ABN 60 083 141 664

The Peak Body Representing Allied Health in Australia
Incorporating AHPARR (Rural & Remote), National Allied Health Classification Committee and National Alliance of Self Regulating Health Professions

Submission to the Independent Hospital Pricing Authority

regarding

Development of the Australian Mental Health Care Classification Public Consultation Paper 2

by

Allied Health Professions Australia

December 23, 2015

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Introduction

Allied Health Professions Australia appreciates the opportunity to respond to the Public Consultation Paper 2 on behalf of those professions most involved in mental health services in Australia. These are psychology, social work and occupational therapy although some of the other professions clearly find themselves providing specific (and adapting) services to mental health patients in the course of their public sector and private professional work. This would include professions such as speech pathology, dietetics and physiotherapy.

While allied health may not account for a significant cost component, much of the work of these professions is part of the core multidisciplinary service within the public sector management of mental health patients. As such, allied health plays a significant and critical role. This is the case, for instance, with cognitive-behavioural, non-pharmaceutical interventions, discharge planning, re-integration in the community and carer support. This may become increasingly significant with the growing emphasis on recovery and community-based interventions.

Consultation Questions

1 A*re the variables included in the draft AMHCC, Version 1, relevant to clinicians, health service managers and other stakeholders.*

Although small in costing by comparison with nursing, hospital, pharmacy and other inpatient services, allied health contributes a significant and important part to hospital inpatient and acute community-based mental health services. They are critical in the implementation of multidisciplinary care. Social work services, particularly, are a significant contribution to the inpatient intervention with key roles with family, friends, employers and other community networks. These intervention should not be underestimated in the outcomes of an admission. Key psychological and occupational therapy interventions can influence the course of the admission and the likelihood of a successful discharge.

As a consequence of this, allied health professionals want their critical role acknowledged and characterisation of the costs of the service to better reflect not only their role but also the crucial clinical and human factor issues that underpin a best-practice service. As one of the mental health practitioners commented, “it is incredibly frustrating to find the demographic information contributes to the costing model as much as any patient-specific characteristics”.

The second frequently expressed concern about the identified and confirmed variables in the above report is that the costing study inevitably draws its data from current practice and established procedures which arouses fears that it will continue to fund the *status quo* and render the possibility of serious reform extremely unlikely. Until there are mental health services that actually deliver standardised, evidence-based pathways of care, it will not be possible to determine properly whether such interventions contribute to the cost and how best to fund and support those interventions. Contemporary policy pronouncements from the National Mental Health Commission emphasise the significance of alternative approaches. Such approaches must be linked to hospital admission, discharge and community placement planning. Community-based interventions should not be seen as separate from the acute treatment process.

It is important to highlight the fact that many of the mental health teams across Australia do not implement and pursue evidence- based practice. One of the examples of this can be found with regard to the case management role which many allied health professionals have been recruited for, and shepherded into. Such a role not only denies the unique contribution that each allied health professional can bring to mental health patients but is now clearly shown by evidence overseas and in Australia to be the least effective utilisation of professional resources. Queensland Health, for instance, supported by the recent work of the Allied Health Workforce Group and the Minister, is exploring ways of moving its psychologists out of non-evidence-based work and into the delivery of evidence-based interventions. It would be a tragedy if the funding mechanisms became a barrier to such much-needed reform.

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

Many of our practitioners were perplexed that location in Australia did not demonstrate its impact on costs. Many of our practitioners in regional, rural and remote areas are keenly aware of the impact that distance and the availability of resources can have on the provision of services and impinge on not only effectiveness but costs of travel, length of stay and access.

Secondly, AHPA received some comments about the lack of support for patient characteristics such as functionality and social location in the community. So many of our practitioners are familiar with the critical importance of living circumstances and family/carer availability that the absence of measures, or better measures, of factors such as functionality and social supports were a source of serious concern.

While AHPA does not have specific suggestions of other variables that might be included, it does have some concerns with the nature of the variables that were utilised. There are some suggestions above that bear upon the better refinement of variables. However, the one area of particular concern to allied health were the AIHW Intervention Codes which were utilised in this costing study. It was identified prior to the costing study that these variables needed to be revised to better reflect current practice. And it is noted that AHPA was not the only group of professionals who felt this way. This, it is argued, should occur before any further analysis or costing be done.

The other variable that should be refined as a cost factor, even though it is also probably quite small in the overall scheme of things, is what is called consultation liaison psychiatry. While this has been standardly viewed as a consultant psychiatrist issue, it is a relevant issue for many allied health who provide services into mental health units and other ward units while not being directly employed by those services. This is more a question of local accounting and management processes, but would benefit from a standard approach across the range of services to ensure that the actual costs of the mental health service are fully and clearly represented.

It may be important to explain that the consultation liaison role referred to above is, to some extent, more complex for allied health than it is for psychiatry. For many allied health, it involves not only the provision of services by various acute hospital allied health units (e.g., occupational therapy responding to a referral for a specific patient in a mental health unit or a mental health patient in another hospital unit), but it may be, for instance, the provision of services by allied

health from a community health centre to either the acute mental health service or the Emergency Department of the hospital.

Finally, it is disappointing that there has been no attempt to find ways of recording the 'source' of the intervention costs with regard to the responsible professional group as a way of better understanding effective and beneficial interventions. The problem for allied health is that, regardless of the intervention that is undertaken, the cost is primarily attributable to a general bucket of staff salary costs thereby preventing a meaningful evaluation of cost variations related to specific professions' interventions.

It may be worth considering an idea that came from one of the allied health managers, contributing to the feedback on the consultation paper, who reported on the work of the Health Roundtable. Apparently it conducted an analysis linking allied health activity to the relative-stay index in the acute medical setting. There was a positive relationship and, given the costs of length of stay, it would be a worthwhile factor to consider in future studies.

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

This somewhat overlaps with Issue 1 and the sensitivity of the variables to clinicians and even health service managers. Some of the subgroupings seem blunt. One example is the gross grouping of individuals with regard to age. The age range of 0 to 17 years to cover Child and Adolescent Mental Health Services raises a number of concerns because it groups together individuals with extremely different needs. Certainly this area needs further analysis and AHPA urges the Mental Health Working Group to reconsider this broad age grouping.

Furthermore, the conclusion that Phase of Care and HONOS complexity are the only components of discriminant tree interest (even if justifiably so) does leave some factors that are important to clinicians, based on their experience, somewhat undervalued. Those factors considered to be of importance, as stated previously, are issues such as best practice, evidence-based interventions and discipline specific interventions.

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

There were no significant suggestions or criticisms of the plans for the next stage of development.

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

AHPA has no new items that it would suggest need to be taken into account during the next stages of development. However, it will take the opportunity to comment further on one issue of continuing concern.

AHPA has repeatedly expressed its view that costing based upon current practice fails to account for, or provide flexibility for, improved practice procedures. While it understands that this is a

separate issue to costing, AHPA nonetheless feels that costs studies need to reiterate their limitations and highlight the need for other or higher level organisations to take these professional and practice issues into account. If the analysis of costs is based on the current, less-than-optimal practice, then you will only get a costing procedure reflective of less than optimal practice. It is the commitment of all professionals in mental health that reform and improvement of practice will form a clear part of the road ahead. Costing procedures need to support and encourage this.