The Royal Australian & New Zealand College of Psychiatrists

RANZCP Submission to the Independent Hospital Pricing Authority's consultation paper on the Development of the Australian Mental Health Care Classification

Improving the mental health of our community

309 La Trobe Street, Melbourne VIC 3000 Australia
T +61 3 9640 0646 F +61 3 9642 5652
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

Consultation Questions

About the RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a bi-national college has strong ties with associations in the Asia-Pacific region, such as the Asian Federation of Psychiatric Associations, and globally, with organisations such as the World Psychiatric Association.

The RANZCP has more than 5000 members, including around 3700 fully qualified psychiatrists and almost 1200 members who are training to qualify as psychiatrists. Psychiatrists play a crucial role in the provision of mental health care for the community. We utilise a range of therapies, including medication, psychotherapy and other treatments to provide clinically effective, safe treatment for vulnerable people

The RANZCP welcomes the opportunity to respond to the Independent Hospital Pricing Authority's (IHPA) Consultation Paper on the *Development of the Australian Mental Health Care Classification* system (Consultation Paper). The RANZCP's feedback is set out below.

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

   The international experience in classifying mental health care demonstrates a very broad range of approaches and the weakness to explain cost variance. Despite these weaknesses, the systems of mental health care have continued in these countries and large amounts of health spend have been diverted into a coding industry.

   The RANZCP also notes that it is unclear how applicable the international approaches are for child and adolescent mental health since the mental health care clusters and the Canadian System for Classification of In-Patient Psychiatry are used for adults only.

   Feedback from RANZCP child and adolescent psychiatrist members has identified additional costs involved in providing mental health care to this age group - driven by factors such as:
   - high rates of co-morbidity and psycho-social complexity
   - the need to engage and work with various other parties (other than the individual) e.g. family, schools, welfare agencies, which may involve considerable time and travel
   - comparatively poor fit with diagnostic classificatory systems
   - greater reliance upon psycho-social (rather than biological) treatments.

   Therefore, RANZCP believes that the IHPA needs to consider how developmentally appropriate the Australian Mental Health Care Classification (AMHCC) system is and to recognise the impact of social factors, family functioning as well as organic / somatic co-morbidities.

   The RANZCP also notes that there are no specific sections on children and adolescents in the previous reports used in the development of the AMHCC. The cost drivers were identified by:
   - Firstly, a literature review, which categorised cost drivers into: patient illness factors, patient characteristics (which does include socioeconomic factors), treatment factors and provider factors. Of the 58 studies included in the review, four studies included children and adolescents

only, one study included “adults and children” and six included adults, children and older persons. For 15 of the studies, age range was not mentioned.
- Secondly, existing data collections were examined and New South Wales, Queensland and Victoria took part. Admitted and ambulatory data was included. Children were part of both sets of data with a higher proportion of children included in the ambulatory data set across the three jurisdictions.
- The child cost drivers were then analysed as part of the whole and no particular section describes cost drivers for children separate to other age groups.

Given that the AMHCC does not currently cater for the mental health needs of children and adolescents, it is important that the system adopted is sufficiently flexible to account for likely changes to models of care for these age groups. Ideally, the system adopted would capture data in a form that is also suitable for additional research.

The RANZCP notes that the mental health care classificatory system described for the Netherlands appears to be fairly sophisticated and might suggest a helpful strategy to capture the complexity and co-morbidity in the child and adolescent group.

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

The RANZCP considers that – if possible – Australia should have an AMHCC that accounts for the most cost variance and makes sense to consumers and providers at a clinical and recovery level. The AMHCC should also be simple to administer and not lead to a net increase in administrators / coders or a decrease in clinical resources.

3. Are there any other principles that should be considered in developing the AMHCC?

Yes. In developing the AMHCC, the RANZCP believes that efficient and effective care that incorporates evidence supported practice and improved outcomes (clinical and recovery based) should be identified and supported.

The RANZCP also considers that Principle Two (clinical meaning) and Principle Four (patient / consumer based) principles should also include a statement around the importance of the systemic approach – that is, not just refer to an individual patient / consumer but to the whole system around the child.

4. Are there further data or other limitations of which the AMHCC should be aware?

The RANZCP notes that mental health care requires key partnerships with many other areas and service providers, including the National Disability Insurance Scheme, primary health, rehabilitation, vocational, accommodation and psychosocial services. The AMHCC should consider how to ensure that this partnership work is recognised.

5. Are there any other key considerations that should be taken into account in developing the AMHCC?

Other key considerations that should be taken into account in developing the AMHCC are the: developmental stage, intellectual capabilities, and somatic co-morbidities and how these impact on mental health care costs.

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

In regards to the cost drivers that should be considered in the development of the AMHCC, the Consultation Paper states in relation to research conducted by the University of Queensland (pp. 21):

> *The results of the quantitative analysis are consistent with the literature and confirm that mental health costs are driven by multiple factors, including (but not limited to) complications and comorbidities, symptom severity and function as well as some contribution from patient diagnosis as a lesser contributing factor.*

The RANZCP believes that the above description of cost drivers focuses on individual centric factors rather than system centric ones and that there should be a reference to system cost factors as these are vital drivers of outcomes and costs for child and adolescent mental health.

The RANZCP is also concerned that social determinants of mental health are not identified. An example is the case of a child with divorced parents with opposing and very different views on what is necessary for the treatment for their child. For clinicians, this often means that more than double the effort is needed, for instance, to clarify basic organisational issues such as informed consent for treatment than is the case when treating one adult.

Additionally, the RANZCP considers that a weighting system for systemic issues is needed for child and adolescent mental health services (CAMHS). For instance, the importance and impact of the school system on a child is great. Children spend a high percentage of their waking hours at school interacting with their teachers and peers. Therefore, intervening to alter the quality of the school environment can make a large difference to the child's mental health issues. This goes beyond care coordination to active interventions.

Other cost drivers that the RANZCP believes should be considered in the development of the AMHCC are: risk of aggression, suicide, social needs, accommodation, occupation, social and family supports.

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

In relation to the proposed architecture of the AMHCC, the RANZCP received feedback from Fellows who are child and adolescent psychiatrists and consultation-liaison (CL) psychiatrists. This is set out separately below.

Feedback from RANZCP Child and Adolescent Fellows

The Consultation Report sets out descriptive terms for phases of care in the Mental Health Costing Study – initial assessment, acute, functional gain, intensive extended and consolidating gain.

However, different issues arise for children with different presentations and that these phases of care seem adult focused and harder to fit with the needs of children and adolescents. For example, acute and functional gains phases are inter-related and impact on each other in a child and adolescent setting. The intensive extended phase for children and young people can be about keeping them alive long enough to allow brain maturation.

Reassessing the phase of care every 14 days seems a reasonable way of capturing cost drivers in the inpatient setting.

Feedback from RANZCP Consultation-Liaison Fellows

Feedback from RANZCP CL Fellows indicates that the concurrence of a 'mental health episode' and a 'non-mental health related episode' of illness is the norm rather than the exception and the inter-relationship of the two considerably complicates each of these.

At this point, it is not clear whether the separation of the two and the removal of any diagnostic component (including medical comorbidity) from the proposed AMHCC will in any way undermine the ability to detect costs or inputs attributable to CL staff. It is likely that this gap may manifest in the inability to capture data related to informal consultation or liaison activities, which is detailed further in the RANZCP's response under Question 11.

While the categories of 'selected interventions' appear to cover much of the work of CL psychiatry, there are some gaps. These include: subsequent review assessments after a comprehensive mental health assessment, cognitive and capacity assessments and the preparation of reports for tribunal hearings such as the Guardianship Tribunal.

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

The RANZCP does not have a response to this question.

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

The key issues in regards to psychological interventions are being developmentally appropriate, focusing on systemic interventions, particularly family environment, the role of school and other statutory bodies such as child protection.

The area that weights a diagnosis and leads to non or delayed responsiveness to treatment and, therefore, is a huge cost driver is social adversity. A number of risk factors around social adversity have been identified. These include: life events and situations (divorce and family breakup, physical, sexual and emotional abuse, homelessness), community factors (isolation, lack of support services), school context (bullying, peer rejection, inadequate behaviour management), and family factors (family violence and disharmony). These need to be reflected in classification and also designation of treatment interventions.

While family therapy has been included as an intervention, the RANZCP considers that the essential systemic work that goes beyond care coordination has not been captured. For example, the mental health of a child's parent/s, attitude and quality of school environment or quality of caregiving environment in residential setting. The developmental stage and intellectual capabilities of the child is also important here as this impacts on how the child copes within his or her environment. For instance, a crisis can be triggered by school-related stressors, which can often be due to the child being in the wrong school (mismatch between high school demands with regard to the developmental stage and intellectual capabilities).

Consultation and liaison is a vital role of CAMHS: this includes primary and secondary consultations to other stakeholders regarding their needs as well as care coordination and development of interventions for all of the relevant systems in a child's life. These interventions may not include direct contact with the child or his or her family but add significant value and must be costed.

Similarly, University of Queensland reports previously noted that:

- Other stakeholders stressed a need to ensure that systemic interventions, particularly relevant for children and adolescents, are included in the interventions classification (pp. 80). Guardianship and child protection legislation were also proposed as important drivers of costs, particularly for children and adolescents (pp. 81) (University of Queensland, 2013a).
- There are a number of deficits in the scope of the literature regarding cost drivers of mental health services, including a lack of studies focusing on children and older people, and limited ability to address potentially important predictors such as socio-economic characteristics, environmental factors and factors such as levels of social cohesion largely due to the limited scope of administrative datasets (University of Queensland, 2013b).

The RANZCP also has concerns about the table of National Outcome and Casemix Collection measures in Table 3 (pp. 29). These are that:

- the Strengths and Difficulties Questionnaire is not valid within 14 days and, therefore, does not lend itself to being used within the phases of care architecture where outcomes need to be measured fortnightly
- stakeholder feedback has already noted that the "Strengths and Difficulties Questionnaire for children cannot be re-collected in less than a month" (University of Queensland, 2013a pp. 79).

10. Are there particular aspects or areas of the AMHCC that should be prioritised in its development or aspects that should be developed at a later stage?

The RANZCP does not have a response to this question.

11. Are there any further considerations that should be taken into account when developing the AMHCC?

Yes. The RANZCP believes that the AMHCC's development should be aligned with the finalisation of the National Mental Health Service Planning Framework.

The RANZCP also has concerns about aspects of the AMHCC's development process to date in regards to the Mental Health Costing Study (Costing Study).

One concern is that the Costing Study went ahead without prior rigorous work on the AMHCC - in particular, the face validity of the categories to clinicians and without the classification consultations with clinical experts, which should have preceded the Costing Study.

Another is that the menu of mental health interventions to be chosen by respondents in the Costing Study is based on an over-inclusive descriptive listing of interventions, including irrelevant ones, gathered in an exercise coordinated by the Australian Institute of Health and Welfare (AIHW). Feedback from RANZCP members suggests that the AIHW did not intend its all-inclusive list of interventions – which were sourced from suggestions made by constituent organisations – to be used for such a purpose.

The RANZCP notes that the IHPA is now asking clinicians to nominate interventions being used in routine services. However, some interventions in this list are obscure and unlikely to be used while there is little differentiation between, range and granularity of community interventions, for instance.

RANZCP Fellows also participated in the Costing Study. Feedback from RANZCP CL Fellows from the two NSW sites where the CL data was being collected during the six month Costing Study suggests that their experiences were variable. Fellows also identified that the variable vigilance and commitment of individual clinicians to data entry was a potentially problematic issue.

For instance, at Concord Hospital - where clinical staff seemed unaware of the Costing Study or what it was for - data entry was performed by manual entry into the patient's electronic "Powerchart", which is not a full electronic medical record but rather a record of patient tests and consultations. Some clinicians reported that they found the data entry cumbersome and that there was no suitable category in which to place some interventions. These interventions included:

- attending liaison attachment meetings where general discussion of medical / surgical team patients occurred but not discussion on specific individual patients that the CL team had been consulted about
- informal discussions or advice (e.g. on the phone / in the hospital corridor) regarding patients who were not being formally consulted on by the CL team
- interventions performed after a patient was discharged (e.g. liaison with a General Practitioner or Community Mental Health Team).

At Royal North Shore Hospital, there was an awareness by some CL consultants of a number of weeks (not six months) of innovative data collection. Here, clinicians used a small portable device that read a bar code on the relevant patient's identification sticker and then the clinician entered the data. Feedback from clinicians indicated that they found this method to be user-friendly and acceptable for their needs. They also reported that the activity domains seemed to be appropriate and relevant and that it was helpful that data could be entered by a registrar, for instance, on behalf of another clinician. Although they did not seek to enter data that occurred after the discharge of patients, RANZCP Fellows commented that this method would theoretically enable the entry of data about other activities that were performed by CL teams after the patient was discharged, provided the system accepted such information. This would ideally be up to a three month window.

A related concern is the need for the data entry system to be able to receive the late entry of data. If data entry is not able to be done contemporaneously, data entry tasks might, in practice, be saved up until the end of the rotation or a quiet week. There must be capacity for the system to accept this kind of data.

References

University of Queensland (2013a) Cost Drivers and a Recommended Framework for Mental Health Classification Development Mental Health Service Cost Drivers Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project
Volume 1. Available at:
www.ihpa.gov.au/internet/ihpa/publishing.nsf/content/B2E9449CF2587A68CA257AD900131C84/$File/UQ_Stage%20B%20Final%20Report_Vol%201.pdf (accessed 5 February 2015).

University of Queensland (2013b) Cost Drivers and a Recommended Framework for Mental Health Classification Development Mental Health Service Cost Drivers Final report for Stage B of the Definition and Cost Drivers for Mental Health Services project
Volume 2. Available at:
www.ihpa.gov.au/internet/ihpa/publishing.nsf/content/B2E9449CF2587A68CA257AD900131C84/$File/UQ_Stage%20B%20Final%20Report_Vol%202.pdf (accessed 5 February 2015).