

13 January 2016

Mr James Downie  
Acting CEO  
Independent Hospital Pricing Authority  
PO Box 483  
DARLINGHURST NSW 1300

By email: [submissions.ihpa@ihpa.gov.au](mailto:submissions.ihpa@ihpa.gov.au)

Dear Mr Downie

**Re: Development of the Australian Mental Health Care Classification: Public consultation paper 2**

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to comment on the *Development of the Australian Mental Health Care Classification: Public consultation paper 2* (the Consultation Paper).

The RANZCP notes that the Consultation Paper presents version 1.0 of the Australian Mental Health Care Classification (AMHCC) and represents the start of an ongoing process of implementation and refinement.

The RANZCP notes that the AMHCC version 1.0 is based on six variables: setting, mental health phase of case, age group, mental health legal status, Health of the Nation Outcome Scale (HoNOS) and Life Skills Profile (LSP-16).

As the creation of the AMHCC is a challenging and complex task, we would like to acknowledge the progress that the IHPA has made to date and reiterate our ongoing support for a robust service data framework for Australian mental health services.

To help inform the ongoing development of the AMHCC, the RANZCP would like to highlight the following issues.

***Child and adolescent mental health care***

In its [February 2015 submission in response to the IHPA's first consultation paper on the AMHCC](#), the RANZCP identified the need for the IHPA to consider a broad range of variables for child and adolescent mental health care under the AMHCC, including the interface between mental health care services and other government agencies. In the interim, the RANZCP requests further information from the IHPA about the following decisions in relation to child and adolescent mental health care and the AMHCC as set out in the Consultation Paper:

- The RANZCP notes that the Factors Influencing Health Scale and the Children's Global Assessment Score were tested in relation to consumers in the 0-17 year age group. However, the Consultation Paper states that 'due to low sample size there was insufficient evidence to support the inclusion of either as a variable at this stage' in the AMHCC. While we understand that this information was based on data obtained through the 2014 Mental Health Costing Study, we request further detail about the specific data that the IHPA used to make this determination.
- The Consultation Paper found that mental health legal status (MHLS) was a significant cost driver in the admitted setting for those consumers aged 18-64 years in an acute phase of care. In the RANZCP's view, MHLS can also be a significant cost driver for consumers aged 0-17 years and would like to discuss this issue, including potential data sources in greater detail with the IHPA.
- As the Consultation Paper notes, we understand that the goal of the AMHCC is not to explain the total economic costs of mental illness over time, but rather to explain the costs of service delivery by the mental health service sector. While it is clear that many cost contributors will be addressed by the AMHCC, the current version does not appear to include a data strategy to explain costs to the mental health sector of time consuming administrative procedures, particularly in child and adolescent mental health care such as subsequent review assessment, cognitive and capacity assessments and the preparation of reports for tribunal hearings such as the Guardianship Tribunal. It would be helpful to gather data on these aspects of mental health care to objectively understand their contribution to service delivery costs. Further clarification on how the AMHCC will reflect these costs would be valuable to understand and communicate to our members.
- The cost driving impact of social diversity noted in the RANZCP response appears not to be addressed in the Consultation Paper. For all consumers, but particularly for children and adolescents, social determinants can influence the type of treatment required, the level of support needed and the associated costs.
- The RANZCP also has a query regarding the weighted HoNOS score thresholds in regards to '*Weighted HoNOS score threshold for 'high complexity'*'. Currently, the threshold for 'Acute' for a 0-17 year old admitted patient is lower than the threshold for 'Acute' for a 0-17 year old community patient. This appears to be counterintuitive. The table indicates that a patient should be more 'well' when discharged from an inpatient unit than when discharged from community. Yet, the 'Consolidating gain' score for community patients seems very high. The RANZCP suggests that the IHPA review these score thresholds.

### ***Mental health phases of care***

The Consultation Paper's definition of 'mental health care' is care that is 'delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health'.

While we note that the 'Mental Health Care Type' is intended to be broad enough to not provide any impediments to the delivery of mental health services (e.g. in rural or remote areas), the RANZCP is concerned how this definition will link to the AMHCC's definitions of 'phases of care' in practice as it appears that none of the phases of care utilise the management / informed by distinction.

In the RANZCP's view, a person's mental health treatment and care needs to be managed – not merely informed by – a specialist mental health clinician. It would be highly inappropriate for a patient's entire treatment episode to be undertaken without that patient's care ever having been 'managed' (as opposed to just 'informed') by a clinician with specialist mental health expertise.

### ***Data alignment between the AMHCC and NOCC***

The RANZCP also seeks to clarify whether the IHPA is willing to commit to aligning the data of both the AMHCC and the National Outcomes and Casemix Collection (NOCC) without changing the basic rules of NOCC. Almost all Australian mental health clinicians in public practice have been trained in these rules, which align with the National Mental Health Standards. The RANZCP notes that enormous effort would be required if this training had to be repeated.

At our teleconference on 8 January 2016, we note that you mentioned that the IHPA is currently engaging with the Australian Mental Health Outcomes and Classifications Network to align the NOCC and the AMHCC in a way that is least disruptive to clinicians. The RANZCP would welcome the opportunity to be involved in this process.

### ***Implementation***

With the exception of mental health phase of care, the variables described in the Consultation Paper are part of current data reporting. The RANZCP notes that the use of the mental health phase of care as a variable will commence in July 2016 as part of the AMHCC version 1.0 implementation. We consider that it is extremely important that the business rules relating to phase of care are simple and clear, to help engage clinicians to utilise them.

We also note that an AMHCC guidance document is due to be released in early 2016. The RANZCP would be pleased to support any review process related to the development of the guidance document.

### ***Ongoing engagement***

As expressed at the recent teleconference meeting on 8 January 2016, the RANZCP would welcome the opportunity to discuss further aspects of the AMHCC in more detail with the IHPA – particularly the child and adolescent elements of the AMHCC.

We would also be pleased to discuss opportunities about how the RANZCP could inform our members in further detail about the AMHCC, which potentially could include the development of e-learning modules.

If you would like to discuss any of the issues raised in this submission, please contact Ms Rosie Forster, Senior Department Manager - Practice, Policy and Partnerships, RANZCP on (03) 9601 4943 or [rosie.forster@ranzcp.org](mailto:rosie.forster@ranzcp.org).

Yours sincerely



Professor Malcom Hopwood  
**President**

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