

Response ID ANON-DFPF-91TW-N

Submitted to Australian Mental Health Care Classification - Public Consultation No. 2
Submitted on 2015-12-18 15:11:25

Introduction

1 What is your name?

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SA Health

Australian Mental Health Care Classification - Consultation Questions

1 Are the variables included in the draft AMHCC version 1.0 relevant to clinicians, health service managers and other stakeholders?

Yes:

No

No:

No

Comments::

Phase is potentially meaningful but further work is required as identified/planned through the ABF MHWG before robust system-wide implementation can occur. Until then the data item will have limited clinical meaning and utility for classification purposes. CHSALHN identified concerns with the groupings of the phases which we believed added little clinical value to clinicians and added complexity and confusion due to the ambiguous nature of them.

Alignment of Phase with NOCC protocol is problematic in the Community and longer-term Residential settings especially, particularly in relation to identifying thresholds for change from one phase to another (such as defining reasonable length of time that a consumer should be observed to be displaying changed behaviours/symptoms before deciding/recording that Phase has changed), especially where level of acuity increases and then decreases again.

A primary reason for proceeding with caution in this area is that of (re-)training required, especially if/where change in practice is required away from that which has been developed and embedded over a significant period of time and with significant investment of resources via nationally agreed mental health information development strategies.

It is acknowledged that age is a driver however there are concerns with the age groupings being too generic and lacking real meaning especially at the younger end. Age Groupings of 0/15, 16-24, 25-64 & 65+ would align greater with how MH services are delivered within South Australia, and with the nationally defined Target Population data element.

2 Are there other variables that should be considered in later iterations of the AMHCC?

Yes:

No

No:

No

Comments::

Staff discipline FTE -- this is perhaps the most significant variable or driver of cost of mental health services delivery. Who delivers the service, and how many people deliver the service concurrently, drives cost.

Intervention codes may have utility provided the code set is defined and embedded in a way that allows cost variability to be identified without overburdening data entry requirements -- I.E. in a way that differentiates between service provision from same service to different consumers, and between different services to same consumer, without requiring "time-and-motion" data to be captured.

To this end some kind of identification of service type may be useful, e.g. Closed acute ward as distinct from open acute ward, assertive community care vs crisis intervention, specialised perinatal ward as distinct from general adult ward.

In the absence of the above, in the Community setting further investigation/development around Community NMDS Contact data (e.g. volume & duration of contacts, client participating/not participating) has potential explanatory power in relation to community cost drivers within Phase.

The above comments relate to cost drivers – however SA Health notes that costing is not the first or only aim of the AMHCC. Analysis of CMHC Contacts, and the development of appropriately defined service type and/or Intervention codes (defined in such a way as to avoid data entry overburden and to act as a suitable proxy or indicator for Discipline) may be useful for the overall AMHCC purpose as well as just for the costing aspect, and may also have clinical/service utility and meaning.

CHSALHN clinicians identified clinical complexity (ie: diagnosis groupings) and comorbidities as a driver to the care provided to consumers as well that may need to be considered for future iterations of the classification.

Consumer rated data (K10, SDQ) are not included yet mental health services strongly value consumers' perspectives and actively include consumers in care planning and service delivery. Therefore by omitting self-rated measures some explanatory data may be missing.

3. Do the final classification groups have relevance to clinicians, health service managers and other stakeholders?

Yes:

No

No:

No

Comments::

Broadly speaking the groups do make sense. It is difficult to evaluate and confirm the appropriateness of the classification groups without their relative costs weights.

CHSA also has queries in regards to the notion of HoNOS groupings either being "High", "Moderate" or "Unknown". Support for greater granularity in respect to HoNOS groupings is wanted (ie: Mild, Moderate, High, Extreme).

Simple application of "total HoNOS score" overlooks potential valuable meaning/variation in subscale scores. There may be strong explanatory value in, for example, a consumer who has high ratings in one or two subscales compared to a consumer who has lower ratings in all subscales, where both consumers have same total score.

4 Are the priorities for the next stages of development of the AMHCC appropriate?

Yes:

No

No:

No

Comments::

Overall, Yes. Specifically, SA Health supports that application to non-specialised mental health care is not identified as a priority, although it's feasible that some of this work does occur in the Community-managed Health Services space (E.G. if this includes Aboriginal Controlled Community Health Services, where Social & Emotional Well Being workers are employed.)

The work within the Community sector should be cognisant of the diversity of services potentially involved as per the MHNGOE DSS taxonomy, and that operationally there is overlap with clinical services in areas such as psycho-social support and supported social housing.

The development of Youth/Child & Adolescent, Emergency MH, Older Persons, Community Managed MH Services & Residential Mental Health Care Classifications needs to remain front of mind moving forward to ensure that the nuances of each service setting are upheld.

5 Are there any other issues which should be taken into account in the next stages of development?

Yes:

No

No:

No

Comments::

Definitions: greater care needs to be applied where terms adopted for AMHCC purposes have different meanings/definitions from those established within the existing mental health data sets. Specifically this applies to "service setting" where the AMHCC is adopting a broader hospital-based definition of "admitted patient" whereas mental health data sets align "admitted patient" to "psychiatric care days" (I.E. only activity which occurs within designated mental health wards) with all other hospital-based mental health activity (such as consultation-liaison to general wards) being defined as Community mental health. This is one area that should be considered by the upcoming work within the MHWG relating to resolving differences between the MH DSS and existing MH NMDs & NOCC.

First episode: further development required to establish appropriate definition, meaning, utility for this data element. The current working definition derived from New Client Index (which is an "access" measure), and applied to "MH Organisation", is a significant departure from the "First Episode Psychosis" indicator first identified as being a cost driver.

Lead time required by system managers to make changes to data capture systems needs to be taken into account when adding additional data elements to the classification. System Managers need sufficient time to develop systems, as well as undertake training and education to support implementation.

Generally speaking the principle that should be adopted in further developing the AMHCC is: do more "desktop design" before implementing data items/definitions/changes; conduct localised pilot studies as appropriate, as a means of refining data items and definitions, before globally implementing data items/definitions. This is the approach traditionally adopted by the national MHISSC group to positive effect.

Similar to current situation where MHISSC and MHWG members are directly represented on each other's committees, AMHCC classification development needs to be kept aligned with the general higher level governance structures (MHISSC, NHISSC, MHDAPC, AMHC) and national strategic directions (5th National Mental Health Plan, NOCC strategic directions).

6 Do you consent to the answers you have provided being submitted for the consultation?

Yes:

Yes