Submission from

The Australian Association of Social Workers

To the University of Queensland

for the

Consultation on the Definition of Mental Health Services

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AASW Major Concerns

The Australian Association of Social Workers (AASW) has particular concerns about the introduction of an Activity Based Funding (ABF) classification system for mental health services. We consider that the design of the Mental Health (MH) ABF should maintain, strengthen and extend national mental health reforms in which primacy is given to delivering mental health care and support in the person's own setting in their community. It should avoid any interpretation which could lead to a depletion of the range and accessibility of community-based care. Instead, the design should aim at enhancing the availability and accessibility of mental health treatment and support in community settings, which will reduce reliance on high cost inpatient care.

A further consideration is that the casemix formula must be based on contemporary models of mental health care. This would mean inclusion of a psychosocial assessment in addition to the usual mental state examination, and would also encompass psychosocial as well as pharmacological interventions. This is particularly relevant when considering contemporary recognition of the pivotal roles that family support and community acceptance play in the lives of people with mental illness and especially in their recovery. Modern evidenced-based practice acknowledges this component of psychosocial intervention as crucial to treatment and care. The AASW notes and welcomes the development of a nationally agreed set of clinical intervention codes (p.2). However, it is alarming that the target date for the introduction of this classification system is not until 2015.

The MH ABF classification system should also incorporate the participation of consumers and their carers in treatment planning and delivery. In addition, it should make allowance for input to assessment and treatment from relevant other services, such as drug and alcohol, primary health care, and Indigenous health services. In addition to casemix funding, consideration should also be given to block funding for core activities such as partnership building, research and development.

1. Consultation Question

Is a *Mental Health* Care Type the best way of encompassing those admitted services that should form part of a new national mental health classification?

AASW Response

The use of a Mental Health Care Type seems eminently sensible and the associated development of a national Mental Health Care Type is both overdue and welcome. Establishing a national blueprint which includes the identification of care types has been a longstanding objective of the national mental health reform agenda.

2. Consultation Question

What should be the criterion, or criteria, for the definition of services within a national Mental Health Care Type?

AASW Response

Use of a specialist mental health unit or program as the defining 'in-scope' criterion seems the most practical interim approach, given the problem of over-inclusivity identified by the paper in the existing ICD-10-AM diagnostic classification system. The paper also highlights limitations in the use of the more narrowly focused MDC19 category within the current AR-DRG system.

The paper also shows how the category of 'specialised mental health care days' could be deployed to deal with the potential difficulty of specialist mental health care being provided in a non-specialist unit or service. The examples given are well chosen to reflect current practice, such as mental health clinicians attending a person in a public hospital ED who is awaiting admission to a specialist mental health unit.

3. Consultation Question

What community-based mental health services should be defined as mental health services for casemix classification purposes?

AASW Response

Those community-based mental health services to be included in the definition should be those aiming to avert or minimise the need for acute inpatient admission, or to enable early discharge. Examples are mobile outreach home treatment teams, and step-up/step-down residential services which provide a short-term alternative to admission and/or a period of transition after discharge. However, the casemix classification should also encompass services designed to minimise relapse and re-admission.

4. Consultation Question

Are there any services that are provided by specialised mental health units or programs that can be considered primary mental health?

AASW Response

Specialised mental health units or programs provide specialist mental health care, typically characterised as secondary to the primary mental health care provided by GPs and Community Health Centres. Services provided by the Commonwealth funded youth mental health program, headspace, could also be considered to be primary mental health, as the program focuses on early identification and intervention for young people with mild to moderate mental health problems.

5. Consultation Question

Should the mental health classification include alcohol and drug-related disorders? If so, is it the diagnosis or specialised treatment setting that is used as the decisive criterion for inclusion in the definition?

AASW Response

Alcohol and drug-related disorders are often experienced concurrently with mental disorders. However, to avoid the over-inclusivity of the ICD-10-AM diagnostic system already identified, it would seem that the specialised mental health service or program should be the decisive criterion for inclusion.

6. Consultation Question

Should long-term non-acute bed-based clinically-staffed mental health public hospital services be classed as *residential, admitted mental health* or *admitted maintenance care?*

AASW Response

The Consultation Paper suggests that the mental health care currently classified as Maintenance be either renamed as Mental Health or as Maintenance (p.15).

It is desirable that the somewhat anachronistic and vague term 'Maintenance' is replaced. However, it is not clear whether only inpatient services are included in 'long-

term non-acute bed-based clinically-staffed mental health public hospital services', or whether this also covers other services based in community settings and funded by public hospitals. An example is community care units in Victoria.

The Consultation Paper does not identify the implications of just using the term 'Mental Health' as the classification category. An alternative term for this type of service would be 'mental health rehabilitation'. This would also cover inpatient mental health services funded and run by public hospitals which provide longer term treatment and rehabilitation, such as Secure Extended Care Units in Victoria.

7. Consultation Question

Should the Psychogeriatric Care Type continue to exist or should all of the mental health care of older people be defined as Mental Health for classification purposes?

AASW Response

There could be value in using a classification which would enable the differentiation and monitoring of mental health care for older people. For that reason, it would seem that the Psychogeriatric Care Type could usefully be retained.

The potential difficulty posed by some mental health care being provided to older people in specialist aged care units rather than specialist mental health units could be addressed as proposed under Consultation Question 2 in the current document. That is, it would be defined by the specialist mental health program delivering the care – typically mental health clinicians specialising in psychogeriatric assessment and treatment.

8. Consultation Question

Should mental health care in the emergency department (ED) be defined as ED or Mental Health for classification purposes?

If mental health encompasses emergency department care services, how should these services be classified eg. diagnosis based on MDCs?

AASW Response

It would seem that specialist mental health care delivered in EDs should be classified as Mental Health. This reflects the changes in mental health care provision following the mainstreaming of mental health services, and greater use of EDs for first and repeated acute mental health presentations.

Furthermore, in line with the approach proposed in Question 2 of the current document, rather than diagnosis being used as the defining criterion, the category of 'specialised mental health care days' could be used. In this instance, the mental health care would be provided by specialist mental health clinicians.

The Consultation Paper raises possible operational cost implications of including ED care in a Mental Health classification, pointing out that this could result in application of the 'more rigid rule' of mental health legislation to the physical restraint of patients in ED, rather than the 'duty of care' principles which currently used to guide practice (p.17). An alternative interpretation is that the application of mental health legislation to such situations is long overdue. For example, it could ensure that patients' rights are respected, and the use of physical restraints monitored and even possibly minimised or averted through training of ED staff in de-escalation techniques.

9. Consultation Question

Are there other examples of care models or pathways that are broadly similar, but are classified differently by jurisdictions in the mental health patient-level NMDSs?

AASW Response

One example is the home-based acute assessment and treatment provided by mobile outreach teams, such as Psychiatric Crisis Assessment and Treatment Services (CATS) in Victoria, and similar services under different titles in other jurisdictions. Whilst comparable to the HITH program provided by the South Australia Flinders Medical Centre, the patients of CATS have historically not been classed as admitted, even though since its inception in 1988 in Victoria (and earlier in New South Wales), this type of service has been designed to avert hospital admission and/or enable early discharge from an acute inpatient stay. Acute Care Teams (ACT) in Queensland, similar to CATS, are also classed as non-admitted. Community Care Units (CCU) in Queensland are classed as non-acute inpatient services, previously classed as extended treatment, and are specialist rehabilitation services designed to promote recovery in a community setting.

10. Consultation Question

How should current mental health NMDSs be adapted to facilitate the implementation of a mental health service classification without adding to the data collection burden that services and clinicians currently face?

AASW Response

The Consultation Paper identifies the three key steps required to produce a contemporary and comprehensive mental health service classification (p.19). These are the development of a Mental Health Interventions Classification; the establishment of an agreed national classification of services, which mapped services in terms of function not name; and routine linking of National Outcomes and Casemix Collection (NOCC) data to the Mental Health National Minimum Data Sets (NMDSs).

Ways to adapt the current mental health NMDSs to assist implementation of the national mental health service taxonomy and avoid an extra data collection burden requires close familiarity with the current NMDSs. From a service and clinician perspective however, there are at least two critical issues which affect whether data collection is experienced as burdensome. The first is whether information is provided on how the data will be used. The second is whether data reports are available on a regular basis and assist improvement of service performance and clinical practice.

Submitted for and on behalf of
the Australian Association of Social Workers Ltd

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