a population intuitive to the clinician must do so by describing what makes one phase different from another.

Figure 10 within Section 4 of this report for consolidating gain/functional gain indicates that much of the same language and thinking is used by clinicians to allocate these two phases to consumers.

Looking at the definition of functional gain:

> **Functional gain:** The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a consumer with impairment arising from a psychiatric disorder.

In the definition there is also emphasis on improvement of function and in comparison, with intensive extended; there is also emphasis on prevention of deterioration albeit with an emphasis on consumers who have stable patterns of severe symptoms.

> **Intensive extended:** The primary goal is prevention or minimisation of further deterioration, and reduction of risk of harm in a consumer who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period.

The challenge from the clinician's perspective is in trying to understand each of the phases and how they create discreet boundaries amongst themselves according to care, the consumer and the phase itself. This was found to be proving difficult for clinicians when much of the same language is repeated across phases, the phases themselves do not represent the same one thing (care, consumer, outcome) and the phases also provide criteria that are not referenced across each phase.

Some phases reference consumer stability, some do not. Some phases reference care length, some do not. Some phases place emphasis on the same aspect of care or the consumer but provide little to distinguish these overlaps consistently. Clinicians appear to hold different views about what the phases represent when considering the consumer and the definitions currently do little to make the phases more consistently understood.

Both the representation of phases and naming conventions do not currently provide adequate definition parameters. For example, terms such as consolidating gain and functional gain can be considered outcomes of several phases and do not sufficiently define the continuum of care a consumer may need as they recover, because these terms are all considered expected outcomes of many phases. Many clinicians considered that consistently defined naming conventions and definitions will be more intuitive, improve IRR and enable other measures in the AMHCC to distinguish consumer's complexity. Figure 22 provides an indicative visualisation for the kind of overlap both allowed by the definitions provided by IHPA and some of which are also observable when looking at the data generated in this Project.

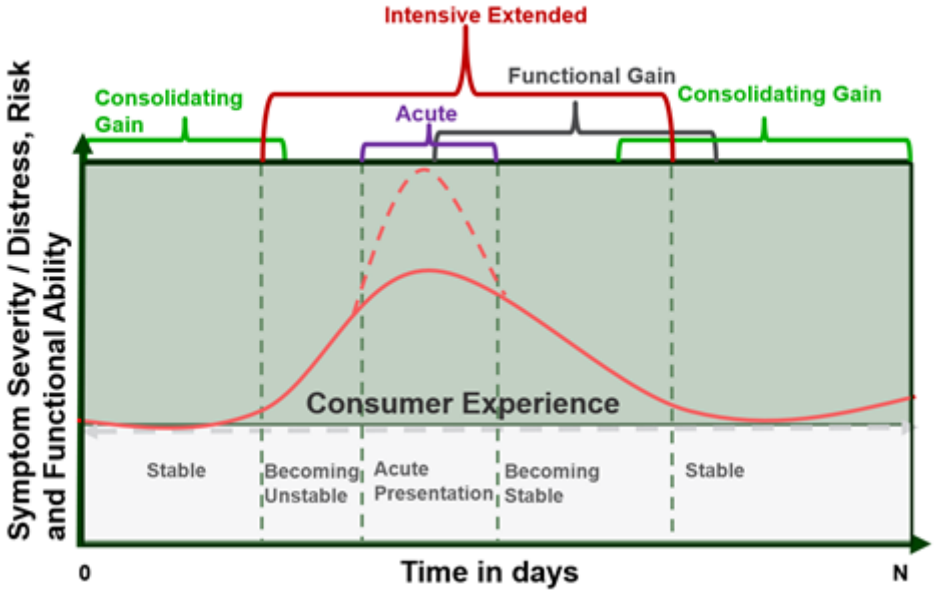

Figure 22: Clinical stability and phase overlap

The phases may simply be attempting to describe too many aspects of the consumer, the care, the environment or the outcome, inconsistently across the phases and with little consistent relationship between the phases to provide enough separation. There is no doubt that a clinical relationship does exists between the phases, the consumer presentation, the care provided and the interplay of these variables as they change over time. It would be reasonable to assume that these same variables also infer some cost/complexity model as a result. A similar observation was made during the original MH-CASC study where the Project authors noted that ‘clinicians argued that some concept like MHFoC was integral to the definition of mental health episodes’.

5.2 Refining each Mental Health Phase of Care

For the MHPoC to have increased reliability and internal validity it must better convey the purpose of each phase by describing the variables mentioned consistently across the phases and which relates to the consumer journey over time. The phases must accommodate both this internal relationship and be consistent across each phase alongside the non-linearity of the journey some consumers may take through the mental health system. This should be accommodated in a way in which the consumer is already captured in their clinical complexity by other aspects of the AMHCC namely HoNOS. The purpose of refinement with respect to each phase includes the reorientation of the phases towards consistent representation of care followed by primary goals related to this care and further descriptions which collectively identify how the goals will be achieved.

Objectives of refinement of the MHPoC should be undertaken on the basis that the MHPoC should serve a purpose in separating the population of consumers into characteristically similar populations, based on care, for sub-episodic periods of time or phases. Care was chosen as the primary emphasis of refinement given that currently the consumer complexity is represented elsewhere in the AMHCC through the utilisation of HoNOS and LSP-16.

Both these aspects of the AMHCC are understood to measure the complexity of the consumer as part of the requirement to quantify resource intensity required for funding purpose. The further development of the MHPoC in a consumer focused direction would have provided little scope for the reminder of the AMHCC to describe the intensity or nature of care being provided or required by the consumer as a result of their complexity.

Acute

Although acute as a phase benefits from the natural relationship between the consumer presentation and the step up or down in service, this relationship can become confusing for clinicians when they attempt to move the consumer from acute or to acute from another phase. The boundary for deciding when a consumer is acute related to presentation may be different to a consumer who is in acute related environment. This is evident where a transition to an alternative phase, from acute, because of recovery, is concerned. Refinement should focus on resolving this problem considering the proposed service and setting agnostic requirements of the phases.

Acute appeared the least problematic of all the phases except for assessment only. However, clinicians appeared to define acute according to the presentation or the environment but did not necessarily hold this view consistently throughout the consumer journey. Equally, acute was most constrained by local business rules that some clinicians suggested prohibited consumers from being classified as anything other than acute when admitted. Acute would benefit best from refinement that defines the phase in terms of the level of care that is required including the resource intensity of providing that care. Clinical presentation is likely to remain useful in describing the criteria for the phase, however, clinical presentation should be the driver for the care being provided rather than the other way around. Consistency in this approach would mean that acute, irrespective of environment equates to the level and intensity of resources used to meet the presentation demands consistently throughout the consumer journey.

Functional gain

Clinicians appear to attach or associate different clinical purpose behind functional gain. The wide variety of interpretation clinicians made is sometimes warranted by the design of the MHPoC. The ability to remain service and setting agnostic coupled with the phase label having much more emphasis on an outcome has led to some clinicians, where local business rules permit, utilising functional gain within an inpatient environment where the majority of functional gain is returned. This in itself is not a bad thing but it is inconsistently understood and applied in practice. Some clinicians have taken the view that functional gain should replace acute given the proportion of function returned to a consumer occurs largely from the point of admission onwards. Other clinicians view this phase as post discharge recovery, other clinicians meet somewhere in the middle of these two views. Clinicians also viewed functional gain as very much a phase for the ambulatory setting where the consumer was expected to undertake traditional community focussed recovery over a longer period of time. Clinical refinement of functional gain should clarify the scope of this phase. If functional gain is to remain predominantly recovery or preventative in nature, then this should be a core focus of the primary goal.

Functional gain is likely to benefit the most, post refinement, when its phase is much more explicitly related to care that is predominantly recovery focussed care. Changes to functional gain will likely impact on subsequent refinement of consolidating gain.

Consolidating gain

Alongside a reorientation of this phase to be much more explicitly describing care, consolidating gain requires much more focus on either being a phase that prevents a deterioration in clinical presentation or a phase that manages a stability in clinical presentation. Some clinical services also indicated that the population of consumers who were stable may also be characterised as two different types of consumer. These populations may be described as stable but requiring ongoing support and stable but requiring no ongoing support and entering a discharge planning phase. Consolidating gain, much like functional gain, requires refinement to ensure that it suitably describes a population of consumers with a reduced scope in order to prevent overlap, especially with functional gain and intensive extended. IHPA may wish, over time, to consider the feasibility of defining a population of consumers who are actively having care transitioned out of health services. There is some consistency in comments from clinicians who participated in this study to suggest that the clinical workload and type varies between this and the consumer requiring ongoing support.

Intensive extended

Intensive extended is the phase that, by definition, is most descriptive of a service intensity and length which clinicians appear to equate to complex consumers who are deteriorating / relapsing and who need additional support as a result. Refinement of this phase should focus predominantly on ensuring it becomes more orientated towards emphasising its relapse preventative nature and ability to handle a degree of pre acute complexity without an indication of phase length as currently exists with the use of extended. The length of phase being indicated as extended automatically excludes its potentially appropriate use by clinicians in an unintended manner. A phase that provides focus on complex care that has not reached acute levels of resource usage, and without the restriction on extended care (though this may still occur) may provide a more consistent relationship with consumers who have that deterioration in presentation, who need extra support, and who may not be acute but who may risk becoming acute without the support.

Assessment only

Although assessment only is a time limited activity rather than describing a phase of care itself, it appears to be consistently understood by clinicians likely as a result of the very specific rule set that governs the use as a phase. The Clinical Refinement Project therefore provided less focus on the refinement of this phase. It is worth highlighting that whilst assessment only is designed to indicate a consumer exiting from jurisdictional health services where no service, following assessment, is being provided, some health services have developed robust intake mental health services that make differentiating between triage and assessment a more complex activity to separate.

Whilst technically not a problem of the phase itself it poses a challenge to jurisdictions that may wish to develop sufficient business system rules to ensure consumers who receive a volume of activity comparable to assessment are allocated to the assessment only phase where not entered into treatment within a jurisdiction service. A recommendation of this Project includes the redefining of this phase to a data item rather than a phase itself in order to allow for greater flexibility in capturing triage and assessment activity under the proposed data item without encumbering this activity with business rules commonly associated with the MHPoC.

5.3 Clinician reporting practices

The AMHCC requires that data are captured in respect to the MHPoC activity unit when the presentation of the consumer changes enough to reflect changing care needs. For a phase to be reported, the clinician is required to undertake a HoNOS (in all settings) and LSP-16 (in ambulatory setting). From a technical perspective the AMHCC requires that the clinician aligns the MHPoC and outcome measurements with care planning in a fluid or ad-hoc way in order to meet the changing and flexible needs of the consumer. In practice however the overwhelming response from clinicians working within jurisdictional health services indicated that both the capture of the MHPoC and the HoNOS/LSP-16 were diarised via the clinical information system to prompt for 90-day review as per NOCC minimum standards.

NOCC protocols allow for ad-hoc or non-diarised collections of MHPoC, HoNOS and LSP-16 however, as explored in Section 4.5 of the report, many clinicians follow diarised protocols aligned with NOCC rather than ad-hoc process. These processes should ideally align where possible to the collection of HoNOS and LSP-16 NOCC protocols as both outcome measures are designed to quantify the complexity of the consumer at the point in which the care needs change.

This was reported by clinicians as posing a challenge for jurisdictions and clinicians working in mental health services. The NOCC protocols for the management of HoNOS and LSP-16 have a long history within jurisdictional health services and those protocols are embedded well within the business and performance reporting rules of jurisdictions and the clinical information systems implemented within those jurisdictions. For the AMHCC and MHPoC to work efficiently at measuring the complexity of care (via phase) and complexity of consumer (via HoNOS/LSP-16) there must be a timing relationship between the capture of both the MHPoC and HoNOS/LSP-16 in order to ensure that one status (phase of care) reflects the other (presentation or consumer complexity). As a consumer changes due to a movement in clinical presentation, the treating clinician, as would be expected with robust care planning, should modify the phase where appropriate and reflect the changes in HoNOS and LSP-16 scores.

Figure 23 illustrates the way in which business systems rules, closely aligned to NOCC collection protocols, may explain a different consumer journey under diarised conditions.

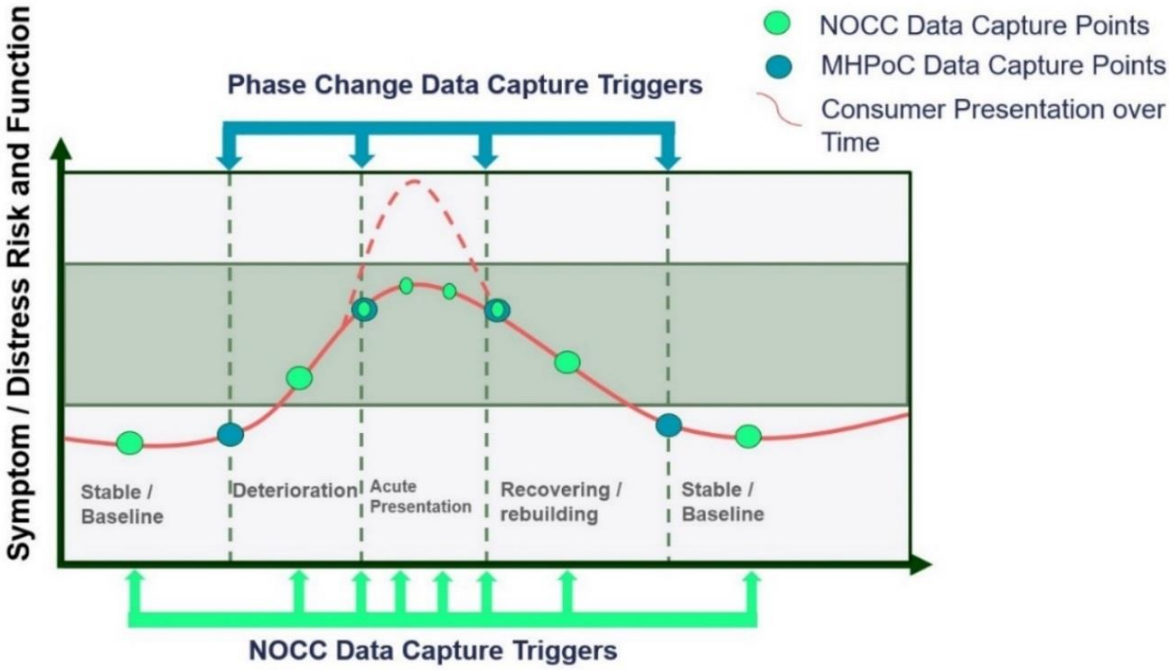

Figure 23: NOCC Diarised data capture vs clinical presentation driven changes to phase

AMHCC is predicated on a tight relationship between the phase, the consumer and the presentation of the consumer and the alignment of data captured simultaneously to take a 'snapshot' of the consumer for classification and ABF purposes. The diarising of this data collection may help to populate data for compliance purpose, but it may also fundamentally alter the story of the consumer moving through the health system and the measurement of their clinical and care complexity. Though this technical challenge is beyond the scope of this Project in terms of refinement, it is worth consideration by IHPA who may wish to consult with the Australian Mental Health Outcomes and Classification Network as it has the potential to alter the profile of consumers' complexity within each phase. The implication of this in practice is likely to be more fully understood through the careful analysis of health datasets provided by jurisdictions.

5.4 Variance in training and impacts on Inter- Rater Reliability

From the commencement of the Clinical Refinement Project, training and education was identified as an important theme in consultations with state and territory jurisdictions, interviews with clinicians, focus groups and survey questionnaires. Over the past three years there has been increased activity by the Australian states and territories in the MHPoC uptake, rollout and training of staff. There was no intention to train mental health clinical staff in this Project but rather to assess what staff were doing and the issues that they had with utilising the MHPoC.

The CAs found considerable training variation across mental health services when integrating the MHPoC into practice along with varying knowledge and skills held by staff.

MHPoC training was a significant issue raised throughout the Project in discussions with state and territory representatives, interviews, focus groups and questionnaires. From the four approaches utilised to collect information for review and refinement of the MHPoC, training was a common theme. The following training barriers were identified from discussions.

- The variation across the states related to the training, collection of MHPoC and linkage to NOCC, e.g. HoNOS.
- The cost of providing training support and the ongoing logistics e.g. staff and training material.
- The inability/variability of information systems to capture the MHPoC and the cost to upgrade.
- Clarity of the five MHPoC category definitions to improve clinical consistency and use as mental health cost driver.
- Whether the MHPoC needed to have specific language for child and adolescents, older persons and indigenous populations.

To achieve the successful adoption of the MHPoC and to ensure a consistent message there would need to be a uniform training approach along with common collection practices and reporting of the MHPoC. There would also be an ongoing requirement for staff education and development to information systems.

Evaluation of training materials and programs alongside analysis of the questionnaires provided to clinicians as part of Project engagement highlighted several issues. Clinicians who had participated in face-to-face training generally indicated that they had a better understanding of the MHPoC. Those that participated in train the trainer sessions indicated that they could train others in the MHPoC but for some participants this ability was not strongly endorsed. Clinicians who had participated in train the trainer approaches indicated that they would need more time to familiarise themselves with training manuals and training materials.

Clinicians reported that not all trainers had formal educational qualifications and some concerns were raised during consultation that this may have a detrimental impact of the consistency of training delivery. Some jurisdictions specifically used nurse educators to support training in the MHPoC as this group had formal training qualifications and the need for ongoing follow-up of ‘trained trainers’ was identified as necessary to ensure training was up to date. Some jurisdictions had identified local data or outcome champions who were able to provide team-based support and ad-hoc or non-formal training on the MHPoC and other outcome or data related items like the HoNOS and LSP-16. In addition, several jurisdictions have developed or are developing e-learning approaches for training the MHPoC.

Feedback from clinicians who had undertaken training indicated that after training, revision of definitions was required as, *"there is still a lot of disagreement"* (about phase allocation). "*The assessment only phase vs acute*" and "*functional gain" vs "intensive extended*" were identified as especially problematic. During one consultation a trainer commented that, *"… it ends up being a matter of opinion."* Other comments suggested that the language of the definitions lack appropriate definition stating, "*The training sessions lead people down a pathway but the phases themselves are not self-explanatory*" and "*The language is not plain English… not self-explanatory*". Other comments suggested that the language utilised and the language missing from the definitions was problematic and that the MHPoC had insufficient defining statements. This mainly centred on the need to include a 'recovery' focus in some areas of the phase or goal of care.

Such concerns supported an emerging theme that training would be better supported by clearer naming conventions and definitions for the phases of care. The IRR study reported the need for more training to resolve the poor IRR. Although the training was reported mostly of a high level, clinicians may soon forget the training unless clear parameters and intuitive terms are used on the MHPoC. There were many positive comments about the MHPoC and that it was representative of what clinicians see as a mix of cases.

However, feedback from some clinicians who had undertaken training indicated that after training, revision of definitions was required as *"there is still a lot of disagreement"* about phase allocation. Some clinicians expressed a desire for training to incorporate real case examples rather than or alongside clinical vignettes in order to standardise the thinking of the local clinical team receiving the training. Preference was expressed for further development of vignettes which may provide greater discrimination between the phases and which are increasingly tailored to differing service settings, age groups with greater distinction between phases. Refinement of the phases in a way that ensures greater exclusivity in the boundary between phases and more intuitive language to describe each phase, to help with increasing the efficacy of training.

5.5 Strengths and limitations of the Project

The qualitative approach taken for the Project was advantageous, as it offered a more suitable method to understanding language and semantic consistency whilst being able to explore deeper insights into behaviour, interpretations, perceptions and specific understandings that clinicians have about what the phase of care might mean. Given the relatively small sample size of services nominated for the Project, interview and focus groups were considered to offer the most adaptive and flexible approach to reviewing the MHPoC and to maximise the potential contribution offered through participant engagement

Access to participants was provided by jurisdictions via a site nomination process. Within these nominated sites participants in focus groups or interviews either self-selected or were instructed to participate by their service managers. This could have biased some of the responses from some participants, yet the results of the survey results showed that participants range in their service experience, were equal in terms of representing inpatient and community care, and half worked with adult consumers with proportionate representation across child and adolescent and older persons mental health services.

Similar variation was noted in the number of associations recorded for clinicians working in very specific service environments i.e. an assessment only service. Whilst nursing clinicians were highly represented (54.9%), the Project involved representation from many professions including nursing, psychology, psychiatry, social worker and occupational therapists.

There was variation in the knowledge of participants in the interviews and focus groups. Some participants had provided training to other clinicians. Other participants were aware of the MHPoC and recalled participating in training but stated that they could not remember the training content. Other participants identified that they had no training in the MHPoC. This variation in understanding of the MHPoC could have influenced the type of information provided by participants.

Similar to variation in training across sites, there was variation in implementation. Some sites had implemented the MHPoC, other sites were in the process or had yet to begin the process of implementation. This resulted in some confusion for participants as they tried to discriminate between the MHPoC and the MHFoC. This inability to discriminate between the two instruments could have led to some of the confusion being expressed in interviews.

Undertaking semi-structured or in-depth interviews requires skilled reflective questioning, and the ability to summarise and control the interviews (Crookes & Davies, 2004). CAs agreed that these skills varied among advisors and this may have contributed to the variability in the quality of interviews. Representation across specialisms including Child and Adolescent Mental Health Service, adult and older adult was mixed with some limitation noted in the inability of the CAs to directly influence the participation of underrepresented clinical specialisms across focus groups and interviews. Results may have varied with more even distribution of participation though this is hard to judge.

A risk identified early in the Project in using the Delphi technique to refine the MHPoC was that the process may restrict the ability of clinicians to provide alternative interpretations or different input into the review and refinement process. As a result, the use of the Delphi process was not pursued for continued review and refinement of the MHPoC as part of this Project.

When discussing suitable refinement methods and options with clinicians, the Project team experienced some difficulties in establishing consistent views from clinicians about the overall purpose of the MHPoC within the broader AMHCC. Clinicians varied in their understanding of the relationship between MHPoC and AMHCC for wider classification purpose.

The exploratory purpose of interviews and focus groups sought to understand in greater detail the cause of poor IRR. Most clinicians working in jurisdictional health services had received training in the utilisation of the phase, yet when looking at local training guidance provided by jurisdictions the relationship between the MHPoC and the AMHCC as it functions for classification for ABF purpose was not prominent. This is entirely reasonable and was an expected observation of the Project. Clinicians are required to understand how to use the MHPoC in clinical practice and not necessarily to understand the interrelationship between information required to allocate the phase of care and other measures collected in the AMHCC as well as ABF funding mechanisms.

This meant that clinicians were much more focused on refinement based on clinical, service or language-based preference rather than refinement from the perspective of the broader function of the MHPoC for classification purposes.

Many clinicians were offered alternative naming of phases or altogether different phase names during discussions. For example, on testing definitions like rehabilitation or relapse prevention as either a replacement for a similar phase or as an entirely new phase, the Project team received mixed feedback about the suitability of the phase name based on the clinicians reasoning that the term may or may not work depending on prior understanding of the phases or notion of what rehabilitation or relapse prevention mean or entail clinically. Clinicians who participated in the Project were unable to identify if, for the purpose of internal consistency, the alternative phase names explored during interview and focus groups, would offer greater internal consistency and greater ability stratify populations.

A validation process was not undertaken as part of the study. Recommendations made as part of this report outline possible routes to validation that can be undertaken by IHPA once consultation of the outcome of the Project is complete.

6. Clinical refinement of the Mental Health Phase of Care

Clinicians aimed to make the MHPoC succeed and many find phase utility in clinical practice useful for case management purposes at a team level. Many clinicians felt it easier to think of the phase in relation to the consumer (presentation and or complexity) or the care (being provided and or environment) depending on the individual phase. Similar observations were made during the IRR study and have been reported as part of the thematic analysis undertaken within this Project.

During the interview and focus group process, clinicians requested that the MHPoC be more intuitive and timelier to collect. Clinicians did not want to be overburdened as they already have a high volume of administrative activity to attend to as part of the routine management of the care of consumers on their caseload or within an inpatient environment.

Through testing of various alternatives to phase names across jurisdictions, the Project team was unable to entirely derive, from clinical consultation and thematic analyses, an alternative to refinement that addressed issues relating to the purpose, naming, boundaries and definitions. Instead, the CAs ensured that the findings included in the new phase definitions were clinically consistent and fit for purpose within AMHCC. Refinement provided an opportunity to use the clinical evidence gathered as part of this Project to address the boundary overlap between phases including inconsistency in the design and language used to describe the existing phases. A series of principles outlined in Section 6.1 of this Report were utilised in the process of refinement to ensure consistency in approach with findings and information gathered during the Project.

The outcome of this approach to refinement provided a series of new phase names designed to replace the existing phase names and which were thought to provide greater internal consistency in relating the phase more explicitly to care. Primary goals of care were refined in line with the new definitions in order to ensure they related to both the new phases and held similar consistency in definition. A degree of clinical content was further described in each phase which relates to the broad clinical activity and intervention representative of the phase.

6.1 Principles for refining Mental Health Phase of Care

A set of principles were defined by the CAs to refine the MHPoC. The purpose was to ensure that the phases of care enable repeatable and consistent application by clinicians when presented with the same consumer presentation, and for collecting ancillary data from the health information systems including cost data. These principles were considered as part of MHPoC refinement during a three-day workshop undertaken by IHPA and which was attended by the six CAs engaged in this Project.

The following principles were used to refine the MHPoC:

- That each phase consistently describes a type of care to be provided to the consumer prospectively.
- The change to an existing phase or creation of a new phase may impact on the number or relationship between all phases. The impact is a consideration during refinement.
- That the primary goal of care be meaningfully related to the care that the clinician intends to provide.
- That service and setting agnostic approaches are taken to describe the phases. This ensures compatibility across the diverse range of services available within Australia.
- That as part of the refinement process, the CAs and IHPA explore the implications for what constitutes a reasonable volume of clinical content (third tier of the hierarchy, Figure 21, Section 5.1.1) as part of any future descriptions of the MHPoC.

6.2 Refined phases and considerations

Tables 5 and 6 outline the refined phases of care, including the phase name, the primary goal of care and the definitions. Each phase is discussed in the subsequent sections outlining key points of differences with the current phases in the AMHCC Version 1.0.

These options were both provided as a result of consultation feedback from the MHWG. This consultation process indicated that there may be merit in Option 1 and its simplified phase structure. There is also acknowledgement that Option 2 has some advantage in broadening the classification to incorporate an additional phase and thereby increase the differentiation that exists between the 2 options.

- Option 1 of the recommendations includes Acute, Subacute, Non-acute MHPoC and Assessment only as a data item.
- Option 2 includes Acute, Subacute, Non-acute, Rehabilitation and Recovery MHPoC and Assessment only as a data item.

These options and their key point of difference are explored fully in the following sections of the report and detailed in Tables 5 and 6 below.

Table 5: Refined MHPoC Option 1

Phase name	Primary goals of care	Phase of care activities
Acute Mental Health Phase of Care	The primary goals of care are intended to reduce high levels of distress, manage complex symptoms, closely monitor and reduce immediate risk.	Provided predominantly in a hospital setting but may also be provided in an assertive community setting. Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.
Subacute Mental Health Phase of care	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to mitigate or prevent relapse into acute mental health ('stepping up in care'). ***or*** The primary goals of care are to restabilise recovery promote a return to previously observed function. To increase independence and social/vocational integration via a program of skills acquisition ('stepping down in care').	Provided in either hospital or community settings. The primary focus is on providing assertive activities and interventions which prevent relapse of an acute phase. Activities include monitoring early warning signs, supports from family and others, medication treatment and safety concerns. ***or*** Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.
Non-acute Mental Health Phase of Care	The primary goals of care include supporting ongoing independence, quality of life and functional stability, that consolidates recovery and assists community integration.	Provided predominantly in a community setting. Low levels of routine activity are required to support and maintain symptoms and impairment that has been stabilised. Engage NGOs and shared care agencies to achieve safe and effective discharge.
Assessment Only Data Item	The goal is to obtain information, including collateral information where possible, in order to determine the consumer complexity and need for intervention.	Includes brief history, risk assessment, clinical screening and information gathering.

Table 6: Refined MHPoC Option 2

Phase name	Primary goals of care	Phase of care activities
Acute Mental Health Phase of Care	The primary goals of care are intended to reduce high levels of distress, manage complex symptoms, closely monitor and reduce immediate risk.	Provided predominantly in a hospital setting but may also be provided in an assertive community setting. Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.
Subacute Mental Health Phase of care	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to mitigate or prevent relapse into acute mental health ('stepping up in care').	Provided in either hospital or community settings. The primary focus is on providing assertive activities and interventions which prevent relapse of an acute phase. Activities include monitoring early warning signs, supports from family and others, medication treatment and safety concerns.
Rehabilitation and Recovery Mental Health Phase of Care	The primary goals of care are to restabilise recovery promote a return to previously observed function. To increase independence and social/vocational integration via a program of skills acquisition ('stepping down in care').	Provided in either hospital or community settings. Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.
Non-acute Mental Health Phase of Care	The primary goals of care include supporting ongoing independence, quality of life and functional stability, that consolidates recovery and assists community integration.	Provided predominantly in a community setting. Low levels of routine activity are required to support and maintain symptoms and impairment that has been stabilised. Engage NGOs and shared care agencies to achieve safe and effective discharge.
Assessment Only Data Item	The goal is to obtain information, including collateral information where possible, in order to determine the consumer complexity and need for intervention.	Includes brief history, risk assessment, clinical screening and information gathering.

6.3 Acute Mental Health Phase of Care definition (Options 1 and 2)

Provided predominantly in a hospital setting but may also be provided in an assertive community setting.

Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.

This phase places emphasis on care that is prompt, high intensity and short term. The primary goals of care are intended to reduce high levels of distress, manage complex symptoms, closely monitor and reduce immediate risk.

Interventions include frequent monitoring and review to address demanding issues as they arise. This MHPoC typically requires frequent contact within ambulatory settings.

Greater emphasis is placed on acute being representative of the care domain in the first instance rather than a measure of the consumer presentation which is now indicated secondary within the primary goal of care. Acute remains service and setting agnostic in principle but with the introduction of subacute, the population distribution of consumers within this phase who reside in the community may change over time.

Most interviewees and focus group participants suggested a strong relationship between acute and the inpatient facility/environment. Previous justification for the utilisation of functional gain towards the latter end of a phase (due to consumer improvement) within an inpatient environment may prove easier to resolve as care within an inpatient environment is largely fixed in cost and nature. Therefore, acute MHPoC, irrespective of consumer presentation improvements, is likely to be adopted throughout the inpatient episode if the jurisdiction can justify the volume of care provided across the phase irrespective of the consumer presentation. However, jurisdictions who have implemented acute community treatment teams may utilise acute care where there is likewise justification that the care being provided is acute in nature. Some of this population of consumers may previously have been indicated as intensive extended.

6.4 Subacute Mental Health Phase of Care definition (Option 1)

This phase places emphasis on assertive care that is of intermediate intensity and short to medium term in both a step up and step down capacity between acute and non-acute care using the following definitions:

This phase is intended to mitigate or prevent relapse into acute mental health ('stepping up in care'). The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. The primary focus is on providing assertive activities and interventions which prevent relapse of an acute phase. Activities include monitoring early warning signs, supports from family and others, medication treatment and safety concerns.

or

This phase is also intended to increase independence and social/vocational integration via a program of skills acquisition ('stepping down in care') The primary goals of care are to restabilise recovery and promote a return to previously observed function. Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.

This type of care is provided in either hospital or community settings.

Interventions are provided with regular contact to prevent deterioration in symptom ('stepping up') and promote functional improvement and recovery ('stepping down').

Within the context of Option 1, subacute has a dual role in the management of consumers who are at risk of further deterioration into acute where no 'step-up' intervention is provided or in the 'step down' from acute where the level of care has reduced in scope outside of acute care provision.

Given that this option focuses the dual aspect of 'stepping up' and 'stepping down' care Subacute is likely to subsume consumers who would have previously been allocated predominantly to functional gain and intensive extended.

Subacute is likely to find predominant use in the ambulatory setting with a lower level of care intensity and resource usage than acute but with a longer potential for care provision over the short to medium term.

6.4.1 Subacute Mental Health Phase of Care definition (Option 2)

Unlike the Option 1 version of subacute, this phase is primarily intended to mitigate or prevent relapse into acute mental health ('stepping up in care') only. Within this context Subacute aims to resolve the difficulties observed in the very specific naming structure of intensive extended which was thought to exclude, from a clinician's perspective, those consumers who required resource intensive care over the short term rather than extended and who may be more easily seen in the community. Therefore, Subacute has a primary role in the management of consumers who are at risk of further deterioration into acute where no 'step-up' intervention is provided where the level of care has reduced in scope outside of acute care provision.

The primary focus is on providing assertive activities and interventions which prevent relapse to an acute phase. Activities include monitoring early warning signs, supports from family and others, medication treatment and safety concerns. Subacute is provided in either

hospital or community settings. The following definition and goals of subacute are articulated as follows for Option 2:

This phase is intended to mitigate or prevent relapse into acute mental health ('stepping up in care'). The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. The primary focus is on providing assertive activities and interventions which prevent relapse of an acute phase. Activities include monitoring early warning signs, supports from family and others, medication treatment and safety concerns.

6.5 Rehabilitation and recovery Mental Health Phase of Care definition (Option 2)

Rehabilitation and recovery, specifically designed for Option 2 of the MHPoC, places emphasis on care that is primarily rehabilitative and recovery focussed. It is important to emphasise that this does not mean that other phases have no recovery focus. Instead this phase intends to represent the primary focus of the clinical care being delivered is rehabilitative and recovery focussed in its nature and can be provided in either hospital or community settings.

This phase is intended to increase independence and social/vocational integration via a program of skills acquisition ('stepping down in care'). The primary goals of care are to restabilise recovery and promote a return to previously observed function. Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.

Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.

6.6 Non-acute Mental Health Phase of Care Definition (Options 1 and 2)

This phase places emphasis on providing ongoing care of low intensity over the medium to long term within an ambulatory setting. The primary goals of care include supporting ongoing independence and functional stability within a predominantly ambulatory setting.

Interventions are provided with routine contact to optimise function, further develop and promote independence and build social and emotional wellbeing whilst planning for discharge or transfer of care from service in the longer term.

Non-acute MHPoC care provides much greater emphasis on setting a threshold for providing care which is defined as neither acute nor subacute in nature. This phase provides much greater emphasis on describing low threshold care which utilises the primary goal of care to describe objectives similar in nature to those found in the consolidating gain phase. Emphasis within this refined phase is placed on the continued engagement of the consumer in their care plan and which may include planning for discharge or transfer of care to external providers. Consumers from consolidating gain are likely to transition to this phase with some consumers found currently within functional gain. This phase places more emphasis on transition out to primary mental health funded services or step down into shared care in the community and other non-government organisation funded health services.

6.7 Mental health assessment only data item definition (Options 1 and 2).

This data item places emphasis on the delivery of a comprehensive mental health assessment performed by a specialised mental health clinician, which results in documented management advice and occurs separately to other MHPoC.

This data item may be provided in either hospital or community settings and may take place over one or more sessions with at least one session involving the presence of the consumer. This phase may include brief interventions, care and family support. For this data item to be applicable the outcome would result in no further intervention or a referral on or into a new care episode.

6.8 Other phase considerations

The CAs originally described, as part of the refinement process, a different phase; rehabilitative and structured therapies. However, this phase was modified into rehabilitation and recovery to overcome the challenge of providing localised interpretation to “structured therapies”. This change was made in response to stakeholder feedback.

Similarly, a phase, previously proposed as maintenance, has had naming modified to read as Non-acute. Maintenance as a phase name received feedback from the MHWG which indicated the challenge of non-contemporary language and negative connotation associated with the term maintenance. The underlying definitions of maintenance have not been altered within this report; only the phase title maintenance has been replaced with non-acute.

6.9 Impact of refinement to current and refined phases

The refinement to the MHPoC has changed the way in which legacy data may be viewed. As the Project findings demonstrated, the mixing of patient outcomes, characteristic, type of care and setting in the current version meant that different allocation was occurring, and the homogeneity of people allocated to a phase has been most likely poor.

Table 7 below illustrates the likely redistribution of consumer populations between phases. This table reflects the nature of refining the phases from the original definition into new phases that are care orientated. The orientation of phases to more strongly associated types of care may mean that populations move from one phase to many phases in some instance. Some phases are likely to experience more movement between phases than others.

Table 7: Possible redistribution of consumer populations to refined phases (Option 1)

	MHPoC Population Migration from AMHCC Version 1.0		
Refined Phase (Option 1)	**Primary redistribution**	**Secondary redistribution**	**Other likely redistribution**
Acute	Acute	Intensive Extended	Functional Gain
Subacute	Intensive Extended	Functional Gain	Acute
Non-acute	Consolidating Gain	Functional Gain	
Assessment only (Data item)	**Assessment Only**		

Table 8: Possible redistribution of consumer populations to refined phases (Option 2)

	MHPoC Population Migration from AMHCC Version 1.0		
Refined Phase (Option 2)	**Primary redistribution**	**Secondary redistribution**	**Other likely redistribution**
Acute	Acute	Intensive Extended	Functional Gain
Subacute	Intensive Extended	Functional Gain	Acute
Non-acute	Consolidating Gain	Functional Gain	
Rehabilitation and Recovery	Functional Gain	Consolidating Gain	
Assessment only (Data item)	**Assessment Only**		

7. Conclusion

The scope of this Project was to review and refine the MHPoC. Review of the phases was undertaken objectively by clinicians across a number of specialisms and disciplines. As a result of the review process a number of findings and way forward for refinement were identified.

Allocating the MHPoC to an individual consumer appears to be challenging for several reasons. The complex relationship that exists between what the phases individually attempt to describe and how those definitions relate to the consumer and the care provided appears to be currently confused. There appears to be a degree of inconsistency with each phase describing different aspects of the care, consumer and or goals or outcomes. This inconsistency appears to be causing a number of difficulties with the boundary between each phase and likely facilitates the poor IRR observed in the original IRR study. This is corroborated by the mixed interpretations to the phases the CAs observed as part of this Project process. If there is inconsistency in what each phase of care attempts to describe in order to convey its relationship to care, then the process of clinical elimination and decision making used to identify the most appropriate phase runs the risk of becoming inconsistently applied by clinicians in practice.

The original intention of the phases in representing the type of care being provided is not consistently designed into the current phases. This is an important aspect of the wider AMHCC as the MHPoC should provide a point of differentiation in the classification to those elements such as HoNOS and LSP-16 which quantify the complexity of the consumer in terms of clinical presentation. There appears to be little value for the classification in quantifying the outcome of the consumer and the consumer presentation within the phases if these aspects are already captured within the classification.

Refinement within this Project has therefore focussed on the reorientation of the phase towards more consistently describing care and its intensity. Refinement has also maintained the original intention that the phase is prospective in nature and both service and setting agnostic in order to accommodate the variety of mental health services existing across Australia. Refinement has also sought to build a more consistent relationship between the phase naming convention, the goal of care and the way in which that goal of care is achieved through high level clinical activities and interventions. It is not the intention of this Project to describe, in full detail, a prescription of activities or interventions that should be undertaken to achieve each phase. High level clinical activities and interventions are meant to be an indication only and exist to provide a guide to clinical decision making in respect to the most appropriate phase allocation.

It is the expectation of this Project team that the refined MHPoC are easier for clinicians to understand due to semantic consistency and design based on consistent principles leading to a greater consistency in application of the phases across clinical services. The refined phases provide a greater distinction between the boundary of each phase whilst also providing greater identification and separation of the primary goals and clinical activities associated with each of the phases.

There are likely to be impacts identified by jurisdictions as part of the implementation of either option of the refined phases that may not have been detected by the scope of this Project. Further testing and an impact assessment has been recommended as part of the outcome of the Project. This should assist IHPA with ensuring that any concerns or feedback provided by jurisdictions is addressed as part of any further implementation plan for the refined phases.

This Project considers the development of business rules associated with implementation of the phases to be the responsibility of IHPA and the jurisdictions and was identified, along with consideration of implementation issues, to be beyond the scope of the original Project. Similarly, future development of training materials should be considered as part of future works that IHPA undertakes as part of the implementation of the refined phases. Nationally endorsed training approaches may provide a more consistent means of interpretation. This will also provide jurisdictions with the opportunity to standardise business rules with training guidance.

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Mental Health Phase of Care Guide (2016)

Appendices

Appendix 1: Jurisdiction site list and count of interview/focus group

Jurisdiction Site List	Interview Count	Focus Group Count
New South Wales	3	13
Western Australia	26	8
Queensland	13	
Tasmania	6	4
ACT	6	
South Australia	2	3
Northern Territory	8	
Victoria		1
Total Count	64	29

Appendix 2: Interview and focus group questions

Interview questions

- Thinking about the idea of phases of illness
    - Can you describe the different phases or stages seen in the consumers you work with?
    - Do the mental health phases of care reflect the phases you see in the consumers you work with? If not how are they different?
- Thinking about the different mental health phases of care instrument
    - What sources of information do you use to allocate the mental health phase of care?
    - Can you talk me through how you allocate a consumer to a mental health phase of care?
    - What information prompts you to change the mental health phase of care?
    - Thinking about each mental health phase of care, how could the goal of care be made clearer? What key words would you suggest?
    - Thinking about each of the mental health phases of care, how could the descriptors be made clearer? Are there any key words you would suggest?
    - Typically, what clinical activities would be undertaken to support a consumer in each mental health phase of care?
    - Can you think of better labels for the different mental health phases of care?
    - Thinking about implementation and practice
    - What training experience has helped you understand the application of the MHPoC? Can you describe or give examples?
    - Have you noticed any difference in the way your colleagues allocate the mental health phase of care, can you describe those differences?
    - How could you make the mental health phase of care more clinically meaningful?

Focus group questions

Activity 1

1. Can you describe the phases or stages seen in consumers you work with?
2. Do the Mental Health Phases of care reflect the phases or stages you see in consumers you work with? If not how are they different?

Activity 2

1. Essential Criteria to allocate a particular phase of care – Are there criteria that you would consider essential when allocating a particular phase of care?
2. Indicators for change in a Phase of Care
3. What activities/resources would you instigate for a particular phase of care?
4. How would you improve the clarity in the MHPoC instrument?

Activity 2 questions became;

1. What consumer characteristics would you expect to see in a consumer of each of the MHPoC?
2. What intervention would you expect to undertake for each of the mental health phases of care
3. What would be the primary goal of care for each of these Mental Health Phases of Care

Appendix 3: Participant survey

Mental Health Phase of Care – Clinical Refinement Project

Participant survey

IHPA

Participant survey

This survey will be used to capture opinions regarding Phase of care. There are no right or wrong answers and it is expected that individual perceptions will differ. Participation is voluntary and information collected will be non-identifiable.

Participant information

Discipline: ☐ Psychologist ☐ Social Worker ☐ Occupational Therapist ☒ Nurse ☐ Medical

Years of experience in MH: ☐ 1-10 ☒ 11-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 50+

Have you undertaken Phase of Care training? ☒ Yes ☐ No

Principle place of work: ☒ Inpatient ☐ Community ☐ Residential ☐ Other

If you responded 'Other', please provide more information:

Consumers you primarily work with:
☐ Children & adolescents
☒ Adults
☐ Older people
☐ Other

If you responded 'Other', please provide more information:

Survey

Please read each statement carefully and note your level of agreement by selecting **one** category. If you do not wish to respond to any statement, leave the category blank.

	Statement	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1.	Face to face workshops would be the best approach to training in the mental health phase of care.	○	◉	○	○	○
2.	It is essential that mental health phase of care training includes real life clinical examples.	○	○	○	◉	○
3.	I think the mental health phase of care training could be adequately delivered online as a self-directed package.	○	○	○	◉	○
4.	The mental health phase of care training is best done in isolation from training in other measures.	○	○	○	◉	○

	Statement	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
5.	The Acute mental health phase of care does describe some of the consumers I work with in clinical practice.	○	○	○	◉	○
6.	The Functional Gain mental health phase of care does describe some of the consumers I work with in clinical practice.	○	○	○	◉	○
7.	The Intensive Extended mental health phase of care does describe some of the consumers I work with in clinical practice.	○	○	○	◉	○
8.	The Consolidating Gain mental health phase of care does describe some of the consumers I work with in clinical practice.	○	○	◉	○	○
9.	The Assessment Only mental health phase of care does describe some of the consumers I work with in clinical practice.	○	○	○	◉	○
10.	The five phases of care generally describe the kinds of consumers I see as part of my practice.	○	○	○	◉	○
11.	I think more than five mental health phases of care would be necessary to describe the kinds of consumers I work with in clinical practice.	○	○	○	◉	○
12.	I think fewer than five mental health phases of care would better describe the groups of consumers that I work with in clinical practice.	○	○	◉	○	○
13.	The mental health phases of care reflect contemporary practice.	○	○	◉	○	○

Further comments