Feedback to Independent Health Pricing Authority (IHPA) from Mental Health in Multicultural Australia (MHiMA) in relation to the consultation questions regarding development of the Australian Mental Health Care Classification (AMHCC)

Friday 13th February 2015

Preamble

This submission focuses on the need to incorporate consideration of Australia's multicultural communities in the development of national efficient pricing for mental health services that respects diversity and promotes fairness/equity and transparency. In this regard we applaud IHPA's Agency Multicultural Plan 2013-15 and endorse the intent and content of the Plan. In particular the current process is an opportunity for IHPA to give effect to the first area of work identified in the Plan, around demonstrating leadership in multicultural access and equity.

We will not review here the self-evident cultural and linguistic diversity of the population. It is, though, important to point out that this diversity is of greater importance, and presents greater challenges, in mental health than in many other domains of health service provision. Every aspect of mental health – including community attitudes towards and knowledge about mental illness, identification of mental health problems and decisions concerning help-seeking, assessment/diagnosis and treatment decision-making, and support for recovery including psychological and social support interventions – is influenced by culture and is made more difficult, and time-consuming, by difficulties in communication. These issues have a direct impact on cost of provision of culturally acceptable and clinically effective services.

Of course, providing services of inadequate quality is not (in the short-term) as expensive as providing high quality, effective services. Failure to provide the highest possible quality services is likely to result in higher costs to the health system in the longer term.

The key impediment to developing, in pursuit of equity, rigorous adjustments for language, culture and ethnicity that are based on good evidence is the lack of the relevant data that are necessary to calculate appropriate adjustments. A study carried out for the National Mental Health Commission concluded that "The key finding of this paper is that in relation to immigrant and refugee communities the necessary data are not available." (Minas, Kakuma et al. 2013)[1] However, the absence of evidence for the need to make appropriate pricing adjustments should not be interpreted as indicating absence of need to make such adjustments.

A related issue is that if the current services that are provided to immigrants and refugees are costed it may well be the case that the cost of standard current services may well not be much greater than the general cost of services. The reasons for this may well be found in the poorer quality of services provided to immigrants and refugees than the services provided to the Australia-born. For example, very little effort is made to fully understand the significance of cultural issues for diagnosis and treatment decisions. Very often interpreters are not provided at all relevant decision-making points in the clinical process, generally because mental health services do not have sufficient funds to provide interpreters. Specialist transcultural services are not consulted anywhere near as often as they should be to clarify issues of diagnosis, treatment and post-discharge clinical and social support and rehabilitation – i.e. recovery-focused services.

The goal of mental health services should not be to treat everyone the same regardless of need. Equity demands that health needs are appropriately responded to, even if for some sections of the community a high quality response is more expensive.

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[1] Minas H, Kakuma R, Too LS, Vayani H, Orapeleng S, Prasad-Ildes R, Turner G, Procter N, Oehm D: **Mental health research and evaluation in multicultural Australia: developing a culture of inclusion**. *International journal of mental health systems* 2013, **7**(1):23.

The factors that make provision of high quality mental health services to cultural minorities and to people whose English fluency is insufficient for effective clinical communication more expensive are not hard to find. The most obvious additional cost is provision of professional interpreting services when these are required. As well as the cost of the interpreter is the additional time that the health professionals need in order to carry out an interpreted interview. Perhaps less immediately obvious, but obvious enough given a moment's thought, is the need for doctors, nurses and other health professionals to spend more time in order to adequately explore the cultural dimensions of illness and treatment. This is extra time with the patient but also extra time with family members who may be very unfamiliar with everything that's happening. The additional costs of consulting with cultural experts is not captured anywhere in our current information systems. Nor is the cost of provision of such cultural expertise.

Familiarity with good clinical practice in a mental health service that serves culturally diverse populations will support the proposition that providing high quality mental health services to immigrants and refugees, particularly when communication is difficult, is substantially more expensive than providing services of equivalent quality to Australia-born populations. Because such services are more expensive, and mental health services are under great pressure everywhere, corners are generally cut and quality of services suffers. This is not equitable and cannot be allowed to continue. Services should be adequately funded to provide the highest possible quality of care to all Australians. This will only happen if appropriate adjustments are made to the pricing formulae.

As mentioned above, the challenge for IHPA is that the data necessary for estimating with confidence the cost of services for immigrants and refugees are generally unavailable. MHiMA therefore recommends that the work that needs to be done to collect the data that will inform efficient and equitable pricing be identified as being a high priority for IHPA. MHiMA would wish to enter into a collaborative relationship with IHPA to design and carry out the necessary studies.

We will now respond to the questions proposed by IHPA.

1. **What are the most important factors to draw from international experiences in classifying mental health care?**

   A very important factor to draw from international experiences in classifying mental health care is the need to include ethnicity data collection from the perspective of mental health services that deliver services to significantly diverse multicultural populations.

   The collection of ethnicity data would contribute to the availability of better quality data on culturally and linguistically diverse (CALD) communities, and particularly, identify populations that are currently invisible. The advantages of using ethnicity include being able to capture the following groups:

- Children born in Australia but brought up in a non-English speaking cultural environment
- Ethnic minorities who migrated from countries such as New Zealand, UK, and USA who affiliate with their cultural background and ethnicity
- Ethnic minorities who can only be identified by ethnicity or sometimes language, for example refugees who were persecuted because of their ethnicity (e.g. Karen born in Thailand).

The omission of key data has long persisted in Australian health and mental health care data collections sets. Current data collection variables in Australia are generally limited to age, country of birth, language spoken at home and sex. Collecting ethnicity data would bring Australia in line with several other comparable countries. There is a preference internationally in comparable countries to Australia for the collection of 'ethnicity' as a primary indicator of cultural diversity (see table below):

Country	**Main variable collected**	**Classification categories**
New Zealand	Ethnicity	4 level classification. Level 1: • European • Maori • Pacific Island • Asian • Other
Canada	Ethnicity	29 ethnic categories and subcategories including • British Isles origins • Aboriginal origins • Caribbean origins • Latin, Central and South American origins • African origins • Arab origins • West Asian origins • South Asian origin
UK	Ethnicity (but uses some racial concepts)	• White (British, Irish, other) • Mixed (White and Black Caribbean; White and Black African, White and Asian, Other mixed) • Asian (Indian, Pakistani, Bangladeshi, other) • Black or Black British (Caribbean, African, other) • Other ethnic group (Chinese, other, not stated)
USA	Race and later limited ethnicity introduced	• Race - American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Black or African American, White • Ethnicity - Hispanic or Latino, Not Hispanic or Latino

In particular reviewing the **New Zealand** – 2003 Mental Health Classification and Outcomes Study (NZ CAOS) maybe a good starting point as their classification builds on Australia's Mental Health Classification and Service Costs (MH-CASC) prototype. As part of the classification system in New Zealand, collection of ethnicity has not only enabled better understanding of population diversity, it has also became a basis for analysing cost differentials; and exploring the reasons for differentials occurring in terms of cost and experience of delivering mental health care to different ethnic groups as outlined in the case study below:

Case Study from New Zealand

As a result of consultation with the National Project Reference Group, the Maori Monitoring and Review group and Pacific representatives, the casemix study includes some classes based on ethnicity.

In all classes that are based on ethnicity, the European/Other class is the least costly. Other trends identified include that Pacific consumers are underrepresented in the classes for older people. They are also more likely to be involuntary consumers and in classes that have major problems. According to the report this suggests that Pacific consumers may be entering the service at a later stage of their illness. When they do enter, their symptoms are more severe preventing them from functioning as well as other consumers.

It was also suggested in the report that clinical staff required training on cross-cultural paradigms relating to mental health. This is to decrease the risk of misdiagnosis or rating consumers incorrectly. A study to investigate the reasons for these differences is warranted according to the report. It was also questioned whether all of the clinical measures used in the study are appropriate for different ethnic groups.

The report suggests that by the time Maori come into contact with specialist mental health services they will experience services as punishment for being ill rather than as contributing towards the process of self-healing. This is also likely to be true for Pacific people.

2. What are the most important considerations in the national context?

A key consideration in the national context is the cultural diversity of the mental health consumer population given 28% of the Australian population is born overseas. This necessitates an approach where the AMHCC is inclusive of diverse consumer related factors as well specialist services that are required to deliver culturally competent and responsive mental health care such as interpreter services, Transcultural Mental Health Services and specialist NGO multicultural mental health support and recovery services. Inclusion of cultural diversity would be in keeping with the principles of the Fourth National Mental Health:

- Respect for the rights and needs of consumers, carers and families
- Services delivered with a commitment to a recovery approach
- Social inclusion
- Recognition of social, cultural and geographic diversity and experience
- Recognition that the focus of care may be different across the life span
- Services delivered to support continuity and coordination of care
- Service equity across areas, communities and age groups
- Consideration of the spectrum of mental health, mental health problems and mental illness.

In addition, the following other areas of mental health reform that should be considered in regard to development of the AMHCC are as follows:

- Outcome of the Commonwealth review of mental health services which was led by the National Mental Health Commission.

- The work of National Mental Health Service Planning Framework (NMHSPF).

- The roll out of care packages for patients with mental health needs that will be eligible for support from the National Disability Insurance Scheme (NDIS) and how patient flows and support will be managed between various care settings. For example a practical concern is that weighting for higher costs in clinical time during discharge planning maybe needed to support CALD consumers in developing their individualised care plans to ensure that community care is available to meet their cultural needs; and prevent subsequent avoidable and more expensive readmissions into acute care.

- Clarity around how the classification and payment regime will factor in the role of specialist mental health services that maybe hidden within episodes or phases of care is also critical. For example, how will the work delivered by specialist services such as state-based transcultural mental health services be captured by the classification systems which then translate into service payments?

As outlined in response to Question 1 the experience to date is that current data systems do not adequately capture the work of specialist transcultural/multicultural mental health services as they have to enter their work on the data system as “OHP” – other service provider. As specialist consultation services their work is alongside the primary treating team and a key risk appears to be that in the phases of care that their clinical work will be “hidden” and therefore omitted from the classification system. If this scenario eventuates the risk is that specialist services will be unfunded and that inequity and service access will be structurally embedded for people of CALD backgrounds. Another key area of data collection within mainstream mental health services is the Health of the Nation Outcome Scales (HoNOS). There are no national standardised tools or user manuals for the collecting of HONOS Data from CALD communities in Australia.

3. Are there any other principles that should be considered in developing the Australian Mental Health Care Classification (AMHCC)?

- Key principles in developing the AMHCC is inclusion of a definition around CALD patient characteristics (as defined in response in to Question 2) and addressing the issue of ethnicity (as outlined in response to Question 1) to bring Australia in line with overseas classification systems in comparable English speaking countries that have culturally and linguistically diverse populations.

- Another consideration should be about the cost difference in delivering care to CALD populations which should include costs associated with delivering the care such as language support and meeting cultural needs to enable recovery and discharge outcomes into community care.

- In adopting the above considerations as principles in development of the AMHCC such an approach would be consistent with utilisation of principles in developing the AMHCC in terms of being cognisant of the classification system being:
  - 'Patient/ consumer based;
  - Minimising undesirable and inadvertent consequences such as preventing invisibility and lack of funding for specialist multicultural/transcultural mental health services that are involved in supporting consumer care that are currently categorised as 'other service providers' and
  - Preventing the differences in service classification and reporting across jurisdictions, such as for residential services, hospital in the home, admissions, patient registration, and forensic mental health services and specialist multicultural/transcultural mental health services given the lack of a nationally uniform approach across Australia relating to service classifications for these types of services.

4. Are there further data or other limitations of which the AMHCC (Australian Mental Health Care Classification) should be aware

Given it is proposed that a change of phase of care will trigger a new collection of outcomes measures and potentially a new ABF payment it is critical that the following issues are addressed:

- Outcomes measures need to collect and report on CALD variables which is currently not the case.

- Phases of care for CALD mental health consumers will require access to specialist services to enable culturally competent and responsive service provision such as specialists assessments from transcultural mental health services, interpreter services and cultural consultants and bilingual workers where available to help facilitate engagement, psycho-education etc.

- Given that the ABF MHC DSS is based on the existing mental health National Minimum Data Sets and that some initial work undertaken by MHiMA indicates limitations in nationally consistent CALD variables being collected and reported in the national minimum data sets. As such it is recommended that a specific project is funded by IHPA to address this issue and to determine to the best way forward for a culturally inclusive AMHCC.

- Such a proposal warrants consideration as:

    - Outcomes data is not reportable by any CALD data variables;

    - Clinical service delivery of specialist services such as transcultural mental health services is hidden in current data collections;

    - Other work by specialist services to improve culturally competent mental health care such as workforce/clinical education is captured in current data systems under non consumer related activity and needs to be factored into the classification system;

    - The AN-SNAP, AR-DRG, HCP, ICD-10, NHCDC, NOCC, NWAU, UDG's and URG's which the AMHCC will rely on as data sources currently do not consider CALD variables to the extent required. As such information on whether or not a CALD patient is being provided specialist service input because of culture is also not reflected in any data collection system;

    - Continued exclusion and failure to address this issue poses the risk of the AMHCC not being inclusive of CALD populations.

5. Are there any other key considerations that should be taken into account in developing the AMHCC (Australian Mental Health Care Classification)?

- MHiMA supports the notion that the Mental Health Care Type should apply to community mental health services in the same way as for admitted care, and be provider agnostic.

- MHiMA seeks clarity from IHPA in its approach to defining the boundary between different phases of mental health care, such as acute mental health care or subacute mental health care. One suggested way to achieve this could be to introduce sub-care types so that within the Mental Health Care Type, there are separate sub-types for each phase of care. An alternative approach is to include phases of care within the mental health casemix classification. The latter approach should be considered to ensure that assignment to a phase of care is based on patient need and characteristics rather than service setting characteristics. It is recommended that phases of care be considered in the classification development, so that a patient can change phases when their level of need changes, resulting in a new casemix class being assigned, and therefore units of payment recognise the contribution and cost of specialist services in contributing to phases of care as needed.

- A piece of work that could assist in considering this issue could be to refer to work funded by the NSW Mental Health Coordinating Council to undertake a Mental Health NGO National Minimum Data Set project to consider what a national mental health NGO minimum data set would look like. The project included delivering mental health NGO service taxonomy, a data set specification and preferred methodology for collection. The outcome of this work can be reviewed at http://www.mhcc.org.au/policy-advocacy-reform/influence-and-reform/community-mental-health-australia.aspx. Another potentially relevant project was one undertaken by the Community Mental Health Australia which was the National Community-Managed Mental Health Sector Organisations Outcome Measurement Project.

6. Are there other cost drivers that should be considered in the development of the AMHCC?

- Given the purpose of the AHMCC is to determine the cost of treatment and care in order to calculate a national efficient price it is important that available information about cost differentials for CALD mental health consumer is factored into the AHMCC.

- A Victorian study published by Renhazo[2] which conducted a cross sectional analysis of the administrative records of clients using community health services in the Northern Metropolitan region in Melbourne as part of a study conducted by the Commonwealth Grants Commission examined cost drivers in service provision to specific groups. The project found that clients from Non English Speaking Backgrounds (NESB) required more consultation time compared to their English Speaking counterparts.

- The available evidence in Australia shows that NESB clients are likely to be late presenters due to lack of English and a variety of other factors relating to access and culture, which could partly explain the longer consultation time. The study concluded there are four key cost drivers for services for NESB clients which are as follows:

    - Increased consultation time;

    - Group attendance to an appointment;

    - Cost of using interpreting services and;

    - The type of service provider that is required e.g. culturally competent clinical engagement and use of bicultural workers.

- As such any adjustment to cost drivers for CALD communities should not be simply based on language adjustment. Adjustments should factor in considerations around cultural consultation/assessment requirements and should allow for when an interpreter is required in addition to a cultural consultation. This level of consideration has been built into some funding models in Australia which have applied weighting for non-English speaking patients on the basis of the level of competence in English as reported in the national census. For instance the funding resource allocation model (RAM) previously in operation in Queensland weighted those who indicated to speak English “not well” or “not at all” in the RAM. Whilst this approach recognised the need for factoring cost of interpreters it has significant limitations as it only reflects the need for interpreting services and does not address cultural factors in health care. Queensland Health at the time of developing the RAM acknowledged this limitation and indicated a future need to investigate the underlying cultural factors affecting need in health care.

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[2] Renhazo, A, International Journal of Migration, Health and Social Care, vol 3, issue 4, Dec 2007

- Development of the AMHCC represents an opportunity for IHPA to address these cost drivers that could potentially be incorporated into a weighting for CALD populations. To date since development of the AMHCC has commenced such considerations do not appear to have been pursued as such information was not available for consideration in the earlier literature reviews undertaken by University of Queensland to inform the basis for developing the AMHCC. This was evident during the consultation in relation to the *Pricing Framework for Australian Public Hospitals 2014-15* which identified a number of issues in relation to the counting and costing of Indigenous patients and Culturally and Linguistically Diverse (CALD) patients. Initial data reviews conducted in 2013 on CALD patients indicated that no adjustment was warranted for this group but IHPA noted significant data limitations and concluded that this issue requires further analysis in 2014 for NEP15.

- Information and proposed approaches in this submission may useful in enabling IHPA to revisit and undertake further analysis relating to CALD population considerations in the development of the AMHCC.

- Specifically, MHiMA would welcome engagement with IHPA on a collaborative basis to ensure NHCDC data is available in an accessible and meaningful form for use by the National Health Performance Authority (NHPA) as the new body charged with monitoring and reporting on health system performance. In addition, engagement in the development of the new National Minimum Data Sets (NDMS) so that the agreed definitions by which data are collected and reported include CALD populations within Patient Classification Systems across all tiers of the health system across Australia would also represent a significant step forward in ensuring the AMHCC factors in CALD populations with the adequate cost drivers built into the new classification system. A key baseline from which this work could be progressed are to reviewing the findings of the recently completed National Mental Health Costing Study which considered the following categories:

    - Consumer-related factors – e.g. diagnosis;

    - Service factors – variations;

    - Treatment factors – little reliable data;

    - Legal status, safety and emergency care – high utilisation of cost;

    - Chronic disease management.

7. Are there any further considerations in relation to the proposed architecture?

- As outlined previously in response to Question 6 the profile of consumers from CALD backgrounds should include broader data variables, rather than just collection of country of birth. The architecture should also have the capacity to collect and enable routine analysis of types and frequency of service access and utilisation by CALD populations and additional costs associated with delivering that care such as language support and meeting cultural needs to enable recovery and discharge outcomes into community care.

8. Is there any further evidence that should be considered in testing the proposed architecture?

The concept of mental health phases care which MHiMA understands is a key element of the AMHCC, which we understand will trigger a new collection of outcomes measures and a new ABF payment regime, is a development that could inadvertently exclude specialist services for the following reasons:

- Outcome measure are not reported by any CALD data variables;

- Specialist services such as Transcultural Mental Health Services, which are specialist consultation services, do not complete outcome measures;

- As only one Phase of Care can be reported at each collection point, Transcultural Mental Health Services which undertake specialist assessments, psycho-education and work with CALD consumers and their families during acute and intensive extended phases of care may be excluded from payments due the current data system reporting their work as OSP (other service provider) rather than PSP (primary service provider) due to being a consultation service i.e. clinical work undertaken by specialist services is currently "hidden" in existing data systems which risks these services from being excluded from the classification system;

- Other factors that contribute to improved culturally competent and responsive care such as workforce education is not factored in. Data systems do collect this type of activity as non consumer related activity but it is not reportable;

- As such MHiMA would welcome discussion and engagement in relation to how these concerns might be addressed.

9. Which psychological interventions, if any, may be of significance in understanding the cost of care?

Psycho-education is a key intervention with CALD consumers which often requires input from specialist services to ensure it is culturally tailored to the needs of the consumer. MHiMA would welcome discussions around how will group work might be understood and factored into the cost of care.

10. **Are there particular aspects or areas of the AMHCC (Australian Mental Health Care Classification) that should be prioritised in its development, or aspects that should be developed at a later stage?**

    As outlined in response to Question 4 given that it is know that are significant limitations in the current data systems in terms of CALD data variables which can result in the AMHCC excluding characteristics for key population groups it is recommended that IHPA consider a CALD Mental Health Costing Study.

    This statement of fact is not contested given that MHiMA produced a spotlight report for the National Mental Health Commission which was also peer reviewed by the ABS and AIHW. The report is entitled: ***"Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion".*** To review the report please see: http://www.mentalhealthcommission.gov.au/our-reports/spotlight-reports.aspx

11. **Are there any further considerations that should be taken into account when developing the AMHCC (Australian Mental Health Care Classification)?**

    - Work has been undertaken in regard to the administration of the HoNOS with CALD consumers reported:
        - http://www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/docs/trans_outcomes_rep.pdf

      This work resulted in the development of the culturally sensitive guidelines for the application of the HoNOS

        - http://www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/docs/cultural_honos.pdf

    - The consumer rated measures MHI and K10 have been translated by the transcultural mental health centres are can be accessed via the following links:

        - http://www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/docs/mhi_translation_rep.pdf
        - http://www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/multilingual.asp
        - http://www.dhi.health.nsw.gov.au/Transcultural-Mental-Health-Centre/Resources/Translations-/Kessler10/Kessler10/default.aspx

- The definition for culturally and linguistically diverse (CALD) as agreed for use by MHiMA is as follows:

  "The term *'people from culturally and linguistically diverse backgrounds'* refers to people who meet one or more of the following descriptions:

  - those whose country of birth has a national language other than English;
  - those who were born in Australia and have at least one parent born in a mainly non-English speaking country;
  - those whose predominant social orientation or identification is with a non-English speaking culture.

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