Independent Hospital Pricing Authority

Mental Health Phase of Care Clinical Refinement Testing Project

Final report

February 2021

IHPA

Mental Health Phase of Care Clinical Refinement Testing Project – final report – February 2021

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Authors

In June 2020, IHPA engaged an external specialist, Jennifer Nobbs, to lead Stage One of the Mental Health Phase of Care Clinical Refinement Testing Project in collaboration with an IHPA project team. This report has been co-authored by Ms Nobbs and IHPA.

Acronyms and abbreviations

ABF	Activity based funding
AMHCC Version 1.0	Australian Mental Health Care Classification Version 1.0
AR-DRGs	Australian Refined Diagnosis Related Groups
2017 Clinical Refinement Project	Mental Health Phase of Care Clinical Refinement Project, 2017-19
Clinical Refinement Testing Project	Mental Health Phase of Care Clinical Refinement Testing Project
AC1	Gwet's Agreement Coefficient statistic
HoNOS	Health of the Nation Outcome Scales
HONOS65+	Health of the Nation Outcome Scales for Elderly People
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents
IHPA	Independent Hospital Pricing Authority
IRR	Inter-rater reliability
LSP-16	Abbreviated Life Skills Profile
2016 IRR Study	Mental Health Phase of Care Inter-Rater Reliability Study, 2016-17
MHWG	Mental Health Working Group
np	Not provided – in instances of very low sample counts (≤ 4), agreement statistics have been suppressed for confidentiality purposes

Study cohorts

Study 1	2016 IRR Study
Option 1	Set of phase of care definitions used in Study 1
Group 1	Respondents in Study 1
Study 2	Clinical Refinement Testing Project – Stage One (this project)
Option 2A	First set of phase of care definitions tested in Study 2: acute, subacute, non-acute, assessment only
Option 2B	Second set of phase of care definitions tested in Study 2: acute, subacute, rehabilitation and recovery, non-acute, assessment only
Group 2A	Respondents in Study 2 that completed training on Option 2A
Group 2B	Respondents in Study 2 that completed training on Option 2B

Mental health phases of care

Refer to sections 1.1.3 and 1.2.2 for definitions.

AC	Acute (Studies 1 and 2, noting definitions differ between Studies)
AO	Assessment Only (Studies 1 and 2, noting definitions differ between Studies)
CG	Consolidating Gain (Study 1)
FG	Functional Gain (Study 1)
IE	Intensive Extended (Study 1)
NA	Non-acute (Study 2)
RR	Rehabilitation and Recovery (Study 2)
SA	Subacute (Study 2)

Contents

Executive summary

Overview

This study concerns the 'mental health phase of care' concept used in the Australian Mental Health Care Classification (AMHCC). The aim of the study is to determine whether proposed refinements to mental health phase of care improve the consistency with which it is applied by clinicians and its clinical meaningfulness. These findings will be used to inform refinements to the AMHCC.

The study compares the existing mental health phase of care definition with two alternative definitions proposed in the 2017 Clinical Refinement Project. The existing definition is referred to here as Option 1 and the two alternative definitions are referred to as Options 2A and 2B.

The differences in phase grouping and terminology across the three definitions can be summarised as:

- Option 1 (existing) – five phases: 'acute', 'functional gain', 'intensive extended', 'consolidating gain' and 'assessment only'.
- Option 2A (alternative) – three phases: 'acute', 'subacute' and 'non-acute', with 'assessment only' becoming an administrative data item.
- Option 2B (alternative) – four phases: 'acute', 'subacute', 'rehabilitation and recovery' and 'non-acute', with 'assessment only' becoming an administrative data item.

The study was designed as an inter-rater reliability (IRR) study in which mental health clinicians from all states and territories participated in one-off online training and survey sessions from August to October 2020. Clinicians were provided with brief training on assigning one of the alternative 'mental health phase of care' options, and then asked to review a series of fictional clinical vignettes and assign a phase to each vignette. Additional quantitative and qualitative feedback was also sought from the clinicians.

The resulting data was combined with data collected in the 'Mental Health Phase of Care IRR Study, 2016-17' (2016 IRR Study), which enabled comparisons to be made on the extent of agreement among clinicians assigning phase of care using the existing definition (Option 1) with those using alternative definitions (Options 2A and 2B).

Drawing together the key findings from the study, there was an overall improvement in the kappa statistic IRR from Study 1 to Study 2. The new phases proposed – 'subacute', 'rehabilitation and recovery' and 'non-acute' – did not offer a major improvement in statistical performance. However, there was consistent clinician feedback which supported the introduction of Study 2 phases, in particular Option 2B.

This report concludes that there is value in incorporating the improvements offered by the new Option 2B phase definitions in the next iteration of the AMHCC.

Age-specific guidance should also be provided to improve the interpretation and use of phase of care within each age cohort. In addition, updates to the classification should also consider how to best describe the 'intensive extended' cohort.

On the basis of these findings, this report proposes two possible approaches to improving the interpretation and use of the phase of care concept:

- Approach 1: Retain the structure and terminology (phase names) of the current mental health phase of care concept, with updates to the individual phase definitions including age-specific guidance.
- Approach 2: Retain the current mental health phase of care concept, with updates to the terminology (phase names) and individual phase definitions, including age-specific guidance.

It is proposed that the 'assessment only' phase is redefined as an administrative data item in both of these approaches.

In addition to these and IHPA's ongoing work program for the AMHCC, the report makes further recommendations to improve education and training resources and increase the value of the AMHCC locally. It also outlines the further work to be undertaken to implement either of the approaches outlined above.

Analytical approach

After data preparation including data exclusions, 257 respondents were included in the final dataset across Options 2A (124 respondents) and 2B (133 respondents), providing 1870 vignette ratings. The prepared data also included 352 respondents and 2113 vignette ratings from the 2016 IRR Study.

Analysis focused on assessing whether the proposed mental health phase of care options outperformed the existing phases in terms of reliability and clinical meaningfulness. Reliability was measured using two approaches, consistent with the 2016 IRR Study:

- Kappa statistic (k): This is a commonly used approach for IRR studies to measure agreement. It considers agreement over and above what would be expected as 'chance' and is therefore more robust than simple raw agreement percentages.
- Raw agreement: This compares the phases of care which respondents assigned to individual vignettes against the 'true' phase described in the vignette, to report the 'percentage correct' rate. For example, if a vignette describes an 'acute' phase, and 60 of 100 respondents rated the vignette as 'acute', then the raw agreement rate would be 60 per cent.

Clinical meaningfulness was assessed using further quantitative and qualitative feedback from the survey and group discussions.

Table 1 sets out the terms used to describe the three datasets being compared in this report.

Table 1: Terminology used to describe study cohorts

Study	Phase of care definitions	Respondents
Study 1: 2016 IRR Study	Option 1: acute, functional gain, intensive extended, consolidating gain and assessment only (AMHCC Version 1.0)	Group 1
Study 2: Stage One of the Clinical Refinement Testing Project (this project)	Option 2A: acute, subacute, non-acute and assessment only (2017 Clinical Refinement Project Option A)	Group 2A
	Option 2B: acute, subacute, rehabilitation and recovery, non-acute and assessment only (2017 Clinical Refinement Project Option B)	Group 2B

Results have been considered by three age cohorts, based on the separation in clinical specialties and the vignettes used in the study: child and adolescent (0-17 years), adult (18-64 years) and older persons (65+ years).

Key findings

The kappa statistic improved from Study 1 to Study 2, demonstrating an improvement in the IRR of phase of care. Clinicians also reported that they preferred the Study 2 phase names and definitions, in particular Option 2B.

Statistical agreement

Overall, there has been an improvement in the kappa statistic from Study 1 to Study 2.

As Table 2 shows, the kappa agreement for Group 1 was 0.396[1]. This increased to 0.441 for Group 2B and further to 0.495 for Group 2A, which represent relative increases in kappa agreement from Study 1 of 11 per cent and 25 per cent, respectively.

Table 2: Overall kappa agreement statistics

Kappa Agreement Statistics		
Group 1	Group 2A	Group 2B
0.396	0.495	0.441

Table 3 shows the same trend increase in the kappa statistic from Group 1 to 2B to 2A across all vignette age groups, albeit with a very minor increase from Group 1 to 2B for adult vignettes, and a minor increase from Group 2B to 2A for child and adolescent vignettes. The significant improvement in kappa agreement statistics for older persons should be noted with caution given the small sample sizes (16 and 15 respondents in Groups 2A and 2B respectively).

Table 3: Kappa agreement statistics by vignette age group

	Respondents			Kappa Agreement Statistics		
Vignette Age Group	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Children and adolescents	64	20	20	0.375	0.450	0.434
Adults	258	88	98	0.351	0.411	0.352
Older persons	30	16	15	0.436	0.616	0.530

The difference in agreement by vignette age group suggests that the phase definitions vary in relevance and applicability by age cohort. This is consistent with clinician feedback discussed below.

Variation between phases

Comparing Options 2A and 2B, and looking further to identify where the greatest variability lies between phase choices, showed that introducing a split between ‘subacute’ and ‘rehabilitation and recovery’ decreased the kappa statistic IRR. This ‘subacute/ rehabilitation and recovery’ variation was supported by raw agreement analysis, which also found some confusion among Group 2B clinicians regarding ‘rehabilitation and recovery’ and ‘non-acute’ phase assignment (section 9.2.4).

Variation across age groups

Aside from the ‘acute’ and ‘assessment only’ phases, there is considerable variation in the phase-level IRR statistics across vignette age groups for each study (see section 9.2.2). This suggests variability in phase application or interpretation across age groups.

[1] Note that the Group 1 statistics reported here vary from those detailed in the IRR Study 1 Report due to differences in data preparation designed to ensure comparability between Study 1 and 2. See sections 8.2 and 8.3 for further details.

Clinician views

The clinician feedback from both the survey and group discussions covered a wide range of issues, of value in both determining the next steps in refining the classification itself, and its implementation. Of most relevance for determining the next steps in this project are the following:

Identifying a preferred set of phases

- In the majority of group discussions, the alternative phase of care definitions were seen to be an improvement on the current definition. Of the two alternative definitions, clinicians reported a preference for Option 2B. Clinicians stated that the proposed phases are clearer and more intuitive and relatable.
- There was feedback that the 'subacute' definition used in Option 2A is too broad. However, there was also feedback that the split between 'rehabilitation and recovery' in Option 2B and 'non-acute' is unclear with significant crossover between them.
- There was feedback that chronically unwell consumers are not well described within the phase definitions, as they are in the AMHCC Version 1.0 with the 'intensive extended' phase.

Considerations in application

- There was caution offered that interpretation of phase of care varies depending on the service setting and age group of the consumer that a clinician is treating, in particular how acuity, risk and level of independence are assessed.
- Clinicians also advised that there is potential confusion if the phase name does not match the name of the mental health team providing care, for example, assigning a 'subacute' phase to someone being seen by an acute service.
- Clinicians reported that phase assignment is frequently focused solely on the phase name, so training should ensure a consistent understanding of these. However, it should also be tailored to account for local terminology and system structures.

Conclusions

Drawing together the key findings from the study, there was an overall improvement in IRR from Study 1 to Study 2, with clinician support for the Study 2 phase of care definitions.

The new phases proposed – 'subacute', 'rehabilitation and recovery' and 'non-acute' – did not offer a major improvement in statistical performance. However, there was consistent clinician feedback which supported the introduction of Study 2 phases, in particular Option 2B.

Whilst Option 2A outperformed Option 2B in IRR, introducing a split between 'subacute' and 'rehabilitation and recovery' decreased the kappa statistic IRR for Option 2B. This should be taken into account when comparing between the Study 2 options and balanced against clinician support for Option 2B.

In light of these findings, the next iteration of the AMHCC should incorporate the improvements offered by the new Option 2B phase definitions.

Across Options 1, 2A and 2B variation was observed in phase of care performance by clinical age group, with definitions best suited to the adult cohort. Consequently, there is value in updating the phase definitions (the primary goal of care) and supporting materials to better describe the goals and risk thresholds as they differ for children and adolescents, and older persons.

There was also consistent clinician feedback that the phase definitions in both Options 2A and 2B do not adequately classify all cases covered by the existing 'intensive extended' phase. This feedback was supported by relatively lower IRR scores among phases other than the 'acute'

phase. Overall, Option 2B provides the best set of phases, but there is an opportunity to refine the AMHCC to better capture this group. This could include, for example, review of Health of the Nation Outcome Scales scores and weightings to refine the AMHCC end classes.

On the basis of these findings, the next iteration of the AMHCC should include the updating of phase of care definitions and supporting materials to:

- **Improve their interpretation and use within each age cohort.**
- **Ensure phase definitions and/or classification end classes adequately classify cases captured under the existing 'intensive extended' phase.**

Regardless of any future changes made to phase of care, there is value in improving the quality and consistency of phase of care training. Feedback from clinicians included that phase assignment is frequently focused solely on the phase name, so training should focus on a consistent understanding of the names, recognising that definitions and supporting materials may not be referenced regularly.

There is also unmet need in community mental health services in some states and territories for phase of care or AMHCC reports to be provided locally to assist in understanding service utilisation for local planning purposes. Promoting local tools such as these will increase the value of the AMHCC locally and improve quality of data through a feedback loop.

These opportunities to improve the implementation and value of phase of care and the AMHCC should be pursued by IHPA and states and territories regardless of the outcome of phase of care definitional changes.

Finally, Stage Two as described prior to the commencement of this study is no longer a suitable option. The recommendations set out in this report include an outline of 'next steps' which involve work to update phase of care definitions based on the findings from this study, and mapping of existing phase of care data to new phase names to further progress the AMHCC work program.

Recommendations

IHPA should continue its normal work program to refine the AMHCC, informed by national data reporting to improve the overall performance of the classification.

In addition to this, two potential approaches to phase of care refinement are set out below. The first approach retains the current phase of care names, whilst the second adopts a new set of phase names.

Approach 1: Retain the structure and terminology (phase names) of the current mental health phase of care concept, with updates to the individual phase definitions including age-specific guidance

There is clear clinician support for Option 2B definitions with some improvement in IRR, but the statistical analysis does not strongly support full adoption of the Option 2B definitions at this point. Therefore, this approach does not change the phase of care names but focuses on improving the phase definitions and supporting material. This approach includes the following changes:

- Retain AMHCC Version 1.0 phase of care names, redefining 'assessment only' as an administrative data item in line with the 2017 Clinical Refinement Project recommendation.
- Develop age-specific updates to the definitions for all phases of care to better describe the goals and risk thresholds as they differ across age groups. These updates should incorporate refinements to the 'acute' phase and 'assessment only' data item definitions proposed in the

2017 Clinical Refinement Project, noting the improvement in IRR when these were applied in Study 2.

- Given clinician support for Option 2B phase names, consider how this language can best be incorporated into the updated phase definitions and/or supporting materials.

Approach 2: Retain the current mental health phase of care concept, with updates to the terminology (phase names) and individual phase definitions, including age-specific guidance

There is clear clinician support for changes to the phase of care names with some improvement in IRR and a preference for Option 2B. Given that routine application of phase of care focuses on selecting a phase based on its name rather than by reference to its detailed definition, the most effective way to improve clarity on phase of care and therefore IRR is to change the names of the phases. This approach includes the following changes:

- Adopt Option 2B phase names and develop age-specific updates to the phase definitions to better describe the goals and risk thresholds as they differ across age groups.
- Noting feedback from the study that the 'intensive extended' cohort are not easily identifiable in the Option 2B phases, a review of patient-level data should be included in the ongoing AMHCC work program to consider whether this cohort can better be described in the classification. This could include, for example, refinement of the end classes.

Further opportunities to improve the consistent application and value of phase of care

The following recommendations should be adopted irrespective of the adoption of either Approach 1 or 2.

Improved education and training resources

- Develop a set of national training resources informed by the findings from this project for local use and adaption, to include age-specific and setting-specific materials.
- Include training materials on the AMHCC as a full classification, so that clinicians can better contextualise phase of care and understand how it works with other classification variables.
- Provide individual feedback to states and territories on Study 2 IRR performance within their jurisdiction, to enable them to target training needs.

Increasing the value of the AMHCC to improve its usefulness and performance

- Through clinician feedback it is clear that a number of community mental health services would find value in local reports on service utilisation by phase of care or AMHCC end class. IHPA should work with states and territories to share examples of where this is currently occurring to enable other jurisdictions to develop similar reports.

Next steps

Further work is required to be undertaken to implement either of the approaches outlined above. The steps required by IHPA include:

- Approaches 1 and 2: Consult with jurisdictions, clinicians and subject matter experts to develop age-specific updates to phase of care definitions and supporting materials.
- Approach 2 only: Undertake work to map existing patient-level phase of care data to the new phase names for AMHCC classification development and pricing purposes. The mapping process should be undertaken in close consultation with jurisdictions through the Mental Health Working Group, informed by the phase of care reassignment process undertaken for

the study's clinical vignettes (section 5.1). This will provide a national dataset suitable for progression of the AMHCC work program, recognising that the dataset will improve over time as the changes to phase names, definitions and supporting materials improve the IRR.

1. Background

1.1 Australian Mental Health Care Classification Version 1.0

1.1.1 Development of the AMHCC Version 1.0

As part of its functions under the National Health Reform Agreement, IHPA has developed a classification for mental health care, the Australian Mental Health Care Classification (AMHCC). The classification improves the clinical meaningfulness of the way that mental health care services are classified and will be used to price mental health services nationally as part of activity based funding (ABF). Admitted mental health care is currently priced using Australian Refined Diagnosis Related Groups (AR-DRGs) (the diagnosis-based system used to classify admitted acute care) and ambulatory/community mental health care is block funded due to less robust activity and cost data.

It has been widely recognised that the AR-DRG system is not an optimal classification for ABF of admitted mental health care due to consumer diagnosis not being the sole driver of costs.

On 25 February 2016, the Pricing Authority approved the AMHCC Version 1.0. The AMHCC was implemented on a 'best endeavours' basis from 1 July 2016, with work to price mental health care using the AMHCC ongoing.

The AMHCC Version 1.0 covers the admitted and community settings. At this stage, there is not enough data to develop the residential setting of the classification, and IHPA will review the development of this branch when more robust data becomes available.

1.1.2 Structure of the AMHCC Version 1.0

Figure 1 and Figure 2 provide an overview of the structure of the AMHCC. There are six major splitting variables: setting, mental health phase of care, age, mental health legal status (admitted only), Health of the Nation Outcome Scales (HoNOS) score, and Abbreviated Life Skills Profile (LSP-16) score (community only).

A detailed description of the classification and each of its variables is provided in the AMHCC Version 1.0 User Manual. Mental health phase of care is described in more detail below.

All the variables except mental health phase of care were established data items collected and reported as part of normal clinical practise. Mental health phase of care was a new concept developed as part of the AMHCC.

Figure 1: AMHCC Version 1.0 admitted setting structure

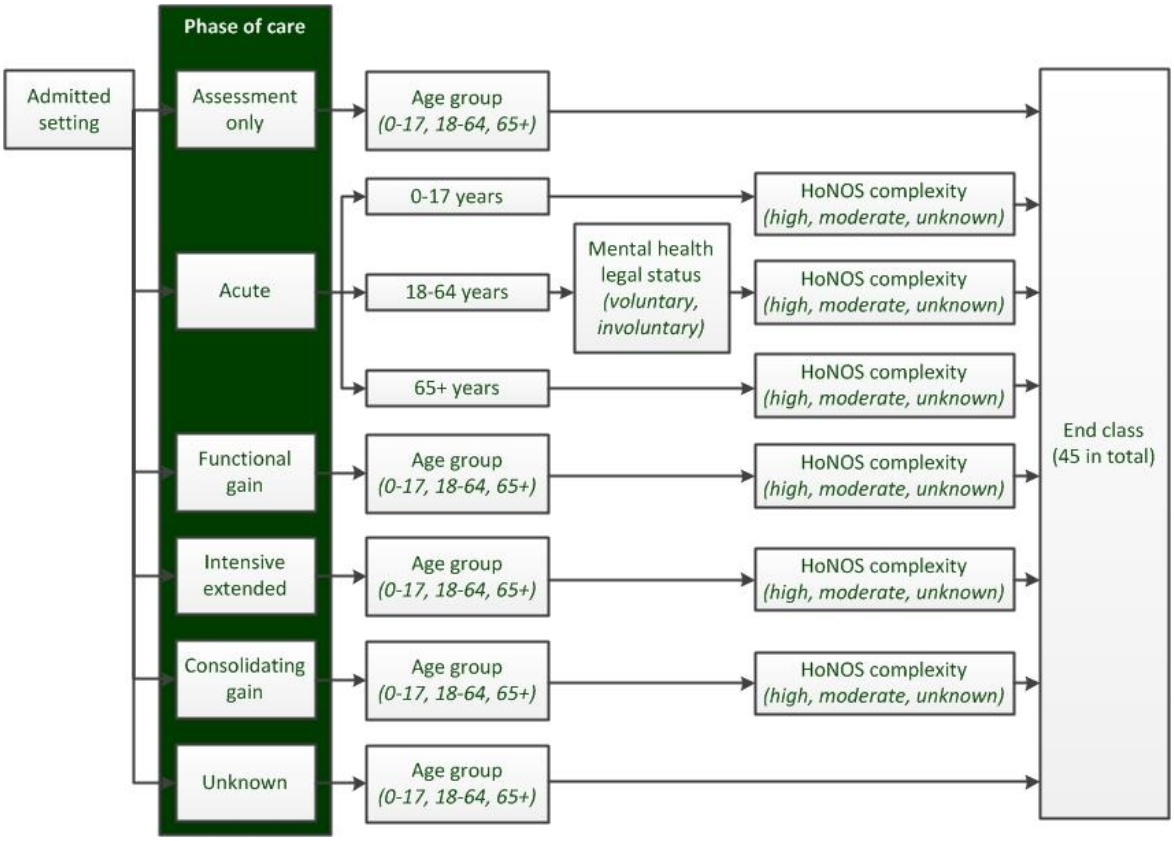
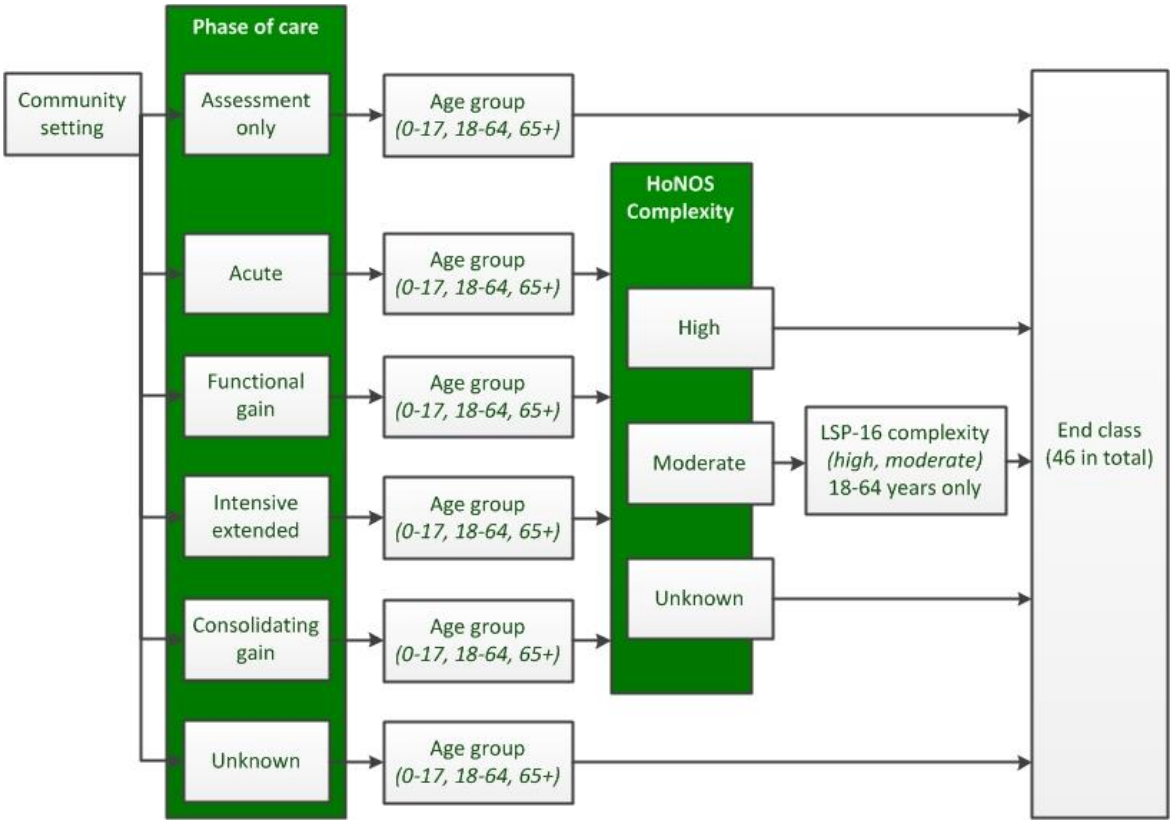


Figure 2: AMHCC Version 1.0 community setting structure



1.1.3 Mental health phase of care

Mental health phase of care is defined[2] as:

The prospective primary goal of treatment within an episode of care in terms of the recognised phases of mental health care. Whilst it is recognised that there may be aspects of each mental health phase of care represented in the consumer's mental health plan, the mental health phase of care is intended to identify the main goal or aim that will underpin the next period of care.

The mental health phase of care is independent of both the treatment setting and the designation of the treating service, and does not reflect service unit type.

In the AMHCC Version 1.0 there are five phases of care, as set out in Table 4.

The mental health phase of care is assessed by a healthcare professional directly involved in a consumer's care. It is the primary goal of care that is reflected in the consumer's mental health treatment plan. The phase of care reflects a prospective assessment of the primary goal of care at the time of collection, rather than a retrospective assessment.

A new phase of care begins either when a consumer commences an episode of care or when the consumer's primary goal of care changes in an existing episode of care. The episode of care is defined as the period between the commencement and completion of care characterised by the mental health care type[3]. An episode of care may have multiple phases of care. The consumer's mental health care needs may change as they move between different phases of an episode and accordingly, the goal of care and the need for resources may change. Consumers may move between any of the phases of care in any order.

Table 4: AMHCC Version 1.0 mental health phase of care definitions

Phase name	Primary goal of care
Acute	The primary goal of care is the short term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder.
Functional gain	The primary goal of care is to improve personal, social or occupational functioning or promote psychosocial adaptation in a patient with impairment arising from a psychiatric disorder.
Intensive extended	The primary goal of care is prevention or minimisation of further deterioration, and reduction of risk of harm in a patient who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period.
Consolidating gain	The primary goal of care is to maintain the level of functioning, or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the patient has stabilised and functions relatively independently. Consolidating gain may also be known as maintenance.
Assessment only	The primary goal of care is to obtain information, including collateral information where possible, in order to determine the intervention/treatment needs and to arrange for this to occur (includes brief history, risk assessment, referral to treating team or other service).

[2] Australian Institute of Health and Welfare. (2018). Mental health phase of care. Retrieved 26 November 2020 from http://meteor.aihw.gov.au/content/index.phtml/itemId/682464

[3] Australian Institute of Health and Welfare. (2018). Episode of mental health care – Identifier. Retrieved 26 November 2020 from http://meteor.aihw.gov.au/content/index.phtml/itemId/654429

The classification also provides for 'unknown phase' that should only be used when a phase of care is unable to be reported to the primary data collection. Where missing or incomplete data (for example, phase of care or HoNOS) is submitted, this will result in an 'Unknown' end class.

There are three descriptive elements to the phases of care:

- Phase name: these are the defined permissible values for the data element 'phase of care'[4].
- Phase definitions: these describe the primary goal of care for each phase of care (as set out in Table 4 for AMHCC Version 1.0).
- Supporting materials: this includes descriptions of consumer characteristics, clinician activity or expectation, and indicators of phase start and end as set out in the *Mental Health Phase of Care Guide*[5].

1.2 Review of mental health phase of care

Upon finalisation of the AMHCC Version 1.0, IHPA developed a schedule for long term review and refinement of the classification. As mental health phase of care was a new concept introduced with the classification and dependent on consistent application amongst clinicians, it has been the early focus of this work.

Two studies were undertaken prior to this report:

- An initial Mental Health Phase of Care Inter-Rater Reliability (IRR) Study over 2016–17 which tested the consistency with which phase of care was applied by clinicians and gathered information about clinicians' views on phase of care.
- A follow up Mental Health Phase of Care Clinical Refinement Project over 2017–19 which built on the findings from the 2016 IRR Study to develop options for new phase names and descriptions to increase clinical understanding, relevance and therefore IRR.

1.2.1 Key findings from the studies

For the AMHCC to function well, mental health phase of care needs to be understood and applied consistently by the clinicians assigning it. The 2016 IRR Study sought to test this by measuring the IRR of phase of care.

IRR is a measure of agreement amongst 'raters'. In the 2016 IRR Study it measured the extent to which different mental health clinicians (the raters) agreed on the phase of care to be assigned to an individual mental health consumer at a given time (as described in a fictional 'clinical vignette').

The 2016 IRR Study found that mental health phase of care currently has poor to fair IRR.

However, there was broad support for the concept and its usefulness in clinical practice, with these IRR results to be expected in early implementation. The 2016 IRR Study recommended a training program to improve understanding and application of the AMHCC and phase of care.

It also recommended that IHPA consider modifications to mental health phase of care definitions and/or phase names that increase clarity and reduce ambiguity.

Based on this recommendation, the 2017 Clinical Refinement Project was undertaken. The aim of the 2017 Clinical Refinement Project was to identify the cause of the poor IRR and refine mental health phase of care to improve the consistency of clinical application.

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[4] Australian Institute of Health and Welfare. (2018). Mental health phase of care. Retrieved 26 November 2020 from http://meteor.aihw.gov.au/content/index.phtml/itemId/682464

[5] Independent Hospital Pricing Authority. (2016). Australian Mental Health Care Classification, Mental Health Phase of Care Guide, Version 1.2. June 2016. Retrieved 21 December 2020 from https://www.ihpa.gov.au/publications/mental-health-phase-care-guide

A detailed review of the phases of care was undertaken by six mental health clinicians. They found that the phases needed to be more consistently aligned, both with each other to avoid overlap, and in their emphasis on describing the phase of intended care to be provided as opposed to the outcome expected of the consumer. Alignment to type of care provided would reduce the overlap between phases and provide a system for clinicians to assess their patients' needs more intuitively.

Two alternative sets of phase names and definitions were developed as part of the 2017 Clinical Refinement Project, both aligned to the primary goal of care. It was recommended that IHPA consult with jurisdictions on these options and test the preferred approach.

1.2.2 Phase of care 'options' proposed by the 2017 Clinical Refinement Project

The 2017 Clinical Refinement Project proposed two alternative options for mental health phase of care, based on detailed clinical review and consultation:

- Option 2A: Three phases ('acute', 'subacute', 'non-acute') and one administrative data item ('assessment only').
- Option 2B: Four phases and one administrative data item – the same as Option 2A except that the 'subacute' phase is split into two phases ('subacute' and 'rehabilitation and recovery').

These are detailed in Table 5 at the end of this chapter. The text used for primary goals of care and activities is the same in both options, with the text used for 'subacute' and 'rehabilitation and recovery' in Option 2B grouped together under 'subacute' in Option 2A.

Assessment only: The 2017 Clinical Refinement Project recommended that 'assessment only' be redefined from a phase of care to an administrative data item to allow for greater flexibility in capturing triage and assessment activity without encumbering this activity with business rules commonly associated with mental health phase of care.

1.2.3 Jurisdictional consultation on phase of care options

In 2019, IHPA consulted with jurisdictions on these options through its Mental Health Working Group (MHWG), which comprises of representatives of all jurisdictions, mental health peak bodies and mental health consumer and carer groups, as well as clinical experts.

Feedback from the MHWG included that Option 2A was more intuitive in terms of intensity of care and would likely result in improved IRR given the lower number of phases of care.

As Option 2B separates consumers into more granular categories, it could potentially allow more distinct costing and pricing. The 'rehabilitation and recovery' phase also aligns to allied health practises. The main concern raised through the MHWG was that this phase could be a part of other phases, especially 'subacute', leading to potential IRR issues.

In line with the 2017 Clinical Refinement Project's recommendation, further testing was supported prior to agreement on the appropriate approach.

1.3 Approach to testing

Following consultation with the MHWG in late 2019, a two-stage testing approach was agreed:

- **Stage One:** Utilise clinical vignettes developed as part of the 2016 IRR Study to assess (a) whether the proposed phase of care options outperform those in the AMHCC Version 1.0, and (b) which of the two proposed options has better IRR.

Then, if required:

- **Stage Two:** Activity and cost data collection from actual consumer episodes to assess the clinical and cost homogeneity of subgroups to determine the most suitable phase of care option.

As Stage Two would be considerably more resource intensive, Stage One vignette testing would provide information on whether either of the proposed new options offered improved IRR, before deciding whether to progress with Stage Two. This document details the Stage One process.

1.4 Related reports

The Mental Health Phase of Care Clinical Refinement Testing Project builds on previous studies undertaken by or for IHPA to develop and refine the AMHCC including:

- Definitions and Cost Drivers for Mental Health Services Project, 2013
- Mental Health Costing Study, 2014-2016
- AMHCC development public consultations: January 2015 and November 2015
- AMHCC Version 1.0 Pilot Study, 2015
- Mental Health Phase of Care Inter-Rater Reliability Study, 2016-17
- Mental Health Phase of Care Clinical Refinement Project, 2017-19

Table 5: 2017 Clinical Refinement Project – proposed phases of care and definitions

Option 2A phase name	Primary goals of care	Activities	Option 2B phase name
Acute	The primary goals of care are intended to reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk.	Provided predominantly in a hospital setting but may also be provided in an assertive ambulatory setting. Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.	**Acute**
Subacute ***or*** **(in Option 1 either goal/ activity may apply)**	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to mitigate or prevent relapse into acute mental health ('Stepping up in Care').	Provided in either hospital or ambulatory settings. The primary focus is on providing assertive activities and interventions which prevent relapse of an acute phase. Activities include monitoring early warning signs, supports from family and others, medication treatment and safety concerns.	**Subacute**
	The primary goals of care are to restabilise recovery and promote a return to previously observed function. To increase independence and social/vocational integration via a program of skills acquisition ('Stepping down in care').	Provided in either hospital or ambulatory settings. Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.	**Rehabilitation and recovery**
Non-acute	The primary goals of care include supporting ongoing independence, quality of life and functional stability that consolidates recovery and assists community integration.	Provided predominantly in an ambulatory setting. Low levels of routine activity are required to support and maintain symptoms and impairment that has been stabilised. Engage NGOs and shared care agencies to achieve safe and effective discharge.	**Non-acute**
Assessment only data item	The goal is to obtain information, including collateral information where possible, in order to determine the consumer complexity and need for intervention.	Includes brief history, risk assessment, clinical screening and information gathering.	**Assessment only data item**

2. Aims and objectives

The aim of the Mental Health Phase of Care Clinical Refinement Testing Project is to determine whether proposed refinements to mental health phase of care, made as part of the 2017 Clinical Refinement Project, improve the consistency with which phase of care is applied by clinicians (its 'inter-rater reliability') and its clinical meaningfulness. These findings will be used to determine whether refinements should be made to the Australian Mental Health Care Classification (AMHCC).

As outlined at section 1.3, a two-stage approach was proposed for the project.

The objectives of Stage One (this stage) were to utilise clinical vignettes developed as part of the 2016 IRR Study to:

- Assess whether the proposed mental health phase of care options outperform the existing phases of care in terms of reliability and clinical meaningfulness.
- Identify which of the proposed phase of care options is preferred.
- Determine whether further testing is required using activity and cost data from actual consumer episodes.

The proposal for Stage Two, if required, would comprise of further testing activity and cost data from actual consumer episodes to further assess the proposed phase of care options.

This report describes the work undertaken for Stage One, the findings and recommendations. The findings detailed here will be considered by IHPA's key stakeholders to inform the next steps in development of the AMHCC.

3. Methodology

Stage One of the Clinical Refinement Testing Project comprised three parts:

- **Part 1:** Study preparation including site/participant nomination and selection, vignette review and selection, development of training materials and development of the survey tool (June to August 2020).
- **Part 2:** Site testing, which involved a series of group training sessions and online surveys. This part collected quantitative and qualitative data about the proposed mental health phase of care options (August to October 2020).
- **Part 3:** Analysis and review of the data, comparison to the 2016 Inter-Rater Reliability (IRR) Study (Study 1), development of recommendations and assessment of these by key stakeholders (September 2020 to June 2021).

Each of these steps are described in detail in the following chapters.

3.1 Terminology: study cohorts

Table 6 sets out the terms used to describe the cohorts being compared in this report.

Table 6: Terminology used to describe study cohorts

Study	Phase of care definitions	Respondents
Study 1: 2016 IRR Study	Option 1: acute, functional gain, intensive extended, consolidating gain and assessment only (AMHCC Version 1.0)	Group 1
Study 2: Stage One of the Clinical Refinement Testing Project (this project)	Option 2A: acute, subacute, non-acute and assessment only (2017 Clinical Refinement Project Option A)	Group 2A
	Option 2B: acute, subacute, rehabilitation and recovery, non-acute and assessment only (2017 Clinical Refinement Project Option B)	Group 2B

3.2 Consistency with Study 1

One of the aims of this project was to assess whether either or both proposed mental health phase of care options outperforms the existing phases, as tested in the 2016 IRR Study, or 'Study 1'.

As this project ('Study 2') utilised clinical vignettes from Study 1, data from the two studies could be directly compared to answer this question. To enable comparison of results, the broad structure of Study 1's training, survey and statistical analysis was maintained where appropriate. In some instances, a different approach was taken, for example due to the use of pre-existing materials from Study 1 such as clinical vignettes, or the application of learnings from that project. Major structural differences to Study 1's approach are discussed below; minor variations are noted in the following chapters.

3.2.1 Testing different phase of care definitions

The main difference between Study 1 and Study 2 was the testing of two different sets of phase of care definitions (Options 2A and 2B, as described in Table 5).

To do this, respondent groups were labelled as either 'Group 2A' or 'Group 2B'. Group 2A received training on Option 2A and rated vignettes using these definitions. After rating the vignettes and returning to the group, Group 2A were introduced to the 'subacute/ rehabilitation and recovery split' and asked to vote, within a group setting, on whether a short series of vignettes were 'subacute' or 'rehabilitation and recovery', and whether the additional phase split made the phases more clinically meaningful and relevant.

Group 2B received training on Option 2B and rated vignettes using these definitions. After rating the vignettes and returning to the group, Group 2B were informed of an alternative option that merged the two phases. They were then asked to vote on whether the additional phase split made the phases more clinically meaningful and relevant.

The approach for splitting respondents into Groups 2A and 2B and training on the change to the phase definitions in described in more detail in the following chapters.

Whilst the 2017 Clinical Refinement Project proposed that 'assessment only' be redefined as an administrative data item, for simplicity in this study all categories were described to respondents as 'phases of care'. Since respondents were not required to apply the business rules associated with assigning a phase of care, this distinction was not considered relevant to the study and allowed training time to focus on the differences between the definitions themselves.

3.2.2 Test-retest reliability

In addition to the main training and testing of phase of care, which was delivered face-to-face in the Study 1 and online in this project, Study 1 included an additional online data collection component to examine the test-retest reliability of phase of care. However, only 26 people (five per cent of total completion rate) participated in both face-to-face and online testing in Study 1.

Based on the low participation rate and limited value obtained from this element of the study, a test-retest component was not included for comparison in Study 2.

3.3 Analytical approach

The report presents:

- Statistical analysis of the data captured through individual surveys in Studies 1 and 2, focusing on the kappa statistic and raw agreement rates. These approaches are described further at section 9.1.
- Summaries of qualitative feedback from Study 2, from individual surveys and group discussions.

3.4 Limitations

3.4.1 Use of clinical vignettes

To ensure consistency between Study 1 and Study 2, clinical vignettes from Study 1 were reused for rating in Study 2. The vignettes are provided at Appendix B.

Vignettes have limitations compared to 'real life' clinical presentations. As was noted in the 2016 IRR Study, 'Although vignettes have the ability to overcome the logistical and ethical issues of undertaking research into clinical decision-making by being efficient, inexpensive and reducing the burden of participation consumers and clinicians, they may not always accurately reflect the

complexity of clinical practice and cannot always convey the rich historical and contextual information that may influence clinical decision-making. The relatively short vignettes developed for this study may not have been detailed enough to adequately reflect clinical complexity' (p.43).

This limitation was noted by respondents in this study (section 9.3.3), who advised that they felt real life application of phase of care would be easier because the clinician would know more about the consumer than can be included in a vignette.

In addition to the overall limitations of using vignettes, it should be noted that Aboriginal and Torres Strait Islander peoples are not represented in the selection of vignettes. This is a limitation of the vignette sample; however, it is unlikely to have had significant impact on the outcomes of the study. Notwithstanding this, attention should be given in developing local training materials for phase of care to ensure that they meet the needs of local services, including specific Indigenous mental health services.

3.4.2 Vignettes rated independently

States and territories have advised that in practice clinicians typically determine phase of care in a multidisciplinary meeting, with input from multiple clinicians. This study required respondents to rate the clinical vignettes independently, without consultation with their colleagues. This approach was necessary to enable comparison with Study 1 which was also structured in this way. However, it is recognised that this does not emulate common clinical practises, and that multi-disciplinary discussions provide clinicians with more information and insight to appropriately assign phase of care.

3.4.3 Phase of care resources limited to phase names, definitions and activities

In order to provide training on all phases of care within the limited time window provided, and to ensure consistency with Study 1, phase of care resources were limited to the phase names, definitions which describe the primary goal of care and typical activities undertaken (as set out in Table 5 at section 1.2.2, with study training materials provided at Appendix D).

In practice, more extensive resources are available to clinicians to assist in assigning phase of care. The *Mental Health Phase of Care Guide*[6] includes further detail on the presentation of each phase for AMHCC Version 1.0, including consumer characteristics, detailed clinician activity or expectation, and indicators of phase start and end. States and territories may also provide locally tailored resources. However, the value of these additional resources should be balanced against feedback from clinicians that often it is only the phase name that is used to assign phase of care.

3.4.4 Low sample sizes for child and adolescent and older persons cohorts

IHPA sought participation from all states and territories and did not set limits or requirements on representation from different locations, settings or specialties. As is discussed at section 4.1, nominations were monitored to ensure representation from a range of groups, with sufficient representation provided from all age specialties.

However, there were significantly fewer participants from child and adolescent and older persons specialties (see section 8.4). This was consistent with Study 1 and mental health services generally, with the sample size sufficient for statistical analysis. However, the limited number of participants, and therefore survey responses and vignette ratings, does result in lower levels of accuracy of survey statistics for these age specialties, which in turn limits the detailed investigations that can be undertaken here.

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[6] Independent Hospital Pricing Authority. (2016). Australian Mental Health Care Classification, Mental Health Phase of Care Guide, Version 1.2. June 2016. Retrieved 21 December 2020 from https://www.ihpa.gov.au/publications/mental-health-phase-care-guide

3.5 Ethics

The 2016 IRR Study (Study 1) did not require ethics approval as it was considered to be 'low risk research', as per the definition by the *National Health and Medical Research Council National Statement on Ethical Conduct in Human Research*[7]. The rationale for this was that information was not collected from or about mental health consumers and involved voluntary participation of non-identifiable clinicians. Due to the same principles applying to this project, ethics approval was not required.

3.6 Project team and governance

The core project team comprised:

- **Mental health expert and project lead:** responsible for leading the project and detailed design, developing all project resources, liaising with project sites and clinicians, running all site training and survey/data collection sessions, working with the analytics expert to make findings and recommendations, and for final report write-up.
- **IHPA analytics expert:** responsible for developing the analytic approach for the project, working with the project lead to ensure the study design support this, and undertaking all analytic work to determine the IRR of the proposed phase of care options and comparison with the previous 2016 IRR Study findings.
- **IHPA project manager:** responsible for developing the initial project plan, coordinating and providing IHPA advice and resources, and reviewing and approving project materials and deliverables.
- **IHPA project support:** responsible for support and advice to the project manager.

The project was overseen by the Director, Classifications at IHPA. The project team reported via IHPA's internal governance structure through to the IHPA Chief Executive Officer and the Pricing Authority. The Pricing Authority must approve revisions to IHPA's classification systems.

Externally, the project team reported regularly to IHPA's Mental Health Working Group (MHWG). The MHWG was the key mechanism for consulting with jurisdictions and mental health stakeholders throughout the project. The Mental Health Information Strategy Standing Committee was also consulted on the study design. In addition to the MHWG, significant updates were provided to IHPA's Technical, Jurisdictional and Stakeholder Advisory Committees.

[7] National Health and Medical Research Council, National Statement on Ethical Conduct in Human Research, 2007 (Updated 2018). Retrieved 21 December 2020 from www.nhmrc.gov.au/guidelines/publications/e72

4. Study participants

In June 2020, IHPA sought nominations from all states and territories for mental health services to participate in the project based on the following criteria:

- The site provides admitted or ambulatory mental health services.
- The site provides either child and adolescent, adult or older persons mental health services.
- Participants must be practising mental health clinicians.
- The site can nominate a site coordinator to promote participation in the testing and facilitate site communication.

Advice was also sought on whether participants had previously participated in the 2014–16 Mental Health Costing Study or the 2015 pilot of the Australian Mental Health Care Classification (AMHCC) Version 1.0 to ensure a diverse representation of experience.

It was determined in consultation with the MHWG that a minimum of two jurisdictions would be required for the project to proceed. No minimum thresholds were set for service setting or clinical specialty, but information was gathered from nominated sites to ensure reasonable representation from both admitted and community services, and across clinical specialties.

4.1 Participating sites

All states and territories provided sites to participate in the project, with 45 of the 46 nominated sites able to participate. One Victorian site was unable to participate due to the limitations associated with the coronavirus pandemic. Appendix A provides a full list of participating sites.

The size of the ‘site’ varied by jurisdiction, with some jurisdictions nominating whole Local Health Networks as individual sites and others choosing individual services. Since respondents completed the survey individually and the online training could take place across locations, a ‘site’ was determined based on the identification of a study site coordinator, for coordination purposes only.

The site coordinators collected lists of potential participants and background information in line with the selection criteria above and assisted the project lead with scheduling training sessions.

This initial information collected about participant background was used for two purposes. Firstly, it was used to identify any nominated persons who were not practising mental health clinicians. This was to address a limitation in Study 1, where 74 of the 434 respondents were excluded from the analysis due to being service managers or team leaders seeking to gain more information about activity based funding (ABF) and the AMHCC. In Study 2, these nominees were not automatically excluded from the study. They were instead advised that they would be free to participate; however, should they not have practised in the last year then their survey response would be removed from the analysis. Some nominees chose to participate in the training session regardless, as an opportunity to learn more about the classification and phase of care.

Secondly, this information was used to ensure reasonably even distribution of background and experience between Groups 2A and 2B nationally. It was not considered in the composition of individual sessions. That is, there was no requirement for a training session to include, for example, only child and adolescent clinical specialists.

The profile of the respondents included in the final dataset is discussed in section 8.4.

5. Vignettes

Study 2 utilised clinical vignettes developed as part of Study 1 to assess whether the proposed phase of care options developed in the 2017 Clinical Refinement Project outperformed those in the AMHCC Version 1.0, and of the two Study 2 options (Options 2A and 2B), which has better inter-rater reliability (IRR). The Study 1 vignettes were proposed for reuse to ensure consistency and enable a direct comparison of results.

5.1 Vignette review

40 one-page clinical vignettes were developed as part of Study 1, with 37 used in the final testing process[8]. Each vignette described a fictional mental health consumer in a single phase of care.

These 37 vignettes were reviewed to assess their suitability for use in this project, with preliminary findings provided to the Mental Health Working Group and six additional mental health clinicians for detailed feedback. The purpose of this review was to:

- Assign the vignettes to the new phase types.
- Incorporate stakeholder feedback on the vignettes from Study 1 that some of the original vignettes lacked enough detail to enable clinicians to accurately assign a phase, which affected the reliability of the study results. This was balanced against the need to limit changes to ensure that the comparison of IRR between the two studies is valid.

All 37 vignettes from Study 1 were found to be suitable for reuse. When reassigned to the new phase types, the vignettes were reasonably evenly distributed across phase types and population groups (child and adolescent, adult and older persons)[9]. These phase assignments are referred to as the 'correct' phase assignments for the vignettes throughout this report.

Minor amendments were made to the text of five vignettes, with the names of the subjects of two vignettes amended to ensure that they were culturally appropriate.

There were some limitations to the vignettes. Only one vignette described an Indigenous consumer, and there were no vignettes which referred to culturally specific mental health services. In addition, in some cases clinicians reviewing the vignettes suggested more extensive amendments that would improve the vignettes' readability but were not critical to their use in the project. It was determined that these suggested amendments and additional Indigenous cases would not be included as it would have affected the consistency of vignettes between Study 1 and Study 2. If these vignettes were to be used for a future project, and consistency between that project and previous studies was *not* required, further amendments could be considered.

5.2 Vignette selection

After determining that all 37 vignettes were suitable for use in Study 2, consideration was given as to how vignettes should be selected and used, taking into account any significant limitations

[8] Three vignettes were excluded during Study 1 as they were related to cases for children aged 0-5 years old, which is a specialised group and were deemed to be unrepresentative of the child and adolescent cohort for the purpose of analysis.

[9] Aged 0-17, 18-64 and 65+ years respectively. These age groups align with those used in the AMHCC Version 1.0.

identified in Study 1's approach as well as any constraints of Study 2, such as the survey tool itself and the selection of study participants.

5.2.1 Number of vignettes per respondent

Respondents in Study 1 reviewed between eight and 10 vignettes each. Since the number of respondents in Study 2 was expected to be lower than the 360 in-scope respondents in Study 1, this project sought to maximise the number of vignettes each respondent reviewed. 35 minutes was allocated within the 45-minute survey for vignette review (the structure and timing of sessions is discussed at section 7.2. Internal testing determined that this allowed time for 12 vignettes to be reviewed per person, without respondents feeling rushed.

5.2.2 Overlapping vignettes

Of the 37 vignettes, 30 'overlapped'. This means that each pair of overlapping vignettes described the same consumer in two different phases of care, with the name of the consumer changed for the second vignette. For example, the vignette 'Daniel' was similar to 'Gary'. The two vignettes described the same consumer, but the vignette 'Daniel' was set six months later than 'Gary'. Daniel was in a 'non-acute' phase and Gary was in a 'subacute/ rehabilitation and recovery' phase. Table 7 lists the overlapping vignettes.

Table 7: Overlapping vignettes (phase of care included in brackets)

First vignette	Overlapping vignette
Jordan (AC)	Theo (AO)
Jade (AC)	Chloe (NA)
Llubica (SA/SA)	Nadeen (SA/RR)
Marcus (SA/RR)	Jack (SA/SA)
Tameka (NA)	Alinga (AO)
Ashley (AC)	Faith (SA/RR)
Jason (SA/SA)	Paul (AC)
Gary (SA/RR)	Daniel (NA)
Barry (SA/RR)	Zlatko (AO)
Jo (AC)	Rose (NA)
Fang (NA)	Bo (AO)
Mara (SA/SA)	Angelina (AO)
Peter (SA/RR)	William (SA/RR)
Eric (NA)	Donald (AC)
Agnes (AO)	Doris (NA)

Key: AC acute, SA subacute, RR rehabilitation and recovery, NA non-acute, AO assessment only

If respondents reviewed two similar vignettes, then there was the potential for confusion. Therefore, in Study 1 the vignettes were grouped into sets for use which were intended to ensure that no 'overlapping' vignettes were seen by an individual respondent. Analysis of Study 1 data suggests that this approach was not always adhered to; however, the intention was a sound one

and therefore the vignettes were reviewed for this project to create a final set of vignettes that did not overlap.

5.2.3 Representation of phases of care

One vignette in each of the 15 pairs of overlapping vignettes was excluded based on the approach of ensuring a balanced representation of each phase of care within the final set. In this way, the 37 vignettes were reduced to 22 (15 overlapping vignettes, plus seven which did not overlap). This included a balance of 'subacute', and 'rehabilitation and recovery' for testing of Option 2B. Consideration was also given to ensuring a reasonably even spread of respondent agreement for phase of care in Study 1.

5.2.4 Age groups

Study 1 grouped vignettes by age group, with most but not all respondents rating vignettes associated with their main target population as practising clinicians. This approach was followed in Study 2 for a core set of age-consistent vignettes. There was also an additional set of vignettes that were rated by all respondents.

In this way, three surveys were designed, each consisting of a core set of five age-consistent vignettes, and with an additional set of seven mixed-age vignettes that were common across all three surveys (of which two were child and adolescent, three were adult and two were older persons). In selecting vignettes, consideration was also given to ensuring a good distribution within each age group (for example, adults should not all be aged 20-30 years).

5.2.5 Balance of other factors

Finally, the vignettes selected were reviewed to ensure balance in terms of gender and inclusion of culturally diverse consumers.

5.2.6 Final selection criteria

In summary, in creating vignette sets the following criteria were used:

- 12 vignettes per set.
- No overlapping vignettes within a set.
- All phase types represented within a set, with as even as possible distribution, including for both 'subacute', and 'rehabilitation and recovery' for testing of Option 2B.
- A reasonably even spread of IRR ratings for phase of care in Study 1.
- A majority of vignettes from the set's core age group, with some vignettes from the other two age groups.
- Reasonable age distribution within each age group.
- Some consistent vignettes across all sets, to ensure a core set of vignettes for comparison across all respondents.
- The vignettes to be balanced in terms of gender, and to include culturally diverse consumers.

This resulted in 22 vignettes being used, grouped as set out in Table 8. The following seven vignettes were present in all three sets: Llubica, Bryce, Jason, Fang, Vivian, Edward and Eric.

The vignettes used in the study are provided at Appendix B. These incorporated the minor amendments described in the vignette review at section 5.1.

Table 8: Vignette sets used in Study 2

Vignette age category	Vignette set 1 – for child and adolescent clinicians	Vignette set 2 – for adult clinicians	Vignette set 3 – for older persons clinicians
Child and adolescent vignettes	Jordan (AC) Llubica (SA/SA) Marcus (SA/RR) Sumaya (SA/RR) Tameka (NA) Jade (AC) Bryce (AO)	Llubica (SA/SA) Bryce (AO)	Llubica (SA/SA) Bryce (AO)
Adult vignettes	Jason (SA/SA) Fang (NA) Vivian (AO)	Ashley (AC) Jason (SA/SA) Barry (SA/RR) Gary (SA/RR) Jo Beth (NA) Fang (NA) Malcolm (AO) Vivian (AO)	Jason (SA/SA) Fang (NA) Vivian (AO)
Older persons vignettes	Edward (AC) Eric (NA)	Edward (AC) Eric (NA)	Edward (AC) Jo (AC) Mara (SA/SA) Antonina (SA/RR) Peter (SA/RR) Eric (NA) Agnes (AO)
Total vignettes	**12**	**12**	**12**

6. Survey design

6.1 Survey tool

Consistent with Study 1, a survey was designed to collect respondents' vignette ratings as well as demographic information and additional feedback. As training sessions took place virtually, an online survey tool was required.

The key considerations in the survey design were data security, ease of use and accessibility for respondents, and the ability of the survey tool to manage the logic rules of the survey. After consideration of a range of different products, Swift Digital's online survey tool was selected. This platform was used by IHPA for a range of surveys and other online communication projects and had previously been assessed to ensure that it met IHPA's data security and privacy standards.

Microsoft Word versions of the survey were produced as a backup in the case of technical issues with the online survey tool. They were required for use in one session affecting eight respondents.[10] In this instance, respondents were asked their clinical age specialty and the appropriate survey was emailed directly to them, to be emailed back within 45 minutes. Respondents were advised that the completed surveys would be stored securely, and their emails containing completed surveys would be deleted to ensure anonymity.

6.2 Survey design

The survey instrument had three sections:

- **Section 1:** Nine questions relating to the background and professional experience of the respondent (completed by all).
- **Section 2:** 12 case vignettes for the respondent to rate the phase of care (vignettes varied depending on the age specialty of the clinician).
- **Section 3:** Seven follow-up questions relating to the rating of vignettes, the phase of care definitions and the training (completed by all).

The survey questions are listed in Table 43 at Appendix C with a comparison against the Study 1 survey questions. Screenshots of the survey itself are also provided at Appendix C.

The completion page from the survey provided a link to a second single-field survey that provided respondents with an option to register their email address for updates on the project. Separating the surveys out in this way ensured that respondents remained anonymous in the main survey.

6.3 Vignette selection in the survey

As described at section 5.2, each respondent rated a set of seven or eight vignettes that aligned with their clinical age specialty as determined by their answer to question 7 in the survey[11]. Additional vignettes to make up a set of 12 were rated by all respondents. This resulted in three sets of vignettes and three versions of the survey: one for each age specialty.

[10] There were eight respondents, of which two were excluded in data preparation – see Table 10.
[11] Question 7: 'What is the main target age group you work with clinically?

The purpose of this structure was firstly to enable each respondent to rate a core set of vignettes that aligned with the age group they are most familiar servicing as a practising professional.

Secondly, the supplementary vignettes of each version were common to the other two versions, either as core or supplementary vignettes, which enabled inter-rater reliability (IRR) to be evaluated across respondents of different survey versions and to be evaluated for respondents rating outside the age group they were most familiar with servicing.

Finally, the supplementary vignettes increased the number of ratings per respondent, which was an important consideration prior to conducting the survey with regard to the ability to bolster sample size in the event that survey participation was lower than expected.

Table 8 at section 5.2.6 details the vignettes contained in each vignette set or survey version, which can be summarised as follows:

- Survey 1 – child and adolescent specialists: seven child and adolescent, three adult, and two older person vignettes.
- Survey 2 – adult specialists: eight adult, two child and adolescent, and two older person vignettes.
- Survey 3 – older person specialists: seven older person, two child and adolescent and three adult vignettes.

Question 2 in the survey[12] also contained a response option of 'I work across all age groups'. This option was included to provide some flexibility in the survey design should poor representation be expected from one age cohort.

Based on the initial information about participants provided by study site coordinators (discussed in section 4.1), it was expected that older persons specialists would be underrepresented amongst participants. Therefore, it was decided that respondents who answered 'I work across all age groups' to question 2 would be directed to Survey 3. This had the benefit of increasing the number of responses to the older persons vignettes, although with the limitation that some of these respondents would not be older persons specialists. Through later review it was determined that this cohort generally cared for adult consumers, with the analysis adjusted to account for this. This is further discussed at section 8.3.2.

6.4 Option 2A and 2B selection in the survey

As the respondent's answer to question 7 determined which set of vignettes they reviewed, so their answer to question 2 determined the phase of care options available to the respondent. An answer of 'Group A' to question 2 meant that Option 2A phases were available for selection. An answer of 'Group B' provided Option 2B phases.

Clear guidance was provided to respondents as to how they should answer this question. Nonetheless, a small number of respondents selected the incorrect Group in the survey, resulting in their response being excluded from the final dataset. This is further discussed at section 8.2.

6.5 Survey distribution and controls

The survey was distributed to respondents via a hyperlink. A separate copy of the survey was generated for each of the 32 sessions, with a unique hyperlink for that session. The survey was only accessible on the day on which the session was scheduled. This was to ensure that

[12] Question 2: 'Which Mental Health Phase of Care Training Session did you attend?' (Group A or B)

respondents in each session could be grouped together accurately and access to the surveys was strictly controlled.

Each response generated a timestamp upon completion. The timestamps were checked after each session to ensure that the survey was completed within the appropriate window, and not prior to or after the session.

7. Training design

Training was modelled on the approach taken in Study 1 to ensure consistency. In Study 1, respondents were trained as a group as determined by those attending a face-to-face session, using a mix of slides and group discussion. Respondents then rated a series of vignettes, with the session finishing with a focus group.

This project followed the same approach, except that the sessions were undertaken via group video call rather than in person. This was in part because of travel restrictions due to the coronavirus pandemic but had the benefit of increasing the number of training sessions available to sites, and therefore the number of respondents.

The format of the sessions was modelled on Study 1, with the structure set out in Table 9.

Table 9: Structure of Study 2 training sessions

Format	Content
Part 1: Group video call (45 minutes)	• Purpose of the project and session, and the AMHCC • Training on phase of care • Instructions on how to complete the survey
Part 2: Individual online survey (45 minutes)	• Link to survey provided for respondents to complete individually
Part 3: Group video call (15-30 minutes, varying based on respondent engagement)	• Group discussion based on a standard set of prompt questions • Presentation and discussion of alternative Option 2A or 2B, with voting on preferred approach and group discussion • Next steps in the project

7.1 Training materials

A handout was shared with respondents ahead of their session. This provided practical information on participation (such as video conference requirements) and a summary table of the phases of care being tested in their session.

The group video calls were supported by a set of training slides. These were shared ‘live’ during the session via the video conference platform and were not made available to respondents ahead of time. The slides varied only depending on whether Option 2A or 2B was being tested in the survey.

The handouts and slides are provided at Appendix D.

7.2 Training sessions

7.2.1 Part 1: Group video call – training

Respondents joined a video call, typically held using Zoom, with alternate video conferencing facilities used in some instances.

The key messages delivered in Part 1 of the sessions are contained within the training slides at Appendix D and included:

- The objectives of the session – same for all respondents.
- The project as part of a long-term program to refine the Australian Mental Health Care Classification (AMHCC) – same for all respondents.
- An overview of the concept of phase of care, and a group discussion of each phase in turn including its definition and identification of key considerations – differing for Group 2A/2B.
- Group discussion on the phase of care represented in three short vignettes and a series of multiple-choice quiz questions focused on the phase definitions – differing for Group 2A/2B.

7.2.2 Part 2: Individual online survey

The survey design is discussed in section 6.2.

After completing the training session, respondents were instructed how to complete the survey. They were advised that their response would be anonymous. Respondents were instructed that they needed to:

- Select the correct Group in answering survey question 2,[13] as this affected the remainder of the survey, with prompts on this provided in the discussion and handout.
- 'Submit' their survey response prior to returning to the group call, to ensure that group discussions in Part 3 did not affect their survey responses.

Respondents were advised that if they selected the wrong Group or submitted their survey late, then their response would be excluded from the dataset used for analysis.

Respondents were able to contact the study lead throughout the 45-minute survey time for questions or if they experienced technical difficulties.

7.2.3 Part 3: Group video call – discussion and feedback

Respondents were instructed to return to the video call after 45 minutes for a group feedback discussion that lasted 15-30 minutes depending on the level of respondent engagement.

Groups were asked a series of questions to stimulate discussion, including:

- How did you find the process of assigning phases of care in the survey? Which phase was the easiest/hardest to assign?
- Are the definitions easily understandable? How would you improve them?
- Did you prefer the 'subacute/ rehabilitation and recovery' split, or would you rather one 'subacute' phase?
- Could you use these phase definitions and apply them to the consumers you usually see?
- Is the way phases separate out consumers' journeys useful to you?
- Do you prefer the proposed definitions or the current AMHCC Version 1.0 phases?

As part of the group discussion, respondents were introduced to the alternative phase of care Option being tested. Group 2A respondents were introduced to the Group 2B definitions, and vice versa. Brief training was provided on the definitions with some examples, as set out in the slide packs at Appendix D.

[13] Question 2: 'Which Mental Health Phase of Care Training Session did you attend?' (Group A or B)

Questions were then posed to respondents. The purpose of these questions was to embed the alternate option just presented to assist with later discussions:

- Group 2A respondents were asked to review three vignettes and individually decide on whether they thought each of the vignettes described a ‘subacute’ or ‘rehabilitation and recovery’ phase of care.
- Both Group 2A and 2B respondents were then asked whether they thought splitting the ‘subacute’ phase into ‘subacute’ and ‘rehabilitation and recovery’ made the phases more clinically meaningful and relevant to their clinical practice.

Most respondents’ responses were recorded anonymously via Poll Everywhere (an online polling tool). Very small groups or those who were unable to use the polling tool had the option of voting orally or via the video conferencing chat function.

7.3 Consistency with Study 1

The structure and content of the training was broadly consistent with Study 1. The content of the training slides was modelled on those from Study 1, as was the format and length of training sessions. Key differences included:

- Training was delivered via video call; however, sessions were structured to be as interactive as possible and limited to respondents from the same jurisdiction to ensure a similar level of knowledge, shared language and to mimic face-to-face sessions.
- The training component of the sessions was increased from 20-30 minutes in Study 1 to 45 minutes, based on respondent feedback from Study 1 which stated that the brief training, limited practice and lack of feedback hindered understanding.
- There was no test-retest component, as discussed at 3.2.2.

8. Data collection and preparation

8.1 Data collection

The study was conducted over a nine-week period from 28 August to 22 October 2020, with 32 individual training sessions held.

From the 32 sessions, 277 people completed the online survey, of which there were:

- 137 respondents in Group 2A
- 140 respondents in Group 2B.

Table 44 in Appendix E details the number of respondents by session. Sessions ranged from two to 21 respondents. When scheduling sessions, the aim was to include 10-20 respondents per session, but final attendance was determined by clinicians' availability locally.

8.2 Data exclusions

20 of the 277 respondent records were identified as being out of scope and excluded from Study 2 survey data prior to analysis. This compares with 74 respondent records excluded in Study 1.

Table 10 lists the reasons for identifying respondents as out of scope in this study, together with the number of records excluded.

Table 10: Records excluded from the Study 2 dataset

Reason	Excluded records
Respondent did not rate vignettes using the phase of care definitions on which they completed training (Group 2A respondent selected 'Group B' at question 2 of the survey and vice versa)	8
Respondent did not complete mandatory survey fields when completing an offline version of the survey	2
Respondent did not have a clinical discipline	3
Respondent had never practised or had not practised within the last 12 months	5
Respondent did not complete training due to technical issues	1
Respondent did not complete survey in the required timeframe	1
Total number of excluded records	**20**

Table 11 summarises the Study 1 and Study 2 respondent sample sizes before and after these exclusions.

Table 11: Study 1 and 2 respondent sample sizes before and after exclusions

Study	Group	Total respondents	Exclusions	In-scope respondents
Study 1	Group 1	434	74	360
Study 2	Total	277	20	257
	Group 2A	*137*	*13*	*124*
	Group 2B	*140*	*7*	*133*

8.3 Method

This study compares the agreement statistics for the rating of case vignettes using the Australian Mental Health Care Classification (AMHCC) Version 1.0 phase of care definitions in Study 1, and Options 2A and 2B in Study 2.

Several steps in data preparation occurred prior to analysis to ensure comparability of survey statistics across the two studies and the three sets of phases definitions being tested.

8.3.1 Step 1

Study 1 survey data was first restricted to ratings of the 22 vignettes common to Study 2. Table 12 summarises the respondent and ratings sample sizes of Study 1 data before and after restricting to common vignettes.

Table 12: Summary of Study 1 sample sizes before and after restriction to common vignettes

Initial Study 1 sample		Non-common vignette exclusions		In-scope Study 1 sample	
Respondents	Ratings	Respondents	Ratings	Respondents	Ratings
360	3339	-	1187	360	2152

8.3.2 Step 2

Survey data was then restricted to vignette ratings that aligned with the age group the respondent was most familiar servicing as a clinician.

For Study 1 data, this was achieved by excluding eight of 360 respondents that rated vignettes outside their familiar age group. For Study 2 data, this was achieved by restricting the data to ratings of the core vignette sets (that is, excluding ratings of supplementary vignette sets). Ratings of respondents that nominated ‘across all age groups’ as their main target age group were restricted to vignettes from the adult cohort. Whilst this cohort received more older persons vignettes, following comments received in the feedback sessions it appeared that these clinicians likely treated mostly adults, and therefore the data was restricted as such.

Table 13 summarises the respondent and rating sample sizes associated with the age group alignment.

Table 13: Summary of final respondent and ratings sample sizes for analysis

Group	Initial in-scope sample		Age group alignment exclusions		Final survey sample for analysis	
	Respondents	Ratings	Respondents	Ratings	Respondents	Ratings
1	360	2152	8	39	352	2113
2A	124	1488	-	587	124	901
2B	133	1596	-	627	133	969

8.3.3 Step 3

The final step in data preparation sought to account for differences in rating sample sizes across studies and vignettes. For example, the greater a vignette's number of ratings, the greater its influence on the overall agreement statistics (for example, kappa statistics).

Therefore, sample weights were applied to ratings to ensure that each of the 22 vignettes contributed equally to the overall survey statistics. Table 14 summarises rating sample sizes by AMHCC Version 1.0 phases of care after the weights had been applied.

A summary of rating sample sizes by vignette before and after sample weights are applied is provided in Table 45 at Appendix E. This table show that the adult vignettes had a significantly greater influence on agreement statistics prior to weighting, whereas after application of weighting, the influence across vignette age cohorts was much more uniform. The sample is presented like this to assess whether all phases of care are reasonably represented after weights have been applied.

Table 14 shows that each of the AMHCC Version 1.0 phases of care contributed close to 20 per cent of the ratings after weights were applied.

Table 14: Summary of unweighted and weighted ratings by vignette phase and study

	Ratings Sample Size			% Ratings					
				Unweighted			Weighted		
Vignette Phase	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Acute	366	149	156	17.3%	16.5%	16.1%	22.7%	22.7%	22.7%
Functional gain	290	149	156	13.7%	16.5%	16.1%	22.7%	22.7%	22.7%
Intensive extended	448	201	219	21.2%	22.3%	22.6%	18.2%	18.2%	18.2%
Consolidating gain	422	201	219	20.0%	22.3%	22.6%	18.2%	18.2%	18.2%
Assessment only	587	201	219	27.8%	22.3%	22.6%	18.2%	18.2%	18.2%
Total	**2113**	**901**	**969**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

8.4 Final respondent profile after data preparation

The following tables summarise the characteristics of the final respondents in all three Groups after data preparation. The percentage ratings columns provide an indication of the relative influence of the different Groups on overall agreement statistics. As discussed above, all rating and agreement statistics had sample weights applied to enable comparison across studies.

Key observations when comparing Groups 1, 2A and 2B include:

- **Jurisdictional representation** (Table 15): New South Wales had a bigger influence on the ratings sample size in Groups 2A (58.7 per cent) and 2B (50.1 per cent), compared to Group 1 (22.5 per cent). All other states and territories had a reduced or similar influence in Groups 2A and 2B.

- **Clinical discipline** (Table 16): Nurses were the largest group by clinical discipline in all three Groups of ratings, but notably comprised 60.7 per cent of ratings in Group 2B, compared to 49.6 per cent and 36.7 per cent in Groups 1 and 2A respectively.
- **Practising experience** (Table 17): The profile of respondents' years of practising experience was broadly similar across all three ratings groups, with most ratings provided by respondents clustered within the 5-14 years' experience categories.
- **Clinical age specialty** (Table 18): As a result of the data preparation process, representation across age specialisation was evenly balanced.
- **Main service setting** (Table 19): In all Groups more than two thirds of ratings were provided by community mental health clinicians. Almost all of the remainder came from respondents working in admitted services.
- **Phase of care experience** (Table 20 and Table 21): Across all Groups, the majority of ratings came from respondents who said that they had not previously received mental health phase of care training, with only a slight decrease in this when comparing Groups 2A and 2B with Group 1. Study 2 respondents were also asked whether they had participated in a previous AMHCC study, with the majority reporting that they had not.
- **Geographical service types:** Whilst representation of different geographical service types was not a requirement for the study, the 45 participating sites covered a breadth of localities including metropolitan, regional and remote services (Table 41 at Appendix A).

Table 15: Summary of respondent and ratings samples by state/territory

	Respondents			% Ratings		
State/Territory	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
NSW	84	70	59	22.5%	58.7%	50.1%
VIC	46	11	15	13.4%	5.0%	9.6%
QLD	38	8	7	9.9%	6.0%	3.5%
SA	96	7	14	14.1%	4.3%	9.7%
WA	60	18	24	29.5%	14.2%	17.9%
TAS	28	10	1	10.7%	11.8%	0.4%
NT	0	0	4	0.0%	0.0%	1.1%
ACT	0	0	9	0.0%	0.0%	7.7%
Total	**352**	**124**	**133**	**100%**	**100%**	**100%**

Table 16: Summary of respondent and ratings samples by clinical discipline

	Respondents			% Ratings		
Clinical Discipline	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Nurse	190	56	81	49.6%	36.7%	60.7%
Occupational Therapist	28	19	16	7.5%	17.0%	11.7%
Psychiatric Registrar	6	2	4	1.8%	0.9%	3.3%
Psychiatrist	19	5	7	11.2%	6.5%	4.0%
Psychologist	38	12	10	11.1%	11.2%	7.1%
Social Worker	71	30	15	18.9%	27.7%	13.2%
Total	**352**	**124**	**133**	**100%**	**100%**	**100%**

Table 17: Summary of respondent and ratings samples by years of practising experience

	Respondents			% Ratings		
Practising Experience	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
00 - 04 years	58	18	18	12.0%	16.5%	10.6%
05 - 09 years	65	20	35	15.0%	10.0%	30.8%
10 - 14 years	66	30	18	17.0%	25.2%	14.0%
15 - 19 years	43	20	16	18.4%	20.2%	11.5%
20 - 24 years	39	10	21	14.1%	9.1%	20.1%
25 - 29 years	32	11	6	9.7%	7.3%	5.3%
30+ years	49	15	19	13.8%	11.7%	7.8%
Total	**352**	**124**	**133**	**100%**	**100%**	**100%**

Table 18: Summary of respondent and ratings samples by clinical age specialty

	Respondents			% Ratings		
Main Target Age Group	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Children and adolescents	64	20	20	31.8%	31.8%	31.8%
Adults	258	88	98	36.4%	36.4%	36.4%
Older persons	30	16	15	31.8%	31.8%	31.8%
Total	**352**	**124**	**133**	**100%**	**100%**	**100%**

Table 19: Summary of respondent and ratings samples by main service setting

	Respondents			% Ratings		
Main Service Setting	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Across settings/Other	0	3	8	0.0%	2.2%	4.2%
Community	280	103	83	79.4%	83.5%	67.0%
Admitted	72	18	38	20.6%	14.3%	27.2%
Residential	0	0	4	0.0%	0.0%	1.6%
Total	**352**	**124**	**133**	**100%**	**100%**	**100%**

Table 20: Summary of respondent and ratings samples by mental health phase of care experience

	Respondents			% Ratings		
Training Experience	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
No	234	71	79	71.9%	59.6%	61.7%
Not sure	6	10	11	0.9%	7.4%	8.8%
Yes	112	43	43	27.2%	33.0%	29.5%
Total	**352**	**124**	**133**	**100%**	**100%**	**100%**

Table 21: Summary of respondent and ratings samples by previous study participation

	Respondents		% Ratings	
Previous Study Participation	Group 2A	Group 2B	Group 2A	Group 2B
No	71	81	61.7%	62.5%
Not sure	45	39	29.8%	29.6%
Yes	8	13	8.6%	7.9%
Total	**124**	**133**	**100%**	**100%**

9. Results

9.1 Analytical approach

The objectives of this project included assessing whether the proposed mental health phase of care options outperformed the existing phases in terms of reliability and clinical meaningfulness. This chapter discusses the findings from the vignette rating process (section 9.2) and clinician feedback through both the survey and group discussions (section 9.3) to assess whether there was an improvement in reliability and clinical meaningfulness.

9.1.1 Measuring reliability

Reliability was measured using two approaches, both of which were used in the 2016 Inter-Rater Reliability (IRR) Study:

- **Kappa statistic (k):** This is a commonly used approach for IRR studies to measure agreement. It considers agreement over and above what would be expected as 'chance' and is therefore more robust than simple raw agreement percentages.

  The statistic is a single measure that ranges between -1 and +1, with +1 representing perfect agreement. Although the kappa statistic is commonly used, it is not a perfect measure as there is a need to determine the level of 'chance' agreement. This also affects the interpretation of what a 'good' level of agreement is, and various studies provide differing ranges.

  Rather than set a nominal threshold for an acceptable level of agreement, this report focuses on differences in the levels of agreement across studies.

  The kappa statistics reported here were validated using an alternative agreement statistic known as Gwet's Agreement Coefficient (AC1). The kappa and AC1 statistics showed close alignment across the main results of the study. See Table 46 in Appendix E for a comparison of the two statistics across the studies.

- **Raw agreement:** This compares the phases of care that respondents assigned to individual vignettes against the 'true' phase described in the vignette, to report the 'percentage correct' rate. For example, if a vignette describes an 'acute' phase, and 60 of 100 respondents rated the vignette as 'acute', then the raw agreement rate would be 60 per cent.

  Raw agreement analysis can also look at how incorrect ratings are distributed – in the example above, did the remaining 40 respondents all assign a 'subacute' phase, or were incorrect responses distributed evenly across all phases?

The kappa and raw agreement statistics reported here for Study 1 will not match those in the 2016 IRR Study report. As outlined at section 8.3, Study 1's dataset has been restricted to ensure comparability of survey statistics across the two studies and the three sets of phase of care definitions being tested. Therefore, the kappa and raw agreement statistics have been recalculated for the restricted Study 1 dataset.

9.1.2 Measuring clinical meaningfulness

Clinical meaningfulness was assessed using further quantitative and qualitative feedback from the survey and group discussions. Comments and survey results have been summarised and discussed.

9.1.3 Age group-specific analysis

The following statistical analysis focuses on separate discussion of child and adolescent (0-17 years), adult (18-64 years) and older persons (65+ years) cohorts. This is because:

- The AMHCC uses 'age group' as a major splitting variable (see section 1.1.2).
- The respondent groups rating the vignettes were separate from each other (for example, child and adolescent clinicians rated child and adolescent vignettes – this is discussed at section 8.3.2).
- Whilst responses had been weighted in the overall analysis to account for differences in rating sample sizes and enable comparison between them, there remained a significant difference in these sample sizes, and only considering all age groups together would give undue weight to the smaller child and adolescent and older persons groups.
- Clinician feedback (discussed at section 9.3) included that interpretation of phases of care varied by age cohort, for example, the level of independence of consumer, the threshold for admission to hospital etc.

9.2 Findings from the vignette rating process

9.2.1 Overall inter-rater reliability

Overall, there has been an improvement in the kappa statistic from Study 1 to Study 2.

As Table 22 shows, the kappa agreement for Group 1 was 0.396[14]. This increased to 0.441 for Group 2B and further to 0.495 for Group 2A, which represent relative increases in kappa agreement from Study 1 of 11 per cent and 25 per cent, respectively.

Table 22: Overall kappa agreement statistics

Kappa Agreement Statistics		
Group 1	Group 2A	Group 2B
0.396	0.495	0.441

Table 23 shows the same trend increase in the kappa statistic from Group 1 to 2B to 2A across all vignette age groups, albeit with a very minor increase from Group 1 to 2B for adult vignettes, and a minor increase from Group 2B to 2A for child and adolescent vignettes. The significant improvement in kappa agreement statistics for older persons should be noted with caution given the small sample sizes (16 and 15 respondents in Groups 2A and 2B respectively).

Table 23: Kappa agreement statistics by vignette age group

	Respondents			Kappa Agreement Statistics		
Vignette Age Group	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Children and adolescents	64	20	20	0.375	0.450	0.434
Adults	258	88	98	0.351	0.411	0.352
Older persons	30	16	15	0.436	0.616	0.530

The difference in agreement by vignette age group suggests that the phase definitions vary in relevance and applicability by age cohort. This is consistent with clinician feedback discussed at section 9.3, and further in the conclusions at section 10.1.1.

[14] Note that the Group 1 statistics reported here vary from those detailed in the IRR Study 1 Report due to differences in data preparation designed to ensure comparability between Study 1 and 2. See sections 8.2 and 8.3 for further details.

9.2.2 Kappa statistics by phase of care

Table 24 to Table 26 shows the kappa agreement of phase of care across Groups 1, 2A and 2B. Table 27 to Table 29 split this further by vignette age group. Overall, kappa agreement has improved in the consistent phases ('acute' and 'assessment only') from Study 1 to Study 2. A direct comparison of the remaining phases cannot be made between the studies, but there is an overall trend of improvement between them, if 'functional gain', 'intensive extended', and 'consolidating gain' are considered on a spectrum of acuity broadly aligned with 'subacute', 'rehabilitation and recovery' and 'non-acute'.

Table 24: Kappa agreement statistics by phase of care – Group 1

Kappa Agreement Statistics				
AC	FG	IE	CG	AO
0.498	0.237	0.375	0.430	0.464

Key: AC acute, FG functional gain, IE intensive extended, CG consolidating gain, AO assessment only

Table 25: Kappa agreement statistics by phase of care – Group 2A

Kappa Agreement Statistics			
AC	SA	NA	AO
0.653	0.407	0.476	0.505

Key: AC acute, SA subacute, NA non-acute, AO assessment only

Table 26: Kappa agreement statistics by phase of care – Group 2B

Kappa Agreement Statistics				
AC	SA	RR	NA	AO
0.517	0.321	0.370	0.459	0.557

Key: AC acute, SA subacute, RR rehabilitation and recovery, NA non-acute, AO assessment only

Looking further by age in Table 27 to Table 29, agreement was reasonably consistent across the age groups for 'acute' and 'assessment only' phases, with some variability in 'acute' for the older persons cohort in Group 2A.

In Group 1, the lowest agreement scores are for children and adolescents in 'functional gain' and 'intensive extended' phases, compared to the highest Group 1 score being for children and adolescents in a 'consolidating gain' phase. With the exception of 'acute' phases, this is broadly consistent with both Groups 2A and 2B where the level of agreement improved for the child and adolescent cohort as acuity decreased.

The other more significant variation is that between adult 'subacute' ratings in Group 2A (0.327) compared to the same vignettes in Groups 1 (broadly mapping to 'functional gain', 0.203) and 2B (0.104).

Additionally, the 'subacute' phase provided the lowest kappa agreement in Groups 2A and 2B for both child and adolescent and adult vignettes, but performed well in both Groups for older person vignettes (notwithstanding the difference in 'subacute' definitions between Groups). This was reflected in the 'functional gain' phase showing low performance in Group 1 for both child and adolescent and adult cohorts.

Table 27: Kappa agreement statistics by vignette age group and phase of care – Group 1

	Kappa Agreement Statistics				
Age Group	AC	FG	IE	CG	AO
Children and adolescents	0.483	0.166	0.185	0.670	0.471
Adults	0.430	0.203	0.388	0.284	0.458
Older persons	0.526	0.309	0.576	0.316	0.381

Key: AC acute, FG functional gain, IE intensive extended, CG consolidating gain, AO assessment only

Table 28: Kappa agreement statistics by vignette age group and phase of care – Group 2A

	Kappa Agreement Statistics			
Age Group	AC	SA	NA	AO
Children and adolescents	0.597	0.273	0.495	0.491
Adults	0.605	0.327	0.343	0.481
Older persons	0.728	0.592	0.620	0.512

Key: AC acute, SA subacute, NA non-acute, AO assessment only

Table 29: Kappa agreement statistics by vignette age group and phase of care – Group 2B

	Kappa Agreement Statistics				
Age Group	AC	SA	RR	NA	AO
Children and adolescents	0.466	0.199	0.427	0.470	0.582
Adults	0.560	0.104	0.220	0.388	0.563
Older persons	0.512	0.607	0.461	0.533	0.518

Key: AC acute, SA subacute, RR rehabilitation and recovery, NA non-acute, AO assessment only

9.2.3 Kappa statistics by service setting

Table 30 compares the kappa statistic across service settings. The first category '[clinician works] across settings/other' was only available to respondents in Study 2. Comparing admitted and community settings, the agreement statistics are reasonably similar across all three Groups, with a slight improvement in the community setting.

Table 30: Kappa agreement statistics by main service setting

	Respondents			Kappa Agreement Statistics		
Main Service Setting	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Across settings/Other	0	3	8		np	0.631
Community	280	103	83	0.429	0.518	0.490
Admitted	72	18	38	0.330	0.504	0.435
Residential	0	0	4			np

In instances of very low sample counts (≤ 4), agreement statistics have been suppressed for confidentiality purposes, and marked as 'np' (not provided)

Table 31 compares the kappa statistic across service settings and breaks this down further by age group. Residential and 'across settings/other' ratings are not included in this table due to low sample sizes. Given the overall differences in ratings across age groups, together with clinician advice about how risk and the threshold for admission to hospital vary depending on the age of the consumer (sections 9.3.2 and 9.3.3), it is possible that the IRR of phase of care differs by age and setting. However, the sample sizes in this study are too small to obtain meaningful results in this area.

Table 31: Kappa agreement statistics by main service setting and vignette age group

		Respondents			Kappa Agreement Statistics		
Setting	Age Group	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Community	Children and adolescents	59	16	17	0.397	0.505	0.493
	Adults	202	73	57	0.359	0.414	0.419
	Older persons	19	14	9	0.535	0.621	0.543
Admitted	Children and adolescents	5	3	3	0.313	np	np
	Adults	56	13	30	0.312	0.415	0.257
	Older persons	11	2	5	0.302	np	0.579

In instances of very low sample counts (≤ 4), agreement statistics have been suppressed for confidentiality purposes, and marked as 'np' (not provided)

9.2.4 Raw agreement by phase of care

Table 32 to Table 34 present the raw agreement rates by phase of care for Studies 1 and 2. The purpose of this analysis was to identify not just what proportion of respondents identified the correct[15] phase for the clinical vignettes, but to consider how incorrect ratings were distributed.

Table 32: Summary of raw agreement ratings by vignette phase of care – Group 1

		% Ratings by Phase					
Vignette Phase	Ratings	AC	FG	IE	CG	AO	Total
Acute	366	72.7%	10.6%	12.2%	0.8%	3.7%	**100%**
Functional gain	290	7.3%	57.1%	19.5%	11.8%	4.2%	**100%**
Intensive extended	448	3.3%	17.9%	70.4%	8.1%	0.3%	**100%**
Consolidating gain	422	0.6%	19.3%	4.7%	66.6%	8.9%	**100%**
Assessment only	587	17.8%	4.5%	6.4%	5.5%	65.9%	**100%**

Key: AC acute, FG functional gain, IE intensive extended, CG consolidating gain, AO assessment only

Table 33: Summary of raw agreement ratings by vignette phase of care – Group 2A

		% Ratings by Phase				
Vignette Phase	Ratings	AC	SA	NA	AO	Total
Acute	149	65.3%	26.1%	1.3%	7.4%	**100%**
Subacute	350	1.4%	60.9%	34.3%	3.4%	**100%**
Non-acute	201	0.0%	2.8%	88.2%	9.0%	**100%**
Assessment only	201	8.4%	7.5%	8.7%	75.4%	**100%**

Key: AC acute, SA subacute, NA non-acute, AO assessment only

[15] The clinical vignettes used in the study were reviewed by clinicians to reach agreement on phase assignment, referred to here as the 'correct' phase. This is discussed at section 5.1.

Table 34: Summary of raw agreement ratings by vignette phase of care – Group 2B

Vignette Phase	Ratings	% Ratings by Phase					
		AC	SA	RR	NA	AO	Total
Acute	156	60.3%	31.9%	1.7%	0.0%	6.2%	**100%**
Subacute	133	2.6%	45.5%	36.6%	13.4%	2.0%	**100%**
Rehabilitation and recovery	242	1.6%	14.2%	52.2%	26.0%	5.9%	**100%**
Non-acute	219	0.0%	1.8%	13.7%	81.1%	3.4%	**100%**
Assessment only	219	5.3%	5.6%	2.5%	8.1%	78.4%	**100%**

Key: AC acute, SA subacute, RR rehabilitation and recovery, NA non-acute, AO assessment only

Correct phase was assigned by the majority of clinicians for each of the three Groups. However, in the case of Group 2B 'subacute' vignettes, this majority was only 45.5 per cent, with 36.6 per cent of the clinicians incorrectly assigning the 'rehabilitation and recovery' phase, and 13.4 per cent of clinicians incorrectly assigning the 'non-acute' phase (Table 34).

Of similar marginal performance among Group 2B, only 52.2 per cent of clinicians correctly rated 'rehabilitation and recovery' vignettes, with 26.0 per cent incorrectly rating them as 'non-acute', and 14.2 per cent incorrectly rating them as 'subacute'.

These observations indicate improvements are needed in the definition and/or differentiation of 'subacute', 'rehabilitation and recovery' and non-acute' phases within Option 2B.

This correlates with feedback from clinicians, discussed at section 9.3, that:

- There is significant overlap between the 'subacute', 'rehabilitation and recovery', and 'non-acute' phases.
- The definitions do not appropriately capture chronically ill consumer as the current 'intensive extended' phase does.

In combination, this results in a lack of clarity as to which phase of care to assign to a consumer.

9.2.5 Raw agreement by age group

To better understand where there is variation in the phase of care assignment, and if the phases and/or descriptors are affected by the age of the consumers, Table 35 to Table 37 break down the raw agreement by age group.

Each table presents the same information as above but separated out by the age of the consumer in the vignette and therefore also the age specialty of the clinician rating the vignette. It should be noted that fewer respondents rated the child and adolescent and older persons vignettes, compared to the adult ones, with the agreement ratings therefore based on a smaller sample size.

In all three study Groups, the pattern of correct/incorrect ratings is broadly similar across all age groups.

However, there are some variations. For example, a significant proportion of older persons 'assessment only' vignettes were rated as 'acute' in Group 1 (48.3 per cent), with this reducing in Groups 2A (25.0 per cent) and 2B (20.0 per cent).

In Group 2B, only 15.0 per cent of child and adolescent 'subacute' vignettes were rated correctly, with 'rehabilitation and recovery' assigned in 75.0 per cent of cases. Conversely, 86.7 per cent of older persons 'subacute' vignettes were rated correctly in Group 2B. This suggests that the phase definitions may be more relevant and/or appropriate for some age groups.

Table 35: Summary of raw agreement ratings by vignette phase of care and age group – Group 1

Vignette Phase	Age Group	Ratings	% Ratings by Phase					
			AC	FA	IE	CG	AO	Total
Acute	Children and adolescents	65	65.9%	7.6%	23.5%	0.0%	2.9%	**100%**
	Adults	254	76.8%	5.9%	3.9%	0.8%	12.6%	**100%**
	Older persons	47	77.5%	15.9%	5.0%	1.7%	0.0%	**100%**
Functional gain	Children and adolescents	94	3.3%	45.1%	30.6%	15.4%	5.6%	**100%**
	Adults	152	16.4%	63.2%	2.6%	7.9%	9.9%	**100%**
	Older persons	44	6.8%	66.1%	16.9%	10.2%	0.0%	**100%**
Intensive extended	Children and adolescents	35	2.9%	25.7%	68.6%	2.9%	0.0%	**100%**
	Adults	396	5.2%	20.0%	59.5%	14.8%	0.6%	**100%**
	Older persons	17	0.0%	5.9%	94.1%	0.0%	0.0%	**100%**
Consolidating gain	Children and adolescents	34	0.0%	2.9%	2.9%	94.1%	0.0%	**100%**
	Adults	371	1.2%	22.4%	4.9%	59.6%	11.8%	**100%**
	Older persons	17	0.0%	29.4%	5.9%	52.9%	11.8%	**100%**
Assessment only	Children and adolescents	59	6.8%	11.9%	13.6%	1.7%	66.1%	**100%**
	Adults	499	8.0%	3.0%	6.0%	10.1%	72.9%	**100%**
	Older persons	29	48.3%	0.0%	0.0%	0.0%	51.7%	**100%**

Key: AC acute, FG functional gain, IE intensive extended, CG consolidating gain, AO assessment only

Table 36: Summary of raw agreement ratings by vignette phase of care and age group – Group 2A

Vignette Phase	Age Group	Ratings	% Ratings by Phase				
			AC	SA	NA	AO	Total
Acute	Children and adolescents	40	70.0%	22.5%	2.5%	5.0%	**100%**
	Adults	77	74.0%	10.4%	1.3%	14.3%	**100%**
	Older persons	32	56.2%	37.5%	0.0%	6.2%	**100%**
Subacute	Children and adolescents	60	1.7%	58.3%	36.7%	3.3%	**100%**
	Adults	242	2.5%	59.9%	32.8%	4.7%	**100%**
	Older persons	48	0.0%	64.6%	33.3%	2.1%	**100%**
Non-acute	Children and adolescents	20	0.0%	0.0%	100.0%	0.0%	**100%**
	Adults	165	0.0%	5.5%	79.5%	14.9%	**100%**
	Older persons	16	0.0%	0.0%	93.8%	6.3%	**100%**
Assessment only	Children and adolescents	20	5.0%	15.0%	10.0%	70.0%	**100%**
	Adults	165	1.7%	7.5%	12.4%	78.3%	**100%**
	Older persons	16	25.0%	0.0%	0.0%	75.0%	**100%**

Key: AC acute, SA subacute, NA non-acute, AO assessment only

Table 37: Summary of raw agreement ratings by vignette phase of care and age group – Group 2B

			% Ratings by Phase					
Vignette Phase	Age Group	Ratings	AC	SA	RR	NA	AO	Total
Acute	Children and adolescents	40	57.5%	37.5%	2.5%	0.0%	2.5%	**100%**
	Adults	86	66.3%	24.4%	3.5%	0.0%	5.8%	**100%**
	Older persons	30	60.0%	30.0%	0.0%	0.0%	10.0%	**100%**
Subacute	Children and adolescents	20	0.0%	15.0%	75.0%	5.0%	5.0%	**100%**
	Adults	98	1.0%	34.7%	34.7%	28.6%	1.0%	**100%**
	Older persons	15	6.7%	86.7%	0.0%	6.7%	0.0%	**100%**
Rehabilitation and recovery	Children and adolescents	40	2.5%	5.0%	55.0%	27.5%	10.0%	**100%**
	Adults	172	2.3%	30.8%	51.7%	14.0%	1.2%	**100%**
	Older persons	30	0.0%	6.7%	50.0%	36.7%	6.7%	**100%**
Non-acute	Children and adolescents	20	0.0%	5.0%	10.0%	85.0%	0.0%	**100%**
	Adults	184	0.0%	1.2%	15.7%	76.4%	6.8%	**100%**
	Older persons	15	0.0%	0.0%	13.3%	86.7%	0.0%	**100%**
Assessment only	Children and adolescents	20	0.0%	0.0%	5.0%	10.0%	85.0%	**100%**
	Adults	184	0.6%	11.3%	2.6%	11.2%	74.4%	**100%**
	Older persons	15	20.0%	0.0%	0.0%	0.0%	80.0%	**100%**

Key: AC acute, SA subacute, RR rehabilitation and recovery, NA non-acute, AO assessment only

9.2.6 Raw agreement by vignette

Finally, the raw ratings have been considered by vignette. The purpose of this is to determine whether there are particular vignettes with lower agreement ratings, and the impact of this. These tables are presented at Appendix E, summarised by each of the Groups in Table 47 to Table 49, and then detailed by vignette in Table 50 to Table 52.

There were a small number of vignettes for which the phase assigned by the majority of clinicians was not the correct phase: two child and adolescent vignettes ('Marcus' and 'Llubica') and two older persons vignettes ('Edward' and 'Antonina'). However, overall the proportion of correct and incorrect ratings was reasonably consistent, and where there was disagreement, for example, for the vignette 'Marcus', the distribution of ratings across different phases was similar across the Groups. This suggests that there may be issues with the specific vignettes rather than the phase definitions.

None of these vignettes were in the adult cohort – the most accurately assigned age group – and three of the four were 'subacute' or 'rehabilitation and recovery', which were less consistently applied phases. This suggests that it is most likely that the high proportions of incorrect ratings are as a result of less applicable phase definitions in these age groups, combined with the natural variation in the 'ease' of assessment of phase of care across vignettes.

9.2.7 Key findings from the vignette rating process

In summary, the statistical analysis of the vignette rating process found that:

- Overall, there has been an improvement in the kappa statistic from Study 1 (0.396) to Study 2, with Option 2A delivering the best IRR (0.495), compared to Option 2B (0.441). This trend is the case across all age groups and is reasonably consistent across service settings.
- Comparing Options 2A and 2B, and looking further to identify where the greatest variability lies between phase choices, showed that introducing a split between 'subacute' and 'rehabilitation and recovery' decreased the kappa statistic IRR.
- This 'subacute/ rehabilitation and recovery' variation is supported by raw agreement analysis. This showed that the correct phase of care was assigned by the majority of clinicians across

all vignette phases and all three groups. However, in one case among Group 2B clinicians, this majority was under 50 per cent. In this instance, the 'subacute' vignettes were correctly rated by only 45.5 per cent of clinicians, with 36.6 per cent of clinicians incorrectly rating them as 'rehabilitation and recovery'.

- There was also some confusion among Group B clinicians regarding 'rehabilitation and recovery' and 'non acute' phase assignment, with the 'rehabilitation and recovery' vignettes correctly rated by 52.2 per cent of clinicians, but with a significant proportion of clinicians (26.0 per cent) incorrectly rating them as 'non-acute'.
- Finally, IRR is less consistent for the child and adolescent and older persons age groups. For children and adolescents, the IRR decreases as the acuity of presentation does, and the raw agreement saw 'rehabilitation and recovery' assigned in 75.0 per cent of 'subacute' cases. Conversely, 86.7 per cent of older persons 'subacute' vignettes were rated correctly in Group 2B. This suggests variability in phase application or interpretation across age groups.

9.3 Findings from clinician discussion and feedback

Additional feedback was sought from respondents through the survey and group feedback sessions, in three different ways:

- survey responses providing ratings on a series of questions
- free-text feedback fields in the survey
- group discussion in the feedback session, including rating Options 2A and 2B.

9.3.1 Survey: rating the process

In Study 2, respondents were asked to provide rated responses to a series of questions, with responses mandatory. The results are detailed in Table 53 to Table 57 at Appendix E.

After assigning a phase of care to each vignette, respondents were asked to rate how confident they were in assigning the phase of care. Broadly, confidence and accuracy increased together. This was the same for both Group 2A and 2B respondents (Table 53).

At the end of the survey, respondents were asked to rate overall how confident they were in assigning a phase of care to the vignettes, on a scale of 0-10. The results were similar across Groups 2A and 2B, with over 85 per cent of both Groups rating their confidence at between five and eight, and approximately one third of respondents in both Groups rating 'seven' (Table 54).

Respondents were also asked 'How well do the phases of care describe the consumers that you see at your service?' and 'Are the phase of care concepts and definitions meaningful and relevant to your clinical practice?' Responses to both questions were similar across Groups 2A and 2B, with both Option 2A and 2B viewed as relevant and meaningful (Table 55 and Table 56).

Finally, respondents were asked if the length of time allocated for training was sufficient, to inform national guidance and future jurisdictional training. Over 85 per cent of respondents in both Groups felt that the training was the right length of time (Table 57). State-level breakdowns of these results will be provided to jurisdictions to inform future training needs.

9.3.2 Survey: written comments

Respondents were also provided with non-mandatory free-text fields to provide further comments on the phases of care, training and vignettes.

Of the 277 respondents, 129 provided comments in the free-text fields of the survey. Of these responses, 10 were excluded from the quantitative analysis at for the reasons set out at section 8.2, and have therefore been excluded here as well, resulting in comments from 119 respondents.

47 per cent (56) of the 119 respondents who provided comments were in Group 2A, and 53 per cent (63) were in Group 2B, representing a similar distribution to that of the overall respondent base (48 per cent and 52 per cent respectively). The distribution of respondents who provided comments broadly matched the distribution of overall respondents by jurisdiction, service setting and clinical discipline.

The comments were reviewed and grouped into four broad themes. Most comments related to the phase of care definitions, with the most common piece of feedback being general support for the new definitions. Respondents also identified specific issues with the new phase definitions and areas for improvement.

Comments are summarised in Table 39 at the end of this chapter,

9.3.3 Group feedback sessions

Immediately following the survey, the group returned to the video call for a group feedback discussion that lasted 15-30 minutes depending on the level of respondent engagement. It included additional training on the alternate Study 2 phase of care Option (2A or 2B).

The general response from 21 of the 32 groups was that the proposed definitions were an improvement on the current Australian Mental Health Care Classification (AMHCC) Version 1.0 phases. Respondents stated that the proposed phases were clearer and more intuitive and relatable.

Most groups reported that the ‘assessment only’ and ‘acute’ phases of care were the easiest to identify in the vignettes. For those respondents testing Option 2A, feedback included that the broad ‘subacute’ definition was confusing, as was the split between ‘subacute’ and ‘non acute’. For those testing Option 2B, a number of respondents said that they found it hard to know when to apply ‘rehabilitation and recovery’ compared to ‘non acute’.

A number of respondents advised that chronically unwell people are not well described within the phase definitions, as they are in the current version of the classification with ‘intensive extended’.

Several groups noted that the definitions on their own are not sufficient and that training is essential for understanding the phases. However, they cautioned that that phase assignment is frequently focused solely on the phase name, so training should ensure a consistent understanding of these.

Comments made during these sessions are detailed in Table 40 at the end of this chapter.

Comparing Options 2A and 2B

As part of the group discussion, respondents were introduced to the alternative approach being tested. Group 2A respondents were introduced to the Group 2B definitions, and vice versa. Brief training was provided on the definitions. Questions were then posed to respondents. The purpose of these questions was to embed the alternate option just presented to assist with later discussions.

Group 2A respondents were asked to review three vignettes and individually decide on whether they thought each of the vignettes described a ‘subacute’ or ‘rehabilitation and recovery’ phase of care. This data was collected to provide further insights into how reliably clinicians could identify these two phases of care. However, as this was a non-mandatory question with respondents able to observe how the rest of the group was voting, there are limitations to these findings, including that respondents were limited to only two phase options – they could not choose to rate a vignette as, for example, ‘non-acute’.

Table 58 at Appendix E shows the results of this question. In each instance over 80 per cent of respondents assigned the correct phase.

Both Group 2A and 2B respondents were then asked whether they thought splitting the 'subacute' phase into 'subacute' and 'rehabilitation and recovery' reduced, made no difference to, or increased clinical meaningfulness.

227 of the 277 participants[16] responded, with the results shown in Table 38. The same limitations applied to this question as the previous one. Nevertheless, there was a strong preference for the Option 2B definitions, in particular amongst Group 2A respondents.

Table 38: Group question: 'Overall, does splitting the 'subacute' phase into 'subacute' and 'rehabilitation and recovery' make the phases more clinically meaningful and relevant to your clinical practice?'

Group	Having two phases reduces clinical meaningfulness	Having two phases makes no difference to clinical meaningfulness	Having two phases increases clinical meaningfulness	Total responses
Group 2A	9	7	97	113
Group 2B	40	18	56	114
Total responses	**49 (22%)**	**25 (11%)**	**153 (67%)**	**227**

Following this, each group discussed the two options. Within the group discussions, the general view in 16 of the 32 groups was that they preferred Option 2B. Three groups expressed a preference for Option 2A, and three groups had mixed views. Other groups either did not express a view or focused on discussing the difference between 'rehabilitation and recovery' and 'non-acute'.

Nine groups advised that the 'real issue' was the lack of clarity between the 'rehabilitation and recovery' and 'non-acute' phases. Respondents expressed views that 'subacute' and 'rehabilitation and recovery' are very different, but there is significant crossover between 'rehabilitation and recovery' and 'non-acute', and that this was confusing.

9.3.4 Key findings from clinician discussion and feedback

The clinician feedback from both the survey and group discussions covered a wide range of issues, of value in both determining the next steps in refining the classification itself, and its implementation. Of most relevance for determining the next steps in this project are the following:

Identifying a preferred set of phases

- The majority of groups felt that the proposed definitions are an improvement on the current phases of care. Of the proposed options, clinicians reported a preference for Option 2B. Clinicians stated that the proposed phases are clearer and more intuitive and relatable.
- There was feedback that the 'subacute' definition used in Option 2A is too broad. However, there was also feedback that the split between 'rehabilitation and recovery' in Option 2B and 'non-acute' is unclear with significant crossover between them.
- There was feedback that chronically unwell people are not well described within the phase definitions, as they are in the AMHCC Version 1.0 with the 'intensive extended' phase.

[16] There were 277 respondents, with 20 responses excluded in the statistical analysis presented earlier in this chapter. However, it was not possible to identify those excluded records in the analysis presented in Table 58 and Table 38.

Considerations in application

- There was caution offered that interpretation of phase of care varies depending on the service setting and age group of the consumer that a clinician is treating, in particular how acuity, risk and level of independence are assessed.
- Clinicians also advised that there is potential confusion if the phase name does not match the name of the mental health team providing care, for example, assigning a ‘subacute’ phase to someone being seen by an acute service.
- Clinicians reported that phase assignment is frequently focused solely on the phase name, so training should ensure a consistent understanding of these. However, it should also be tailored to account for local terminology and system structures.

Table 39: Summary of 'free-text' responses in the survey – Study 2

Theme	Summarised comments
Phase of care definitions (84 comments)	The proposed definitions are an improvement on the current ones. Clients that I see are all at the acute end of the spectrum – there needs to be more distinction here. The phase definitions are too broad, with 'grey areas' as to which phase a consumer is in. There is significant overlap between the 'subacute', 'rehabilitation and recovery', and 'non acute' phases. The definitions do not appropriately capture chronically ill clients as the current 'intensive extended' phase does. Clients change phases too frequently to use this. The phase definitions do not capture the experiences of children and adolescents, or older persons, or thresholds for intervention and risk management for these groups. I am unsure about the application of 'assessment only'. The definitions appear tailored to community services. The definitions do not consider risk management, explain how comorbidities are considered, capture intensity of care, or differentiate more between outcome and presentation. It is hard to identify how a consumer's baseline fits into phase of care. The use of 'recovery' implies a prior level of functioning that may not be relevant. This is administrative – it is not relevant to clinical practice.
Training approach (38 comments)	The training approach was good. More examples of cases within the training session would be helpful; and conversely, less time should be spent on examples and more time on the definitions. More training is needed before phase of care can be assigned. More discussions around 'incorrect' answers in training would be helpful. It would be helpful to explain what is not used in making a phase determination. A flowchart for decision making and/or additional documentation would be helpful. More placement specific training would be helpful. More background on IHPA and how the data is used would be helpful.
Clinical vignettes (31 comments)	Vignettes were relevant to consumers with sufficient detail provided. More detail is needed in the vignettes; conversely, the vignettes are too long It is hard to identify acute cases in the vignettes. It is hard to rate vignettes outside of my age specialty. Phase of care in the vignettes was just determined by the intervention. Some of the vignettes represent more than one phase.
Use of phase of care in funding (7 comments)	Phase of care on its own is not enough to determine funding. How will these changes impact funding? This is not an appropriate funding model.

Table 40: Summary of feedback from group discussions – Study 2

Theme	Summarised comments
Assigning phase of care	There were mixed views on how straightforward the survey process was, with several groups commenting that they felt real life application would be easier because the clinician would know more about the consumer than can be included in a vignette. Most groups reported that the 'assessment only' and 'acute' phases of care were the easiest to identify in the vignettes. Conversely, some respondents said that they found it hard to know when to apply 'assessment only' as this assessment was their core business, in particular child and adolescent specialists. Several respondents did not identify any 'acute' vignettes: 'As a community clinician I am trying to keep people out of hospital so do not want to identify them as acute; people in different services might have a different view.' Several respondents identified potential confusion were the proposed phases to be implemented, if the phase name does not match the name of the mental health team providing care, for example, assigning a 'subacute' phase to someone being seen by an acute service. For those respondents testing Option 2A, feedback included that the broad 'subacute' definition was confusing, as was the split between 'subacute' and 'non acute'. For those testing Option 2B, a number of respondents said that they found it hard to know when to apply 'rehabilitation and recovery' compared to 'non acute'.
Improving the definitions and supporting materials	A number of respondents advised that chronically unwell people are not well described within the phase definitions, as they are in the AMHCC Version 1.0 with 'intensive extended'. Several groups raised concerns about the use of the word 'recovery' in only one phase name, which suggests that it is not important in other phases of care. Some respondents asked for further guidance on what is meant by 'short, medium and long term' in the phase definition supporting materials. Other respondents noted that 'risk management' needs to be better addressed in the definitions including for different cohorts. Several groups noted that 'step up/down care' has local meaning and could be confusing if included in phase definitions. Several groups noted that training needs to be tailored locally. Several groups noted that the definitions on their own are not sufficient – training is essential for understanding the phases. However, they cautioned that that phase assignment is frequently focused solely on the phase name, so training should ensure a consistent understanding of these.
Comparing the current phases of care (Study 1) and the proposed alternatives (Study 2)	The general response from 21 of the 32 groups was that the proposed definitions were an improvement on the current AMHCC Version 1.0 phases. Respondents stated that the proposed phases were clearer and more intuitive and relatable. Some respondents who were not in favour of the proposed definitions saw current and proposed definitions as 'equally bad'. Others preferred the current phases because of their 'recovery focus'.

Theme	Summarised comments
Local value	Most groups felt that the phase of care definitions could be used locally to help with service planning, analysis and resource allocation. Several groups said that the new definitions could be useful in providing a shared language to communicate with other parts of the hospital system. Several respondents noted that phase should be used alongside other variables in analysis, for example, the Health of the Nation Outcome Score. Several respondents saw the value for service planning but cautioned against using the phases clinically. Many respondents from community mental health teams said that they currently lacked meaningful data beyond overall caseload counts, and that they would value additional insights to support local planning.

10. Conclusions

10.1.1 Overall conclusions

Drawing together the key findings from the study, there was an overall improvement in inter-rater reliability (IRR) from Study 1 to Study 2, with clinician support for the Study 2 phase of care definitions.

The new phases proposed – 'subacute', 'rehabilitation and recovery' and 'non-acute' – did not offer a major improvement in statistical performance. However, there was consistent clinician feedback that supported the introduction of Study 2 phases, in particular Option 2B.

Whilst Option 2A outperformed Option 2B in IRR, introducing a split between 'subacute' and 'rehabilitation and recovery' decreased the kappa statistic IRR for Option 2B. This should be taken into account when comparing between the Study 2 options and balanced against clinician support for Option 2B.

In light of these findings, the next iteration of the Australian Mental Health Care Classification (AMHCC) should incorporate the improvements offered by the new Option 2B phase definitions.

10.1.2 Areas for additional refinement

Across Options 1, 2A and 2B variation was observed in phase of care performance by clinical age group, with definitions best suited to the adult cohort. Consequently, there is value in updating the phase definitions (the primary goal of care) and supporting materials to better describe the goals and risk thresholds as they differ for children and adolescents, and older persons.

There was also consistent clinician feedback that the phase definitions in both Options 2A and 2B do not adequately classify all cases covered by the existing 'intensive extended' phase. This feedback was supported by relatively lower IRR scores among phases other than the 'acute' phase. Overall, Option 2B provides the best set of phases, but there is an opportunity to refine the AMHCC to better capture this group. This could include, for example, review of Health of the Nation Outcome Scales scores and weightings to refine the AMHCC end classes.

On the basis of these findings, the next iteration of the AMHCC should include the updating of phase of care definitions and supporting materials to:

- **Improve their interpretation and use within each age cohort.**
- **Ensure phase definitions and/or classification end classes adequately classify cases captured under the existing 'intensive extended' phase.**

10.1.3 Improved implementation

Regardless of any future changes made to phase of care, there is value in improving the quality and consistency of phase of care training. Feedback from clinicians included that phase assignment is frequently focused solely on the phase name, so training should focus on a consistent understanding of the names, recognising that definitions and supporting materials may not be referenced regularly.

There is also unmet need in community mental health services in some states and territories for phase of care or AMHCC reports to be provided locally to assist in understanding service

utilisation for local planning purposes. Promoting local tools such as these will increase the value of the AMHCC locally and improve quality of data through a feedback loop.

These opportunities to improve the implementation and value of phase of care and the AMHCC should be pursued by IHPA and states and territories regardless of the outcome of phase of care definitional changes.

10.1.4 Environment for further testing and refinement

In late 2019, prior to the commencement of this study, a two-stage testing approach was agreed with jurisdictions:

- **Stage One:** Utilise clinical vignettes developed as part of the 2016 IRR Study to assess (a) whether the proposed phase of care options outperform those in the AMHCC Version 1.0, and (b) which of the two proposed options has better IRR.

Then, if required:

- **Stage Two:** Activity and cost data collection from actual consumer episodes to assess the clinical and cost homogeneity of subgroups to determine the most suitable phase of care option.

As Stage Two would be considerably more resource intensive, Stage One vignette testing would provide information on whether either of the proposed new options offered improved IRR, before deciding whether or not to progress with Stage Two.

This report concludes that Option 2B offers improved IRR and clinical validity. The recommendations detailed in Chapter 11 relate to providing age-specific updates and mapping existing patient-level phase of care data to the new phase names.

Future work should centre on desktop exercises to be undertaken in consultation with jurisdictions, clinicians and subject matter experts. These activities do not require a major costing study to proceed or implement.

For this reason, the report determines that Stage Two as described above is no longer required for ‘next steps’.

11. Recommendations

11.1 Recommended approaches

IHPA should continue its normal work program to refine the Australian Mental Health Care Classification (AMHCC), informed by national data reporting to improve the overall performance of the classification.

In addition to this, based on the findings in the previous chapter, two potential approaches to phase of care refinement are set out below. The first approach retains the current phase of care names, whilst the second adopts a new set of phase names.

Approach 1: Retain the structure and terminology (phase names) of the current mental health phase of care concept, with updates to the individual phase definitions including age-specific guidance

There is clear clinician support for Option 2B definitions with some improvement in inter-rater reliability (IRR), but the statistical analysis does not strongly support full adoption of the Option 2B definitions at this point. Therefore, this approach does not change the phase of care names but focuses on improving the phase definitions and supporting material. This approach includes the following changes:

- Retain AMHCC Version 1.0 phase of care names, redefining ‘assessment only’ as an administrative data item in line with the 2017 Clinical Refinement Project recommendation.
- Develop age-specific updates to the definitions for all phases of care to better describe the goals and risk thresholds as they differ across age groups. These updates should incorporate refinements to the ‘acute’ phase and ‘assessment only’ data item definitions proposed in the 2017 Clinical Refinement Project, noting the improvement in IRR when these were applied in Study 2.
- Given clinician support for Option 2B phase names, consider how this language can best be incorporated into the updated phase definitions and/or supporting materials.

Limitations

The changes to definitions and supporting materials offer the potential to improve the consistency of phase of care assignment; however, clinicians have reported that phase allocation is frequently based only on the phase name itself. Therefore, the impact of this approach is likely to be limited and should only be progressed if it is accompanied by significant clinician training and local efforts to ensure that resources – definitions and supporting materials – are readily available to clinicians when assigning phase of care.

Approach 2: Retain the current mental health phase of care concept, with updates to the terminology (phase names) and individual phase definitions, including age-specific guidance

There is clear clinician support for changes to the phase of care names with some improvement in IRR and a preference for Option 2B. Given that routine application of phase of care focuses on selecting a phase based on its name rather than by reference to its detailed definition, the most effective way to improve clarity on phase of care and therefore IRR is to change the names of the phases. This approach includes the following changes:

- Adopt Option 2B phase names and develop age-specific updates to the phase definitions to better describe the goals and risk thresholds as they differ across age groups.
- Noting feedback from the study that the 'intensive extended' cohort are not easily identifiable in the Option 2B phases, a review of patient-level data should be included in the ongoing AMHCC work program to consider whether this cohort can better be described in the classification. This could include, for example, refinement of the end classes.

Limitations

Whilst Approach 2 presents a greater opportunity for improving IRR through phase name changes, it does still require significant clinician training to ensure consistent understanding of the new phase names.

Further, this approach does not explicitly address concerns raised by some clinicians that the 'intensive extended' cohort is not well captured in the Option 2B phases. Refinements to the overall classification offer opportunities to do this in the end classes but will not be immediately visible to clinicians. If this approach is adopted, broader training on the AMHCC should explain how phase of care is only one element of the overall classification.

11.2 Further opportunities to improve the consistent application and value of phase of care

The following recommendations should be adopted in all instances.

Improved education and training resources

- Develop a set of national training resources informed by the findings from this project for local use and adaption, to include age-specific and setting-specific materials.
- Include training materials on the AMHCC as a full classification, so that clinicians can better contextualise phase of care and understand how it works with other classification variables.
- Provide individual feedback to states and territories on Study 2 IRR performance within their jurisdiction, to enable them to target training needs.

Increasing the value of the AMHCC to improve its usefulness and accuracy

- Through clinician feedback it is clear that a number of community mental health services would find value in local reports on service utilisation by phase of care or AMHCC end class. IHPA should work with state and territories to share examples of where this is currently occurring to enable other jurisdictions to develop similar reports.

11.3 Next steps

As discussed at section 10.1.4, 'Stage Two' as proposed at the start of this study is no longer a viable option. However, further work is required to implement either of the approaches outlined above. The steps required by IHPA include:

- Approaches 1 and 2: Consult with jurisdictions, clinicians and subject matter experts to develop age-specific updates to phase of care definitions and supporting materials.
- Approach 2 only: Undertake work to map existing patient-level phase of care data to the new phase names for classification refinement and pricing purposes. The mapping process should be undertaken in close consultation with jurisdictions through the Mental Health Working Group, informed by the phase of care reassignment process undertaken for the study's clinical vignettes (section 5.1). This will provide a national dataset suitable for

progression of the AMHCC work program, recognising that the dataset will improve over time as the changes to phase names, definitions and supporting materials improve the IRR.

Appendix A. Study sites

Table 41: List of participating sites

Jurisdiction	Study site
New South Wales (15)	Central Coast Local Health District
	Hunter New England Local Health District
	Illawarra Shoalhaven Local Health District
	Mid North Coast Local Health District
	Murrumbidgee Local Health District
	Nepean Blue Mountains Local Health District
	Northern NSW Local Health District
	South Eastern Sydney Local Health District
	South West Sydney Local Health District
	Southern NSW Local Health District
	St Vincent's Health Network
	Sydney Children's Hospital Network
	Sydney Local Health District
	Western NSW Local Health District
	Western Sydney Local Health District
Victoria (4)	Alfred Mental Health – Community
	Austin Health
	Barwon Health
	St Vincent's Hospital Melbourne
Queensland (8)	Central Queensland
	Children's Health Queensland
	Gold Coast
	Metro North
	Metro South
	South West
	Sunshine Coast
	Wide Bay

Jurisdiction	Study site
Western Australia (12)	Bentley (Child & Adolescent Health Service)
	East Metropolitan Health Service
	Fiona Stanley Fremantle Hospital Group (South Metropolitan)
	Goldfields Region (WA Country)
	Great Southern (WA Country)
	Kimberley (WA Country)
	North Metropolitan Health Service
	Perth Children's Hospital
	Pilbara (WA Country)
	Rockingham (South Metropolitan)
	South West (WA Country)
	Wheatbelt Mental Health (WA Country)
South Australia (2)	Northern Adelaide Local Health Network
	Southern Adelaide Local Health Network
Tasmania (2)	Adult & Older Persons Community Mental Health Services – North
	Child & Adolescent Mental Health Services – North
Australian Capital Territory (1)	Mental Health Justice Health Alcohol and Drug Services
Northern Territory (1)	Top End and Central Australia Mental Health Services

Appendix B. Vignettes

Table 42: List of vignettes used in Study 2 (phase of care type included in brackets)

Child and adolescent vignettes	Adult vignettes	Older persons vignettes
Jordan (AC)	Gary (SA/RR)	Agnes (AO)
Tameka (NA)	Ashley (AC)	Eric (NA)
Marcus (SA/RR)	Jason (SA/SA)	Jo (AC)
Llubica (SA/SA)	Fang (NA)	Mara (SA/SA)
Jade (AC)	Barry (SA/RR)	Peter (SA/RR)
Bryce (AO)	Vivian (AO)	Antonina (SA/RR)
Sumaya (SA/RR)	Jo Beth (NA)	Edward (AC)
	Malcolm (AO)	

Key: AC acute, SA subacute, RR rehabilitation and recovery, NA non-acute, AO assessment only

Jordan

Child and adolescent

Name: Jordan, 8 Jordan lives at home with his father and 3 year old sister, following the death of his mother 18 months ago from breast cancer.	
Behaviour	Jordan has been referred to your service by his treating psychologist after a recent contact. Jordan has been refusing to sleep in his own bed at night for some days now and his father has noticed a number of scratches and bite marks on his left arm, which he tries to hide. Jordan also told a teacher at school that he can hear his late mother talking to him when he is alone, particularly at night, and reported that he bites himself to make him feel better and for the 'voice' to stop.
Physical	Jordan's weight is at the lower end of what would be considered normal for his age and height. He has taken to only eating white or orange foods. Jordan has also been noted to have soiled himself a few times after school and then hiding his underpants from his father, who found them in the backyard.
Symptoms	Jordan is seen muttering to himself with a deep frown on his face when sitting in the waiting room. He is seen to be rocking himself backwards and forwards on the chair, clutching at his left arm. He is only sleeping 3 to 4 hours a night.
Social	Jordan has refused to leave the house on the weekends and his father says he does not want his friends to come to his home. He has not played soccer for 6 weeks and says that one of the boys on the team hates him.
Family/ carer	Jordan's father is very distressed and he is thankful that he is getting support from his mother. Jordan and his sister do not interact at all and he is somewhat distant to his father.
Interventions	Jordan is reviewed by the CAMHS Team on a weekly basis. Consideration is given to referring him to the Children's Hospital due to his weight loss. His father is contacted daily by the acute mental health team for support.

Phase of care	Acute

Tameka

Child and adolescent

Name: Tameka, 16 Tameka is a 16 year old young woman of Maori heritage who lives with her parents, four older siblings and maternal grandmother. She is in Year 11 at the local Catholic High School.	
Behaviour	Tameka has been diagnosed with a Conduct Disorder when she was in Year 8 at her previous high school. She has also been diagnosed with ADHD by a Paediatrician when she was aged 8. Tameka has been attending school regularly after a period of intensive intervention involving school, CAMHS and a local church based NGO that her parents are involved with. She is reported to be 'much calmer' at home after a medication change some months ago. Her behaviour at school has improved and she has been asked to join the local drama group which she is very pleased about.
Physical	Tameka has an athletic build and exercises regularly with her father by helping him train the rugby union team that her brother plays for. She is physically larger than the other girls in her class but she has lost 5 kg in the last 6 weeks by cutting back on junk food that she used to enjoy when she was 'unhappy' and now cooks regularly at home with her mother.
Symptoms	Tameka reports that she is sleeping well though sometimes struggles to get up for school in the mornings. She reports that she has been 'counting to 10' when she feels herself getting angry and has also been practicing her relaxation techniques with her aunty. She has been receiving regular pocket money when she completes chores around the house.
Social	Tameka has made a number of friends at school, though her mother says that she tends to spend time with the family on weekends. Her mother has encouraged her to invite her friends over. She has now been given her own room as one of her brothers has recently left home.
Family/ carer	Tameka has a good relationship with her parents and siblings.
Interventions	Tameka attends the local CAMHS monthly with one or both of her parents for support and a 'check in'. She is involved with the local youth service that runs acting classes.

Phase of care	Non-acute

Marcus

Child and adolescent

Name: Marcus, 17 Marcus is a 17 year old boy who has been living in a local Youth Refuge for the past 6 months. He attends your service with a Youth Support Worker who knows Marcus well.	
Behaviour	Marcus has a history of drug induced psychosis and has come to your service after being discharged from an out of area mental health service. His acute symptoms have stabilised. Marcus has reported to have been using cannabis for three years and developed psychotic symptoms which have now been in remission for some months. He presents as somewhat withdrawn and lacking in confidence but warms up after being engaged on neutral topics of interest to him. He says that he would like to get a job like his brother in construction. He also says that he would like to be better able to interact with the other residents in the Youth Refuge but thinks he is 'stupid and will probably say something dumb'.
Physical	Marcus reports that since taking antipsychotic medication, he has trouble 'getting things going down there' and is very concerned about 'not being a real man'. He has also put on a little weight and would like to get back to 'how I was before I got sick' when he was participating in mixed martial arts. He reports that he has enrolled in a gym.
Symptoms	Marcus reports that he will sometimes eat his meals in his room rather than sit in the dining area with other residents because he feels 'nervous'. He says that the medication he takes makes him very 'weak' and worries that he might not be able to work if he feels tired all the time. He feels that with some exercise and minor changes to his medication he may be able to manage this issue better. Marcus does not display any evidence of acute psychotic symptoms.
Social	Marcus has lived in the Youth Refuge for six months after being evicted from his family home due to his aggressive behaviour towards his mother when under the influence of drugs. He has seen his mother only once since being back in the local area. He has one mate in the Youth Refuge that he has known from school. He is not working or studying currently.
Family/ carer	He has a very poor relationship with his mother and little interaction with his siblings. His father separated from his mother a number of years ago and Marcus has had no contact with him since.
Interventions	Marcus is reviewed by your team and his medications are adjusted so that he does not feel as tired. He is referred to an Employment Skills program and is also engaged with a nearby Youth Centre where they train people in mixed martial arts. He also sees the local Youth Drug and Alcohol Service for support and engages in some family intervention work to restore his family relationships particularly with his mother.

Phase of care	Option 1: Subacute Option 2: Rehabilitation and recovery

Llubica

Child and adolescent

Name: Llubica, 15 Llubica lives at home with her parents and two younger sisters, who are from Serbia. She has started to attend a Flexible Learning Centre and is in Year 9 at school.	
Behaviour	Llubica has enrolled at the Flexible Learning Centre two months ago after being expelled from her two previous high schools due to her disruptive and aggressive behaviour. She has a troubled history with school attendance and peer relationships and her parents find it very difficult to manage her at home. Llubica has found it difficult to engage with a number of counsellors and other mental health professionals. Her mother reports that she is oppositional at home and will stand over her 'to get money for drugs'. She has frequently threatened self-harm when she does not 'get her own way' but this has decreased somewhat since starting at her new school.
Physical	Llubica is overweight and complains that the medication she takes is making her 'fat'. She says her friends post mean things about her on Facebook. She has started to drink protein shakes instead of eating regular meals on week days in order to lose weight.
Symptoms	Llubica's mood is highly changeable and she reports feeling 'bored all the time' when she is not with her friends. She reports that she has trouble focusing on her school work and staying calm when people 'say the wrong thing to me'. She reports that she thinks about cutting herself when she gets angry. She demonstrates poor frustration tolerance and affective ability.
Social	Llubica's parents have reluctantly brought her to your service. They appear to lack knowledge about the nature of Llubica's concerns and do not appear to take their daughter's self-harm and other behaviours seriously. They do not like Llubica's choice of friends and think she is a 'bad influence' on her sisters.
Family/ carer	Llubica's parents appear to have a limited understanding of the nature of her particular challenges and report being very frustrated with her lack of progress.
Interventions	Llubica sees her Case Manager at CAMHS once a fortnight. She is enrolled in an Affect Regulation clinic with other young people to help her manage her mood and improve her distress tolerance. Her parents are involved with carer support services and agree to attend psycho education sessions with Llubica's Case Manager. The school counsellor from the Flexible Learning Centre is also engaged by the Case Manager so a treatment plan can be formulated in collaboration with Llubica and her parents as she transitions into her senior school years.

Phase of care	Option 1: Subacute Option 2: Subacute

Jade

Child and adolescent

Name: Jade, 16 Jade is a 16 year old girl that lives at home with her Dad and is in Year 10 at a local high school. Her parents are divorced but they share custody of Jade and her two siblings.	
Behaviour	Jade was diagnosed with Bipolar Affective Disorder during Year 10 exams, eight months ago. She is in regular contact with the local CAMHS team and had a prolonged absence from school at the time and is repeating Year 10 as a result. Jade presents to the Emergency Department one Saturday night after an argument with her boyfriend and has threatened self-harm while intoxicated. She appears elevated in mood and is dressed as a gothic vampire slayer with heavy make-up, fishnets, tall black boots, a cape and a short dress. She is pacing up and down in the waiting area, talking loudly into her phone, being trailed by her mother who is clearly distressed.
Physical	Jade has a number of superficial lacerations to her left forearm, one of which appears to be actively bleeding. She is a tall, slim young woman who looks otherwise well. She has visible psoriasis behind her knees.
Symptoms	Jade is elevated in her mood and very talkative; she is difficult to interrupt. She claims her boyfriend has been cheating on her and she knows this because of 'his eyes'. Her mother reports that she has not slept for 48 hours.
Social	Jade has a small circle of friends at school. She reports being teased at school about her psoriasis.
Family/ carer	She has lived with her dad following her diagnosis but says she gets on well with her mum.
Interventions	A safety plan is negotiated with Jade and her parents and she is discharged to her parents' care. She is also referred to the Community Mental Health Team for close monitoring and support. Her parents are referred to carer support services.

Phase of care	Acute

Bryce

Child and adolescent

Name: Bryce, 13 Bryce is a 13 year old boy who has recently moved into a group home with two other adolescent males, where he is supported 24 hours a day by workers from a local NGO. He has been in foster care since aged 7 and had lived with the same family until an aggressive incident and some contact with the police. He has had no previous contact with mental health services.	
Behaviour	Bryce is seen in your department after falling through the roof over the decking of his group home after he crawled out onto the roof with two other boys after curfew. When confronted about this behaviour, he became verbally aggressive and threatened self-harm. He is a young man who says that he gets 'very angry easily' and is especially upset when he hears loud noises. He has had some difficulties at his new school with anger outbursts in class. He is sitting in your department, watching a video on his phone and laughing at what he sees.
Physical	Bryce has a very large build for his age. He is a little overweight and is self-conscious about this as he says that people 'stare at him' when he tells them his age. He is dressed in a rugby league shirt and shorts. He appears clean and tidy in appearance.
Symptoms	Bryce reports that he feels angry a lot of the time and he is not sure why. He lacks self-confidence and expresses the wish that he could be 'just normal like everyone else.' He reports feeling anxious in large groups of strangers. He sleeps well at night if he can listen to music before bed.
Social	He says he has made a couple of friends at school and has started to play football with a local rugby league team which he enjoys.
Family/ carer	Bryce misses the contact with his two younger siblings who still live with their foster parents.
Interventions	Bryce is interviewed along with the support worker who has attended the appointment with him. Collateral history is gathered from his GP and a developmental profile is formulated with Bryce's assistance. He is referred to the local Youth Service for support with his anger management issues.

Phase of care	Assessment only

Sumaya

Child and adolescent

Name: Sumaya, 11 Sumaya is an 11 year old girl who lives at home with her mother and two older sisters in rental accommodation. They arrived in Australia as settled refugees from Somalia 18 months ago. Her father is deceased, killed in the war seven years previously. He is barely remembered by Sumaya as he had been away fighting for 18 months before his death. She has been seeing you for some months after an initial referral from her primary school. You have a good rapport.	
Behaviour	Sumaya is somewhat withdrawn and hides her face in the side of her mother's clothing. She appears shy and is hard to engage. She has had several episodes at home where she will refuse to leave her mother's side when her mother tries to breastfeed Sumaya's younger sister and has also smacked her other sister when she refuses to go to school with her.
Physical	Sumaya is a slim young girl who appears underweight. Her mother reports that she will only eat broccoli, cherry tomatoes, cheese and plain pasta and she is worried about her health. For the past six months, Sumaya has been pulling out strands of her hair when she is at the school gates.
Symptoms	Sumaya is reported to seem anxious when she has to go to school in the morning and expresses a fear that she is not 'smart like the other girls'. She has developed a number of odd vocalisations when her mother tries to talk to her about her school work. Sumaya sometime wakes in the middle of the night and goes to her mother's bed to sleep.
Social	Sumaya is a talented guitar player and enjoys playing with her two female friends after school. She is somewhat excluded from her larger peer group.
Family/ carer	Her mother has expressed the belief that Sumaya may have been cursed by her grandmother when she left Somalia because she did not approve of her father when he was alive.
Interventions	Sumaya is enrolled in a day program with a focus on addressing her anxiety and confidence in the school setting. Sumaya expresses the wish to be able to walk to school by herself, as it is only 5-minute walk from her home, so a graduated program is planned. Her mother is also engaged in some education and support around assisting Sumaya with her anxiety. Sumaya is also referred to a dietician to discuss her current food preferences.

Phase of care	Option 1: Subacute Option 2: Rehabilitation and recovery

Gary

Adult

Name: Gary, 38 Gary is a single male who has lived with his mother his whole life. He has been case managed across a range of service settings for some years. He has been managed almost exclusively by an acute care team for two years due to the treatment resistant nature of his symptoms. Gary is a challenge to engage. He is currently reporting that he is adherent with his medications but there is some doubt as to the veracity of this claim.	
Behaviour	Gary has a diagnosis of Schizophrenia and has been on a Community Treatment Order in the past but is not at present. He is very reluctant to speak with you and will only do so on the front veranda of his family home, as he says he does not want his mother 'listening in'. Gary makes little eye contact and he seems guarded. He says that the medication is making him 'slow' and that people 'look at me like I'm a zombie'. He reports that the only thing he likes to do is watch DVDs and smoke. He says he cannot listen to music because it makes him 'sad'.
Physical	Gary is overweight and his GP has advised that he is in danger of developing Type 2 diabetes. Gary says that he feels hungry all the time. He also worries that he needs glasses as he has trouble seeing the TV unless he 'sits on top of it'. He says that he feels like he has to burp all the time, so he drinks a lot of soft drinks which he says helps with this.
Symptoms	Gary appears, as is usual, to be responding to non-evident stimuli and mumbles to himself frequently, at times he appears distressed but denies that he is. He says his mood is 'OK' but he has felt better before. He sleeps during the day and is awake at night. He feels that his neighbours joke about him when he comes outside to smoke.
Social	Gary is not able to identify any friends and is socially isolated. He says that his sister sometimes comes to take him out for a meal if he asks. He is worried that his mother is getting old and what will happen to her if she gets sick. Gary has never worked and his siblings want him to move out as their mother is elderly; but they are also worried what will happen to Gary if she doesn't look after him.
Interventions	Gary is engaged with the local community Rehab service for social skills development. An appointment is made for him to speak to a dietician about his weight. His mother is engaged with carer support services and encouraged to support Gary to live more independently with the view to gaining his own accommodation.

Phase of care	Option 1: Subacute Option 2: Rehabilitation and recovery

Ashley

Adult

Name: Ashley, 20 Ashley moved to the area five months ago to commence University. She is living in student accommodation and her family are 500 km away, living in a rural area.	
Behaviour	Ashley has been previously diagnosed with a Borderline Personality Disorder when she was 18. She is pacing backwards and forwards, chewing vigorously on the nails of her left hand and her right arm is bandaged. She is talking loudly into her mobile phone while at the same time glaring at her boyfriend who has accompanied her. When she sees you however, she smiles and hangs up. She speaks in a high pitched voice and appears to be on the verge of tears. She hides her bandaged arm behind her back.
Physical	Ashley is a tall, slim young woman, and appears somewhat dishevelled compared to when she was seen previously one month ago. Her makeup is smudged and she says that the Implanon she has had for four months is not working and is 'poisoning' her. She smells of alcohol.
Symptoms	Ashley is agitated and distressed. She reports that she is thinking of hurting herself and she does not feel she can stop herself. She says she can't cope with being a girlfriend to someone who does not respect her. She has not slept for 24 hours. She is angry and dismissive after initially appearing friendly and smiling.
Social	Ashley says that she is breaking up with her boyfriend because he is a 'lying pig'. She says she will instead go and live with a new female friend as she says she is 'now a lesbian'. She has missed the last week of University, and so is in danger of failing this semester.
Interventions	Ashley is assessed and placed in a safe place until she is sober; her distress is validated and she is encouraged to focus on her previously identified strengths. A safety plan is formulated with Ashley and her family are contacted for further collateral support at Ashley's request.

Phase of care	Acute

Jason

Adult

Name: Jason, 46 Jason is an ex train conductor who lives alone. He has had contact with the mental health service for a number of years.	
Behaviour	Jason has had various diagnoses in the past including Bipolar Affective Disorder, Schizophrenia and Schizoaffective Disorder. He reports that he believes he is being bullied by his brother. He has had one incident in the last 3 months where the police have been called to his house but left without further action. Jason attends your service reluctantly and has done so for some months after referral to an acute care team on discharge from hospital. He is often distant and says that he feels that 'you only talk to me because you have to'. He makes very little eye contact and plays games on his phone whilst meeting with you.
Physical	Jason has gained 12 kg in the past three months and says he cannot afford to eat 'healthy food'. He appears to have persistent open sores on the side of his neck which he repeatedly picks at. He says it itches all the time. Jason says he finds it hard to walk to the shops as he seems to get out of breath easily. Jason reports that he believes the medication he is on is a 'sort of poison'.
Symptoms	Jason appears at times to be responding to stimuli that are not evident to others, though he denies this when asked. He says his mood is 'fine' but his brother thinks that he is 'as flat as a tack'. He sleeps irregular hours and poor sleep has resulted in relapses of his illness in the past. He thinks the neighbours have it in for him, though he does like one lady who lives next door because she bakes him cookies.
Social	Jason's public housing tenancy is in danger due to the lack of cleanliness and complaints by some neighbours. His brother continues to visit regularly, but not as often as he once had, as Jason has reportedly stopped smoking cannabis. He hocked his computer for cash but goes to a friend's place to play online games because he enjoys being part of the clan.
Interventions	Jason has a Case Manager who visits him once a fortnight and he has been referred to a local NGO to assist with living skills and social contacts. His medication is regularly reviewed. He has been engaged with a local bulk-billing GP for metabolic screening and monitoring. Jason and his brother are introduced to a local online gaming group at Jason's request as he identifies having more friends as one of his main treatment goals. Jason's brother is given information on drug use and mental illness and is encouraged to support his brother's abstinence from cannabis.

Phase of care	Option 1: Subacute Option 2: Subacute

Fang

Adult

Name: Fang, 28 Fang is a Chinese woman who has lived in Australia for the past 7 years after arriving with her husband and his family. She is married and has one child. She has been attending your service for the past six months after referral from the community midwife one month post-partum.	
Behaviour	Fang developed postpartum depression after the birth of her child. Fang presents for a scheduled review appointment at your service. She is sitting quietly in the waiting room with her young baby with whom she is smiling and talking quietly. She is dressed fashionably in a designer outfit. She appears animated and chatty. When another young mother enters the room she introduces herself and her baby and the two mothers talk with great animation.
Physical	Fang has now returned to her prenatal weight. She attends boot camp with her sister-in-law two to three days a week after being encouraged to do so by the baby health nurse. She reports residual nausea from her antidepressant medication but manages this with a Chinese herbal remedy. She has now stopped breast feeding.
Symptoms	Fang's mood has improved and she rates it at about '7 out of 10', though she still finds it hard to wake up in the morning. She worries that she is 'not as good as her own mother' in raising her child and constantly compares herself to her mother.
Social	Fang lives with her husband, Julian, who is a doctor at the local hospital. Her husband's parents and younger brother live nearby. Fang reports that her husband is supportive but he works long hours. Her mother-in-law visits most days and helps her with cooking and home duties.
Interventions	Fang's medication regime has been reviewed and is unchanged. She is attending your service for supportive psychotherapy once a month. She has also been referred to a mother and baby group for young mothers who are recovering from postpartum depression. She enjoyed participating in the group and plans to continue participating.

Phase of care	Non-acute

Barry

Adult

Name: Barry, 61 Barry is a married man who lives with his wife in his own home. He is a successful builder and works with his two sons. He has now recovered from his laparoscopic cholecystectomy, though this has taken longer than he might have hoped. He is looking to return to work.	
Behaviour	Barry had previously been seen by your service when he was suffering from anxiety and has been referred again as by his GP as says he is having difficulty returning to work as a builder. Barry presents with his younger son as his wife is unable to accompany him. He is seen to be wringing his hands while he waits to be seen. He has been reluctant to return to work as he feels that he has lost his ability 'to be strong' around his workmates. He has been lying awake at night worrying about being able to work and his son reports that he is 'second guessing himself' in lots of different ways, though Barry says his son 'is making a big deal out of nothing'.
Physical	Barry looks well but has put on some weight since last seen; he says he has been eating 'rubbish food' as it makes him feel better. He has started exercising by going for brief walks with his neighbour each afternoon but says he has to hurry home as he feels too anxious to leave his wife for too long.
Symptoms	Barry reports that he has become more stressed as he is only able to get about four hours sleep a night, nearly every night. He says he is sure that he will 'never be able to sleep properly again', and if this is the case he does not know how he could return to work as planned. He says he gets 'a funny feeling in his chest' when he thinks about going back to work, but he has seen his GP and found no physical cause for concern.
Social	His son Bruce, with whom Barry works, says his father is 'driving Mum crazy' as he does not want to be left alone. In addition, he has had a falling out with two of his friends with whom he plays cards, accusing one of them of 'making eyes' at his wife.
Interventions	Barry is enrolled in a time limited brief CBT program and has a staged approach to return to work that was formulated with Barry. Barry's exercise program is also modified so that he can do more independent activities that take him outside of his home.

Phase of care	Option 1: Subacute Option 2: Rehabilitation and recovery

Vivian

Adult

Name: Vivian, 55 Vivian is 55 and lives alone.	
Behaviour	Vivian has a long history of anxiety and depression and although she has been treated by a psychiatrist in the past, her care is currently managed by her General Practitioner. She is well known to the service and has been visited on multiple occasions. She has been reviewed and follow-up arrangements have been made. Vivian has called the triage line of your service on a regular basis over the course of the last year. She usually calls when she is intoxicated, complaining of the ingratitude of her children, the fact that she is "not understood" and the futility of life.
Physical	Vivian is a small thin woman. She has been a smoker most of her life and suffers from chronic emphysema. As a result, she gets very little exercise and leads a fairly sedentary life. This does not impact her ability to undertake activities or daily living such as domestic chores.
Symptoms	Vivian does feel depressed and is anxious, but these are long term issues that are currently well controlled with Duloxetine.
Social	Vivian's husband died 4 years ago after a short battle with Leukaemia. She has a daughter and son who live locally and are supportive but complain that "mum can be demanding sometimes". Vivian attends a local quilter's group meeting weekly and interacts well in these social settings. She gets a great deal of enjoyment from her involvement.
Interventions	When Vivian calls the Mental Health Helpline after hours, you remind her of the supports that are currently in place such as her General Practitioner and members of her quilters group. You assess her mental state and document your contact with her. You discuss with Vivian the potential to talk though some of the issues she has raised with a Counsellor, which can be arranged by her General Practitioner. Vivian insists that life still isn't worth living but has no active intent or plans of self-harm. The call is terminated after 30 minutes.

Phase of care	Assessment only

Jo Beth

Adult

Name: Jo Beth, 29 Jo Beth is a 29 year old single woman, works as a Librarian at the University and lives with her boyfriend of 8 months.	
Behaviour	Jo Beth has a diagnosis of Obsessive Compulsive Disorder after attending a review at Beyond Blue two years ago. She is seen after attending a monthly review appointment with her primary physician. She is well presented and immaculately groomed. Jo Beth sits fidgeting in her chair with her boyfriend next to her. She makes good eye contact when spoken to. She reports that she has not had any major 'blow ups' at work with her junior colleagues for some months and is proud of her achievements in this respect as it had been a source of some distress to her previously.
Physical	Jo Beth looks well. She is normal weight for her height and has maintained this weight for some time after a period of some weight loss in the previous year. She says she sometimes gets 'stress headaches' but is trying to manage this with Rescue Remedy and some regular Pilates and Yoga. She is sleeping well, sometimes with the aid of a light hypnotic medication. She complains that her medication sometimes makes her nauseous in the mornings.
Symptoms	Jo Beth reports that she feels mildly anxious most mornings and this settles throughout the day. She is still performing a number of self-soothing rituals prior to leaving work each afternoon and has managed to reduce the frequency and number of these rituals. She continues to count her steps to and from work but is not distressed by this.
Social	Jo Beth lives with her boyfriend, after asking him to move in with her. She found this step quite remarkable as she had never previously felt comfortable living with anyone since leaving home. She has some contact with her mother but tries to limit this by being the one 'who does the visiting' so she can leave when she feels she has 'had enough'.
Interventions	Jo Beth's medication regime is reviewed in consultation with her treating psychiatrist and she is encouraged to identify further goals to build on her identified successes in her work setting. Jo Beth is provided with information about a number of smart phone apps to help with stress management and relaxation.

Phase of care	Non-acute

Malcolm

Adult

Name: Malcolm, 57 Malcolm is a 57 year old married man with three adult daughters. He works as a Chief Financial Officer with a large multinational merchant bank.	
Behaviour	Malcolm has presented on the strong advice of his eldest daughter after a significant late night domestic dispute with his wife. He has a history of depression and sits in the waiting area texting on his phone. He is smiling to himself and dismissive of his daughter who is trying to talk to him. He looks at his watch repeatedly while you are talking to him and answers questions with an elaborate vocabulary full of psychological jargon. He sits very still in his chair with his legs crossed and reports that he is 'only here under the greatest of duress'. His daughter rolls her eyes when he says this. He says he is 'only here to keep the princess happy.'
Physical	Malcolm is a powerfully built man with olive complexion and slight astigmatism to his left eye. He has hypertension but says 'so does everyone I know'. He reports that he gets tension headaches 'every Friday at about knock off time'. He drinks 1 bottle of wine every night.
Symptoms	Malcolm reports that 'everything is fine' and believes his wife and daughters 'are over- reacting'. He reports that he 'knows more about this stuff than you do'. He denies feeling depressed and that the medication he takes 'keeps me on the up and up'. He denies any thoughts of self-harm or harm to others. He says he is irritable 'most of the time, especially when I'm losing money'.
Social	Malcolm lives in his own home on the waterfront with his wife, Lucille. He says he has a large circle of 'so called friends', but professes that he can 'barely tolerate most of them because they are imbeciles'. He has a strong relationship with his daughters but 'is no fan of their husbands'.
Interventions	Malcolm is referred to his GP for review of his medications. A comprehensive documentation of his history and current circumstances are provided to his GP.

Phase of care	Assessment only

Agnes

Older persons

Name: Agnes, 82 Agnes is an 82 year-old woman, who has been married to John for 61 years. She has presented to the accident and emergency department.	
Behaviour	Agnes has no reported history of mental health concerns beyond post-natal depression that she had more than 50 years ago. She has presented to accident and emergency because her daughter is concerned about a recent deterioration in her mental state. She is accompanied by her husband who appears somewhat frail. She appears to be picking at her clothing and examining what she sees closely. Agnes appears irritable and difficult to engage. She is having difficulty sitting still and appears to respond sharply to her husband when he tries to reassure her. She is speaking loudly at times and is seen to be calling out 'Here Benji' over and over again.
Physical	Agnes is a woman of medium build; her hair on one side of her head is pressed against her scalp and she appears to have dry mucous membranes; she is complaining of 'having to pass water every ten minutes' and has a flushed appearance. Her husband reports that she has appeared a little unsteady on her feet for the past three days.
Symptoms	Agnes complains of feeling 'hot all over' and she appears disorientated to time and place; she appears to be having difficulty with her concentration and says she feels 'dreadful'. She is sleeping poorly and has been up all night, walking around looking for her dog, who died 7 years previously.
Social	Agnes lives with her husband in their own home. She has frequent contact with her children, grandchildren and great grandchildren and is usually busy in her garden most days. She has a large circle of friends, many of whom she used to work with.
Interventions	A mental state examination is conducted and collateral history gathered from her husband and her GP who saw her a week ago where she seemed 'fine'. The initial impression is that Agnes has a delirium. She is referred to the acute medical team.

Phase of care	Assessment only

Eric

Older persons

Name: Eric, 71 Eric is a 71 year old widowed man, who lives in a self-contained 'granny flat' in the backyard of his eldest daughter's house.	
Behaviour	Eric has been living in the granny flat for two years after a prolonged hospitalisation due to post-operative complications that triggered a severe psychotic episode, which required several months to settle. He presents with his granddaughter, Melanie, for a scheduled review. He is well dressed and groomed and is chatting happily with Melanie. Eric makes good eye contact and does not appear agitated or distressed. Eric engages with other clients in the waiting room prior to his review and is polite and friendly, talking with great pride about Melanie and her siblings, much to Melanie's embarrassment. There are no reports of aggression towards his family and he denies any thoughts of harming himself.
Physical	Eric is a moderately overweight man who has Type 2 diabetes, which is managed by diet and oral hypoglycaemic medication. He finds it hard to 'stick to the diet'. He reports that he does not do much exercise other than 'walk down to the shops every morning', which he says makes him feel 'fresh enough'. There are no further reported concerns post-surgery.
Symptoms	Eric reports that he feels 'pretty good' especially when he looks back to his period of being very unwell after his surgery. Melanie says that she sometimes looks like he is talking to himself, but Eric says that he just 'thinks aloud'. He expresses some anxiety that he is a burden on his daughter as he gets older and worries what will happen if he gets sick again.
Social	Eric enjoys teaching his granddaughter the guitar, for which he was famous for in his home country of Holland. He previously worked as a professional musician and has been thinking about trying to meet up with some other musicians and playing as he misses it. He says that most of his friends have now died and he primarily relies on his family for support and company. Eric feels that his daughter is not too sure what would be helpful and she is very 'protective of him' and 'sometimes treats me like a baby', but he says, 'I suppose that's just part of getting older'.
Interventions	Eric's medications are reviewed and his care plan continues to focus on wellness and improving his physical health with some regular exercise. His daughter is contacted and offered referral to a Carer Support group that meets at the community health centre. Eric is encouraged with his plans to meet up with fellow musicians, which he has indicated that this would give him great pleasure.

Phase of care	Non-acute

Jo

Older persons

Name: Jo, 61 Jo is a 67 year old woman who lives in rental accommodation with her long-term partner.	
Behaviour	Jo has an intellectual disability. She has been previously diagnosed with a Generalised Anxiety Disorder and has had long standing difficulties with benzodiazepine dependence. She is distressed and agitated after being brought in by police after being found in her bathroom by her partner holding scissors to her neck, threatening to 'end it all'. She appears mildly intoxicated and smells of alcohol. Jo is having difficulty articulating her concerns beyond saying that the 'medication does nothing' and that she is 'beyond help'. Her partner reports that she has struck him with a wet tea towel earlier in the day, when he made her tea without milk.
Physical	Jo is a tall slim woman who is neatly and stylishly dressed. She reports that her asthma has been 'playing up with the change in the weather'. She continues to smoke roll-your-own cigarettes. Jo says she has to wear orthotics in her shoes due to chronic plantar fasciitis.
Symptoms	Jo is agitated and distressed; she reports that she has persistent thoughts of harming herself and she has a plan to save up all her medications and overdose on them 'as soon as I get out of here'. Jo's sleep is poor as she wakes at 0300 most days and cannot get back to sleep due to 'worrying about everything'.
Social	Jo lives in a Department of Housing unit with her long term partner and receives the Disability Support Pension. She works part-time at a local hairdresser, which she enjoys. She reports that her sons do not come and visit her as often as she likes, because 'they don't like where I live and they're snobs'.
Interventions	Jo is contained in a safe place until she is sober and then offered oral medication to help her settle as she remains agitated. She is admitted briefly to the Psychiatric Emergency Care Centre (PECC) for further observation and care planning.

Phase of care	Acute

Mara

Older persons

Name: Mara, 69 Mara is a 69 year old, recently widowed woman of Italian heritage. Her husband of 48 years, Roberto, has died 8 months ago after battling a long illness. She lives alone, around the corner from her youngest daughter.	
Behaviour	Mara is a current client of the Older Persons Community MH team and is under active case management. Mara has a long history of Bipolar Affective Disorder (BPAD), first diagnosed when she arrived in Australia from Sicily. During her husband's illness, Mara was hospitalised for mania three times and her treatment is now made more challenging as she has developed chronic renal failure. Mara is a friendly, somewhat overfamiliar woman who looks older than her stated age. She is dressed in black and smiles often when questioned. She claims that she cannot understand English very well (though her daughter disputes this). For over a month she has been seen walking in the very early hours of the morning, muttering to herself. More recently, she struck her youngest grandson as she claims he 'disrespected' her. She says she often 'wishes for death' so she could be with her beloved husband.
Physical	Mara is a small statured woman, slim build but has been putting on weight since she was diagnosed with 'the kidney troubles' about which she appears to have a poor understanding. She frequently feels nauseous in the mornings and blames this on her change of medications in the past few months. She has refused out-right to alter her diet to control her kidney disease. She likes to drink wine with dinner every night.
Symptoms	Mara is slightly elevated in mood and is very talkative. Her daughter reports that since her husband died, she is not sure if Mara is taking her tablets or not. Mara dismisses the concerns of her daughter. She says three months ago she was 'very depressed' but now feels fine. She is sleeping with the aid of hypnotics at night. She denies suicidal thoughts as 'it is a sin' and she has strong religious beliefs.
Social	Mara's daughter has also been diagnosed with BPAD. Mara lives about 500 metres from her daughter's house, in her own home. She has a large circle of friends from the local Italian community and plays cards each Saturday afternoon at the local club. Mara and her daughter 'clash' often to the point where Mara will refuse to speak to her for weeks at a time over some perceived slight.
Interventions	The Case Manager with the Older Persons' Community Team has been closely monitoring of Mara's mental state and physical health status. Her medication regime requires close monitoring due to her renal disease. Mara is visited at home weekly due to her high likelihood of relapse.

Phase of care	Option 1: Subacute Option 2: Subacute

Peter

Older persons

Name: Peter, 85 Peter is an 85 year old man, married to his second wife, Minnie, for 11 years who is 23 years his junior. They live in their own second storey unit. He has two children from his previous marriage who live overseas.	
Behaviour	Peter suffered a stroke a few months ago has subsequently developed a major depressive illness, for which he has been treated with a combination of medication and supportive psychotherapy. He was previously a very active man who ran the local 'Men's Shed' in his area, which he misses a great deal. He presents in company of his wife. Peter appears irritable and dismissive with his wife, when you see them. He reports that he feels as if he is 'trapped under her feet 24/7' to which she nods vigorously. He has tended to try to avoid her for the past few weeks by keeping to himself in the spare room where he has been building model planes. Minnie appears anxious to placate him at all times. He is cooperative with the interview but keeps looking at his watch.
Physical	Peter is a tall, slim man who walks with the aid of a four prong stick and has a residual paresis of his left side which he says he is 'working on like I'm told'. He has some problems with urinary frequency at night. He reports that his appetite is good and he enjoys cooking 'when Minnie lets me'. He denies any other major physical concerns.
Symptoms	Peter reports that his mood is about '6/10' and thinks he might not get much better than that. He has negative thoughts about his future and fears that Minnie will leave him. He has some trouble sleeping due to his urinary frequency. His speech is animated and articulate.
Social	Peter and Minnie report that they are having difficulty negotiating the stairs to their second storey unit. She says that Peter is very reluctant to let his friends from the Men's Shed visit him at home as he feels 'embarrassed'. Peter has also been avoiding speaking to his two children when they call, which upsets Minnie a great deal as she thinks they will blame her for this 'as they have never really liked me'.
Interventions	Peter and his wife are working with the mental health case manager to assist with Peter getting back into his preferred community activity – the Men's Shed. His accommodation is assessed by an Occupational Therapist for modifications to help with mobility and he is enrolled in a swim class at the local leisure centre to help with his physical recovery. His children are also contacted with consent and advised on his progress.

Phase of care	Option 1: Subacute Option 2: Rehabilitation and recovery

Antonina

Older persons

Name: Antonina, 66 Antonina is a 66 year old Filipino woman, who has worked as a foster carer for FACS for many years. She has recently separated from her second husband after reported domestic violence. Her husband has subsequently been diagnosed with an aggressive brain tumour which has accounted for his aggressive behaviour and Antonina reports feeling very guilty about leaving him. Antonina has been previously treated for depression throughout her life but feels that she manages this well.	
Behaviour	Antonina presents in company of her sister; they appear to be identical twins. She is polite and friendly though she appears 'eager to please' and will defer to her sister at times to answer any queries. When Antonina's sister goes out of the room to answer her phone, Antonina reports that she feels irritated with her sister and has always found it difficult to 'stick up for myself around her'. She reports that she has had fleeting thoughts of self-harm but with no intent or pre-made plans.
Physical	Antonina reports that she feels well. She is accustomed to regular exercise and yoga but has let this fall away since her sister arrived. She reports that she experiences mild tension headaches on some afternoons and takes analgesia for this. She is not on any routine medications.
Symptoms	Antonia describes a loss of confidence in herself and has been 'second guessing' herself in relation to reconciliation with her partner. She feels as if she is no longer a 'good person' and does not feel she would be able to take in any foster children at this time, which she misses a great deal. She has some trouble sleeping.
Social	Antonina has a wide circle of friends and has been involved in a voice choir singing group at her local church which she enjoys. Her sister, who has arrived from the Philippines to stay with her, is discouraging when Antonina expresses a wish to try and reconcile with her husband. Her sister feels that she should instead 'look after herself'. Her sister is currently staying with her for an indefinite period of time. Antonina's husband lives just around the corner, after having recovered from recent surgery. He frequently drops round and Antonina pretends she is not home.
Interventions	Antonina is referred to the social worker on your team for support to help her manage her anxiety and for some supportive counselling. With Antonina's help, her sister engages with a Filipino support worker to enable Antonina to comfortably express her strong desire to continue fostering children and resume having some close contact with her husband.

Phase of care	Option 1: Subacute Option 2: Rehabilitation and recovery

Edward

Older persons

Name: Edward, 73 Edward is a 73 year old man who has been with his same sex partner, Gerald, for 41 years. They live in their own unit. Edward has no previous history of mental health concerns. Gerald has recently been admitted to ICU, post-surgery, and Edward has been referred to your service by the ICU social worker due to concerns about his mental health and his ability to look after himself.	
Behaviour	Edward sits slumped in his chair, staring at the floor; he picks repeatedly at the cuticle on his left index finger, where he has a gold ring. He does not make eye contact when he is spoken to. He has acted with frustration towards the social worker who has referred him to your service and says he is only here 'under sufferance'. He reports that if Gerald does not get better he 'can't really see any point in carrying on'.
Physical	Edward is a tall, solidly built man but his clothes appear to be hanging quite loosely on him. His shirt is not buttoned correctly. He has some hearing loss and usually wears hearing aids, but is not wearing them when you see him. He has a pale complexion and looks tired and worn out. He says he has not slept properly since Gerald was admitted to hospital and reports feeling weak and lethargic.
Symptoms	Edward reports a feeling of helplessness about his situation as he says he 'relied on Gerald for everything; he was the boss'. He rates his mood as 'the worst it has ever been' and feels anxious when he leaves the hospital after visiting and this feeling persists until he returns. His appetite is poor. He usually loves to cook but has been relying on cheap take away when he 'can't be bothered'. He says he is being punished for not letting Gerald go to the hospital when he first got sick.
Social	Edward is a retired school teacher and sometimes runs some classes at the Workers Education Authority. He has not done this for some weeks now. He is visited by his younger sister from time to time and says that he and Gerald used to enjoy going to the local club for a Trivia competition on Sunday afternoons.
Interventions	Edward is assessed by the team and is commenced on antidepressants. Regular review appointments are scheduled to allow monitoring of his mental state and physical health as well as his response to medication. Edward's sister is engaged and agrees to visit Edward at home every couple of days.

Phase of care	Acute

Appendix C. Survey

Survey questions

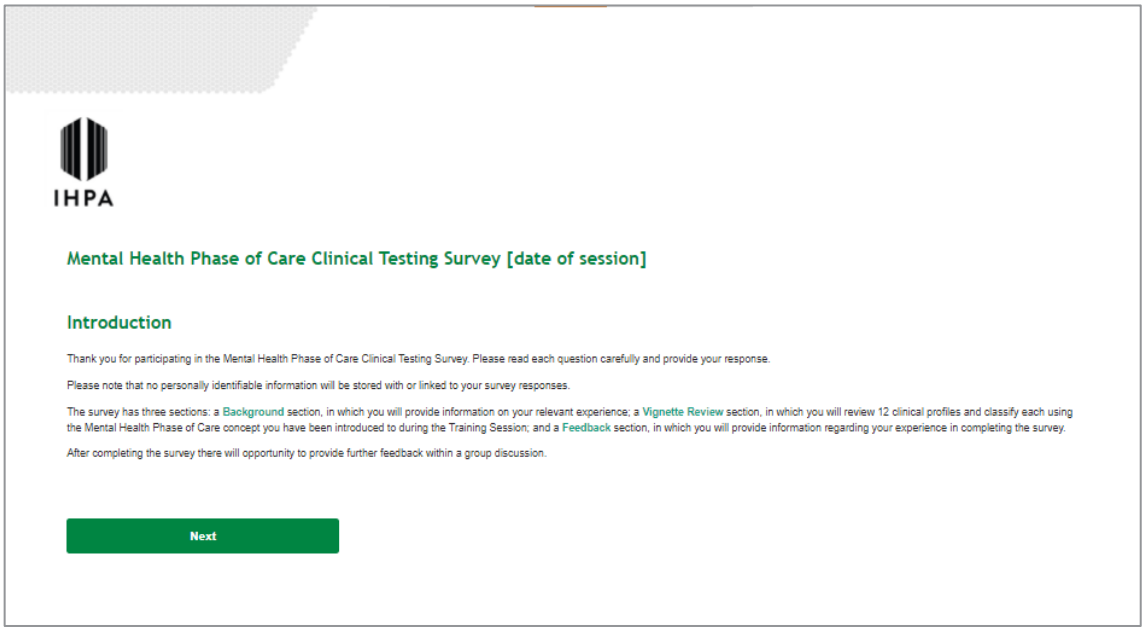
Table 43: Study 2 survey questions

Question	Response options	Question type	Consistency with Study 1
Section 1: background and professional experience			
1. From which jurisdiction are you participating?	Select one: NSW; VIC; QLD; WA; SA; TAS; ACT; NT	Mandatory	Consistent
2. Which Mental Health Phase of Care Training Session did you attend?	Select one: Group A; Group B	Mandatory	N/A
3. What is your clinical discipline? Please select as many as apply.	Can select multiple: Nurse; Occupational therapist; Psychiatric registrar; Psychiatrist; Psychologist; Social worker; Other (please specify); I do not have a clinical discipline	Mandatory	Consistent
4. How many years of experience have you had working in mental health?	Select one: 0-4 years; 5-9 years; 10-14 years; 15-19 years; 20-24 years; 25-29 years; 30+ years	Mandatory	Consistent
5. What is your experience as a practising mental health clinician?	Select one: Currently practising; Not currently practising (please specify the number of years since you last practised); Never practised	Mandatory	Not asked in Study 1 – addresses a Study 1 limitation
6. What is the main service setting in which you work?	Select one: Inpatient; Community; Residential; Other (please specify)	Mandatory	Consistent
7. What is the main target age group you work with clinically? Please select the age group that most closely aligns to your work.	Select one: Children and adolescents (including youth services); Adults; Older persons; I work across all age groups	Mandatory	Consistent, with 'I work across all age groups' added
8. Have you seen or completed 'mental health phase of care training' prior to participating in this project?'	Select one: Yes; No; Not sure	Mandatory	Consistent, with 'not sure' added

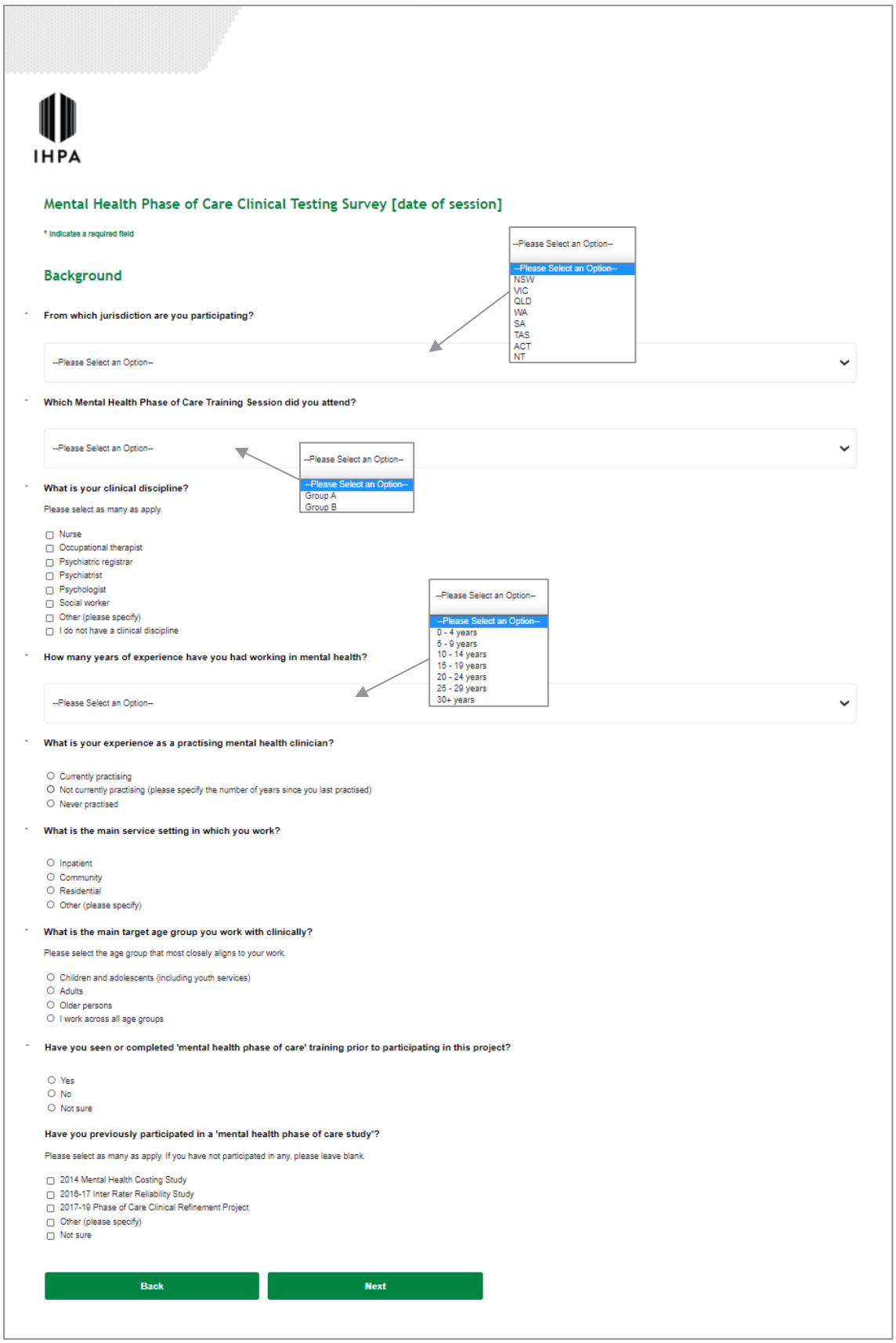
Question	Response options	Question type	Consistency with Study 1
9. Have you previously participated in a 'mental health phase of care study'? Please select as many as apply. If you have not participated in any, please leave blank.	Can select multiple: 2014 Mental Health Costing Study; 2016-17 Inter Rater Reliability Study; 2017-19 Phase of Care Clinical Refinement Project; Other (please specify); Not sure	Optional	Not asked in Study 1
Section 2: vignettes – these two questions apply to each of the 12 vignettes reviewed			
10. Please indicate the mental health phase of care described in the vignette.	Select one, with Option 2A or 2B phases of care appearing depending on the response to question 2 in Section 1.	Mandatory	Consistent
11. How confident are you of your rating?	Select one from a range (0-10): 0 = Not confident at all; through to 10 = Extremely confident	Mandatory	Not reported in Study 1
Section 3: feedback			
12. Overall, how confident were you in assigning a phase to the vignettes?	Select one from a range (0-10): 0 = Not confident at all; through to 10 = Extremely confident	Mandatory	Consistent, with Study 1 using a 0-4 scale
13. How well do the phases of care describe the consumers that you see at your service?	Select one from a range (0-5): Very poorly; Poorly; Adequately; Well; Very well	Mandatory	Not reported in Study 1
14. Are the phase of care concepts and definitions meaningful and relevant to your clinical practice?	Select one from a range (0-5): Not at all meaningful or relevant; Not so meaningful or relevant; Somewhat meaningful and relevant; Very meaningful and relevant; Extremely meaningful and relevant	Mandatory	Not asked in Study 1
15. Do you have any further comments on the phases of care?	Free text	Optional	Consistent
16. Do you think the length of time allocated for training today was sufficient to enable you to understand and use phase of care in your everyday work?	Select one: The training session was too short; The training session was the right length of time; The training session was too long	Mandatory	Not asked in Study 1
17. Do you have any further comments on the TRAINING on phase of care?	Free text	Optional	Not asked in Study 1 (one free text provided)
18. Do you have any further comments on the vignettes or your responses to the survey?	Free text	Optional	Not asked in Study 1 (one free text provided)

Survey screenshots

Introduction (one page)



Background (one page)



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Mental Health Phase of Care Clinical Testing Survey [date of session]

* Indicates a required field

Background

* From which jurisdiction are you participating?

--Please Select an Option--

--Please Select an Option--
NSW
VIC
QLD
WA
SA
TAS
ACT
NT

* Which Mental Health Phase of Care Training Session did you attend?

--Please Select an Option--

--Please Select an Option--
--Please Select an Option--
Group A
Group B

* What is your clinical discipline?

Please select as many as apply.

- [ ] Nurse
- [ ] Occupational therapist
- [ ] Psychiatric registrar
- [ ] Psychiatrist
- [ ] Psychologist
- [ ] Social worker
- [ ] Other (please specify)
- [ ] I do not have a clinical discipline

* How many years of experience have you had working in mental health?

--Please Select an Option--

--Please Select an Option--
--Please Select an Option--
0 - 4 years
5 - 9 years
10 - 14 years
15 - 19 years
20 - 24 years
25 - 29 years
30+ years

* What is your experience as a practising mental health clinician?

- ○ Currently practising
- ○ Not currently practising (please specify the number of years since you last practised)
- ○ Never practised

* What is the main service setting in which you work?

- ○ Inpatient
- ○ Community
- ○ Residential
- ○ Other (please specify)

* What is the main target age group you work with clinically?

Please select the age group that most closely aligns to your work.

- ○ Children and adolescents (including youth services)
- ○ Adults
- ○ Older persons
- ○ I work across all age groups

* Have you seen or completed 'mental health phase of care' training prior to participating in this project?

- ○ Yes
- ○ No
- ○ Not sure

Have you previously participated in a 'mental health phase of care study'?

Please select as many as apply. If you have not participated in any, please leave blank.

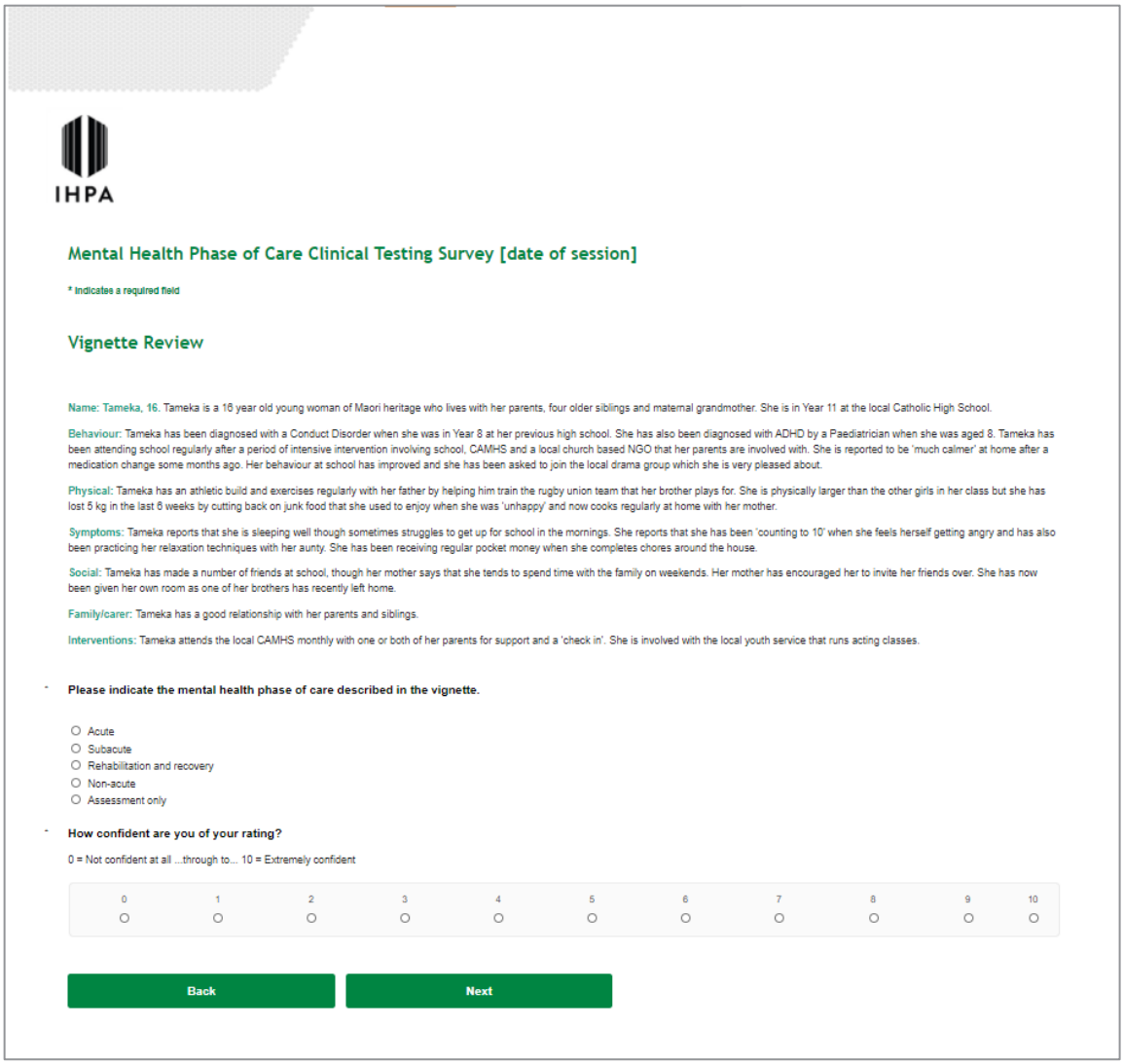
- [ ] 2014 Mental Health Costing Study
- [ ] 2016-17 Inter Rater Reliability Study
- [ ] 2017-19 Phase of Care Clinical Refinement Project
- [ ] Other (please specify)
- [ ] Not sure

Back Next

Vignette review (12 pages) – example

Respondents review 12 vignettes as grouped at Table 8 and detailed at Appendix B.

The example below is for Group 2B and provides five phase of care choices. Group 2A sees four phases choices (options do not include ‘rehabilitation and recovery’).



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Mental Health Phase of Care Clinical Testing Survey [date of session]

* Indicates a required field

Vignette Review

Name: Tameka, 16. Tameka is a 16 year old young woman of Maori heritage who lives with her parents, four older siblings and maternal grandmother. She is in Year 11 at the local Catholic High School.

Behaviour: Tameka has been diagnosed with a Conduct Disorder when she was in Year 8 at her previous high school. She has also been diagnosed with ADHD by a Paediatrician when she was aged 8. Tameka has been attending school regularly after a period of intensive intervention involving school, CAMHS and a local church based NGO that her parents are involved with. She is reported to be ‘much calmer’ at home after a medication change some months ago. Her behaviour at school has improved and she has been asked to join the local drama group which she is very pleased about.

Physical: Tameka has an athletic build and exercises regularly with her father by helping him train the rugby union team that her brother plays for. She is physically larger than the other girls in her class but she has lost 5 kg in the last 6 weeks by cutting back on junk food that she used to enjoy when she was ‘unhappy’ and now cooks regularly at home with her mother.

Symptoms: Tameka reports that she is sleeping well though sometimes struggles to get up for school in the mornings. She reports that she has been ‘counting to 10’ when she feels herself getting angry and has also been practicing her relaxation techniques with her aunty. She has been receiving regular pocket money when she completes chores around the house.

Social: Tameka has made a number of friends at school, though her mother says that she tends to spend time with the family on weekends. Her mother has encouraged her to invite her friends over. She has now been given her own room as one of her brothers has recently left home.

Family/carer: Tameka has a good relationship with her parents and siblings.

Interventions: Tameka attends the local CAMHS monthly with one or both of her parents for support and a ‘check in’. She is involved with the local youth service that runs acting classes.

* Please indicate the mental health phase of care described in the vignette.

- Acute
- Subacute
- Rehabilitation and recovery
- Non-acute
- Assessment only

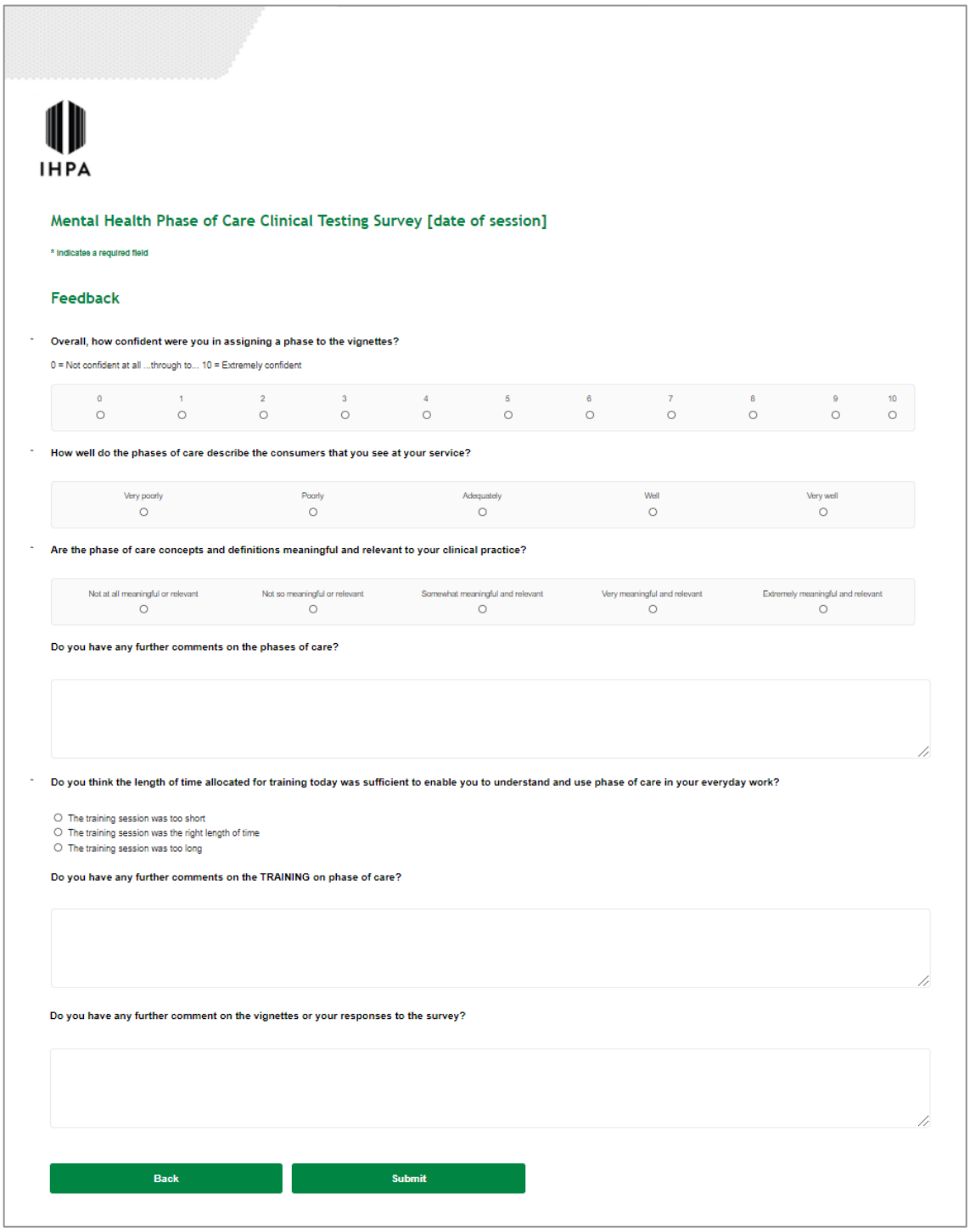
* How confident are you of your rating?

0 = Not confident at all ...through to... 10 = Extremely confident

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

Back Next

Feedback (one page)



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Mental Health Phase of Care Clinical Testing Survey [date of session]

* Indicates a required field

Feedback

* Overall, how confident were you in assigning a phase to the vignettes?

0 = Not confident at all ...through to... 10 = Extremely confident

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

* How well do the phases of care describe the consumers that you see at your service?

Very poorly	Poorly	Adequately	Well	Very well
○	○	○	○	○

* Are the phase of care concepts and definitions meaningful and relevant to your clinical practice?

Not at all meaningful or relevant	Not so meaningful or relevant	Somewhat meaningful and relevant	Very meaningful and relevant	Extremely meaningful and relevant
○	○	○	○	○

Do you have any further comments on the phases of care?

* Do you think the length of time allocated for training today was sufficient to enable you to understand and use phase of care in your everyday work?

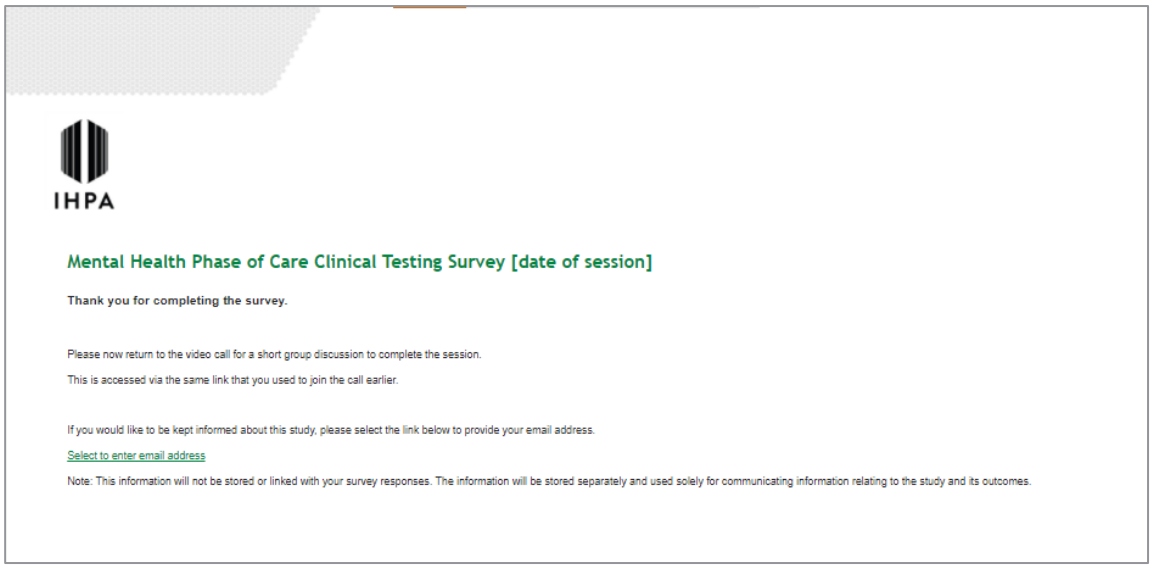
- ○ The training session was too short
- ○ The training session was the right length of time
- ○ The training session was too long

Do you have any further comments on the TRAINING on phase of care?

Do you have any further comment on the vignettes or your responses to the survey?

Back Submit

Completion message (one page)



Separate survey: Email register (one page)

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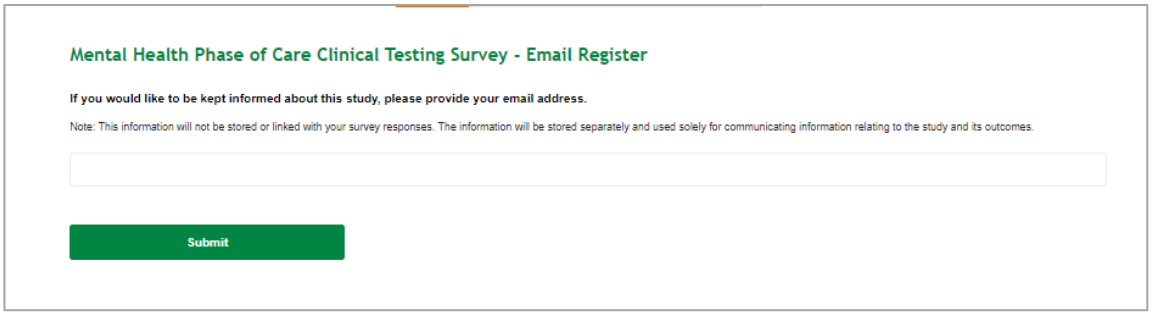


Appendix D. Training materials

Slide deck – Group 2A

Objectives for today

1. Understand the proposed ‘mental health phases of care’ definitions

2. Apply them to some case vignettes so we can test if:
   - they make sense to clinicians
   - they are applied consistently by clinicians

Structure of today

1. **As a group:** training (1 hour)
   - background
   - training
   - worked examples and discussion – ask questions and test ideas

2. **On your own:** survey (45 mins)
   - quick demographic questionnaire
   - rating of case vignettes
   - provide feedback

3. **As a group:** feedback and discussion (15 mins)

4

Where are we in the development process?

We are now on Step 5: review and refinement

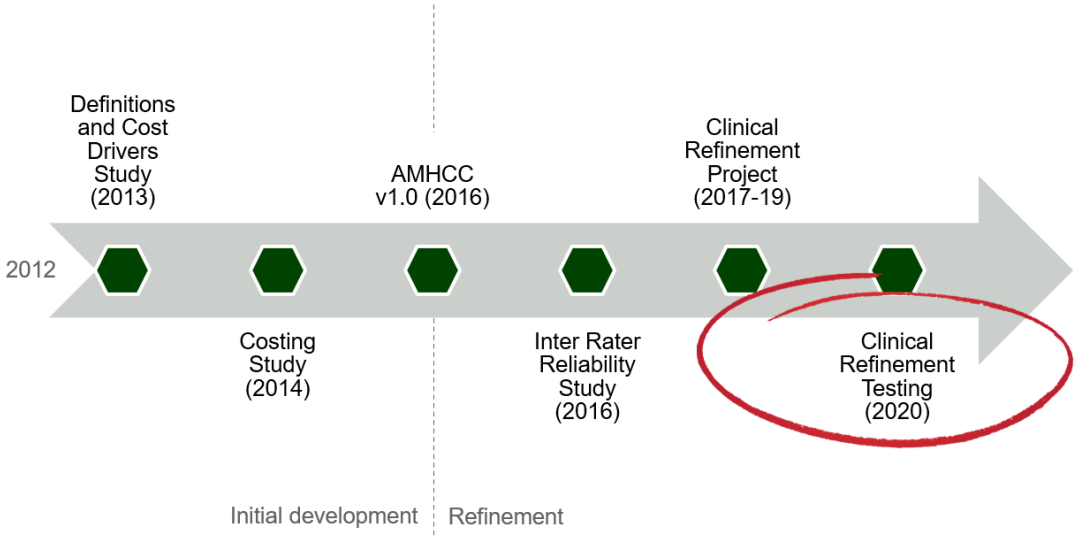
Version 1 of the AMHCC has been built

We are refining it with clinical input, so that it is:

- easier to use
- better describes the different costs of care across the system

5 www.ihpa.gov.au

Where are we in the development process?



Clinical refinement testing project

Testing ‘phase of care’ definitions with clinicians from a range of different mental health services and specialties across Australia

Results will inform possible updates to the AMHCC

State health departments are involved through IHPA’s Mental Health Working Group

What are we testing today?

We are reviewing the AMHCC and testing **new phase types** to see if the AMHCC should be updated to include them

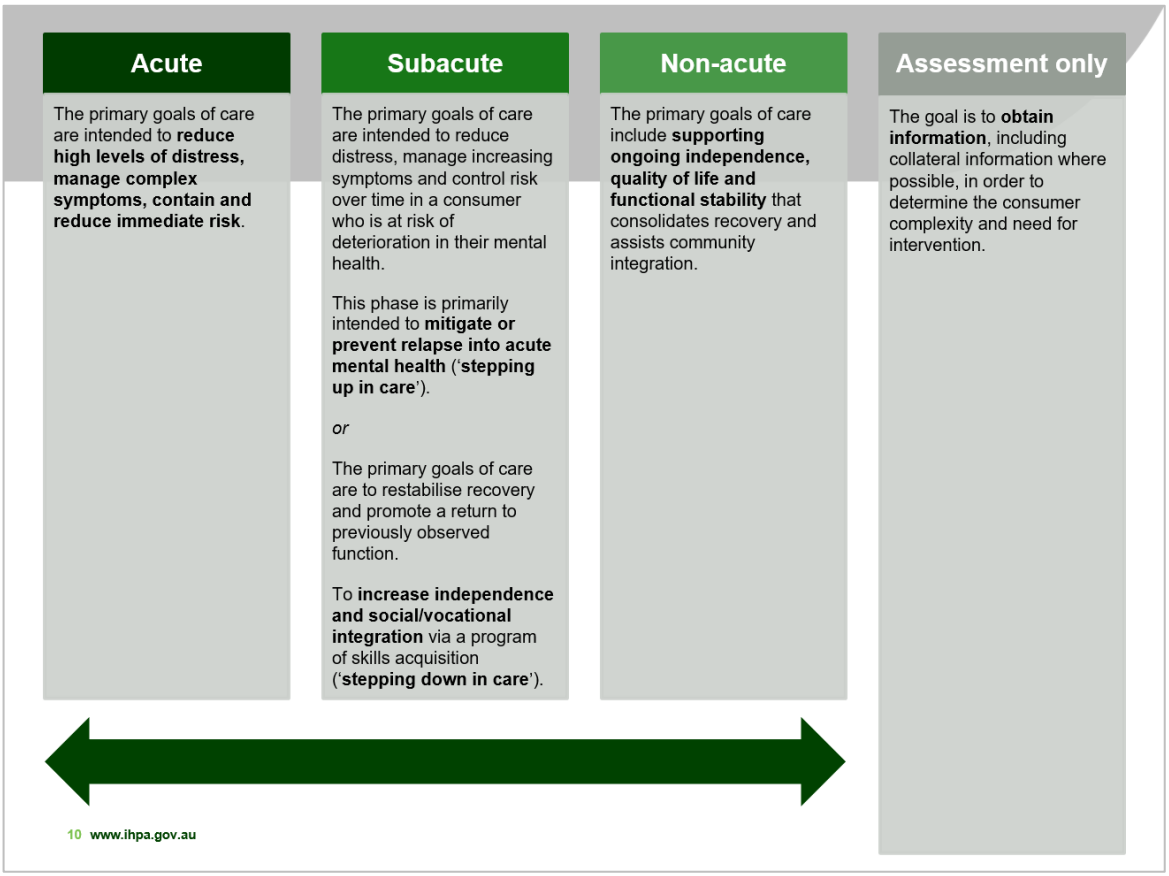
The names of the phases and their descriptions are different to those in the current AMHCC

You don't need any knowledge of the AMHCC to participate

This is **not** training on how to use the AMHCC

Prospective 'phase of care' is **not** the same as **retrospective** 'focus of care'

Mental health phase of care



What is 'phase of care'?

Overall, your goal as a clinician may be to reduce symptoms, improve functioning and support the consumer in their journey of recovery…
but what is their mental health phase of care?

Phase of care describes one part of that journey

It is a consumer-focused **prospective** assessment

It is independent of:

- discipline
- service unit
- type of treatment
- diagnosis

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What is ‘phase of care’?

Phase of care is based on:
✓goal of care ✓consumer characteristics ✓clinical decision

Phase is assessed at the **start of an episode** of care

A change of phase can occur **within an episode** when there is a substantial or sustained change in the consumer’s clinical condition, their requirements for care change or your treatment plan changes

It is completed by **clinicians** on assessment, review or in a multidisciplinary meeting

How is phase of care used?

Used together with other variables in the AMHCC to explain resource consumption (cost) at the consumer level

The other variables are:

- service setting (admitted or community)
- consumer age
- HoNOS score (except for ‘assessment only’)
- *for some groups of consumers:* mental health legal status, or LSP-16

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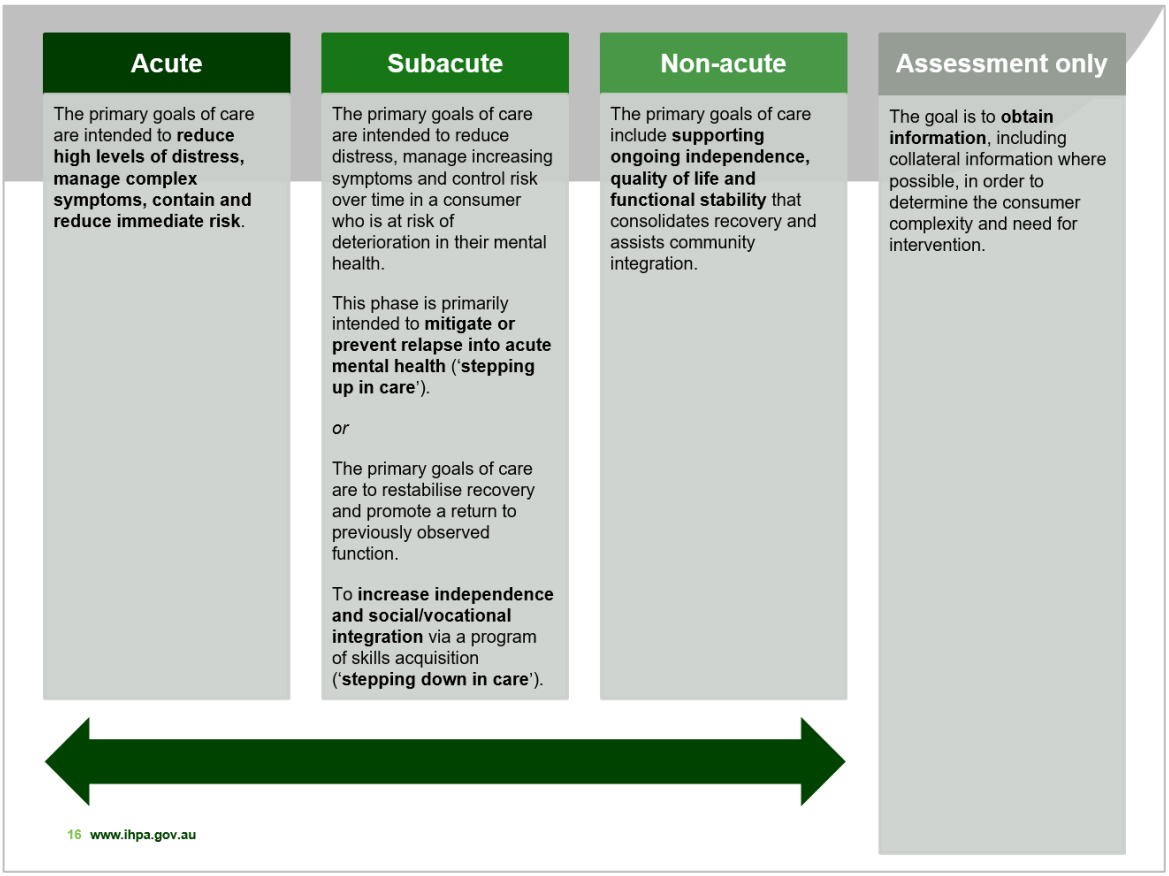
Training approach

1. Overview of the phases
2. Discuss each phase definition in detail
3. Work through some examples
4. Quiz questions for group discussion


Acute
The primary goals of care are intended to **reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk**.
Subacute
The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health.
This phase is primarily intended to **mitigate or prevent relapse into acute mental health** ('**stepping up in care**').
or
The primary goals of care are to restabilise recovery and promote a return to previously observed function.
To **increase independence and social/vocational integration** via a program of skills acquisition ('**stepping down in care**').
Non-acute
The primary goals of care include **supporting ongoing independence, quality of life and functional stability** that consolidates recovery and assists community integration.
Assessment only
The goal is to **obtain information**, including collateral information where possible, in order to determine the consumer complexity and need for intervention.
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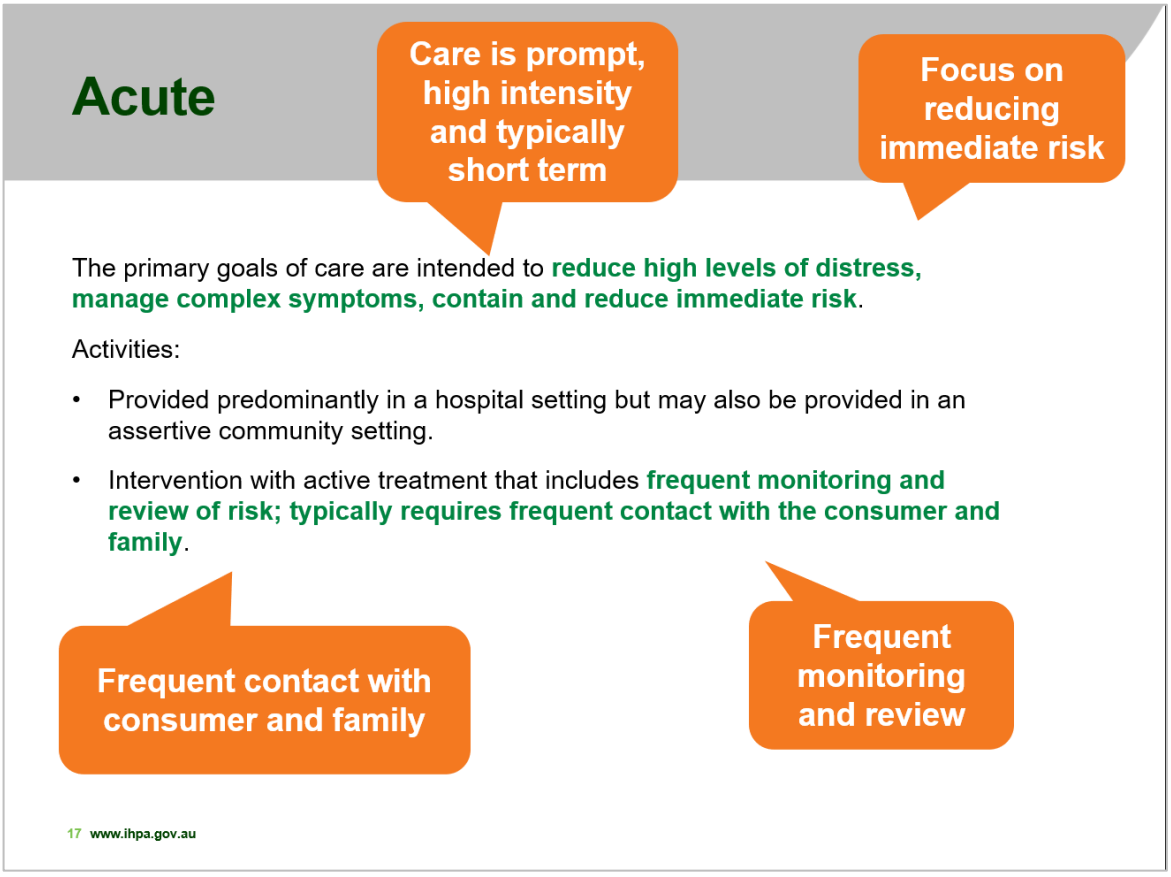
Acute
Care is prompt, high intensity and typically short term
Focus on reducing immediate risk
The primary goals of care are intended to **reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk**.
Activities:
• Provided predominantly in a hospital setting but may also be provided in an assertive community setting.
• Intervention with active treatment that includes **frequent monitoring and review of risk; typically requires frequent contact with the consumer and family**.
Frequent contact with consumer and family
Frequent monitoring and review
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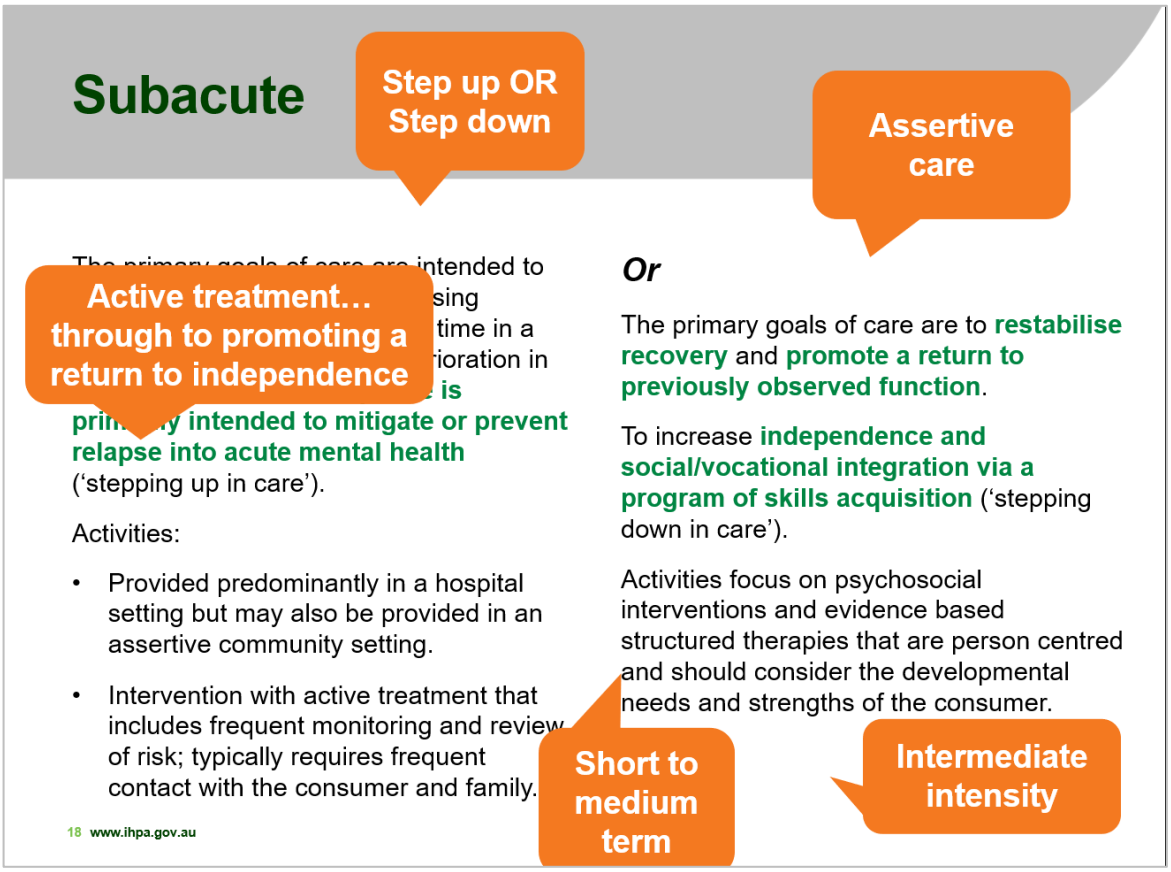
Subacute
Step up OR Step down
Assertive care
Active treatment… through to promoting a return to independence
The primary goals of care are intended to sing time in a ioration in is primarily intended to mitigate or prevent relapse into acute mental health ('stepping up in care').
Activities:
• Provided predominantly in a hospital setting but may also be provided in an assertive community setting.
• Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.
Or
The primary goals of care are to restabilise recovery and promote a return to previously observed function.
To increase independence and social/vocational integration via a program of skills acquisition ('stepping down in care').
Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.
Short to medium term
Intermediate intensity
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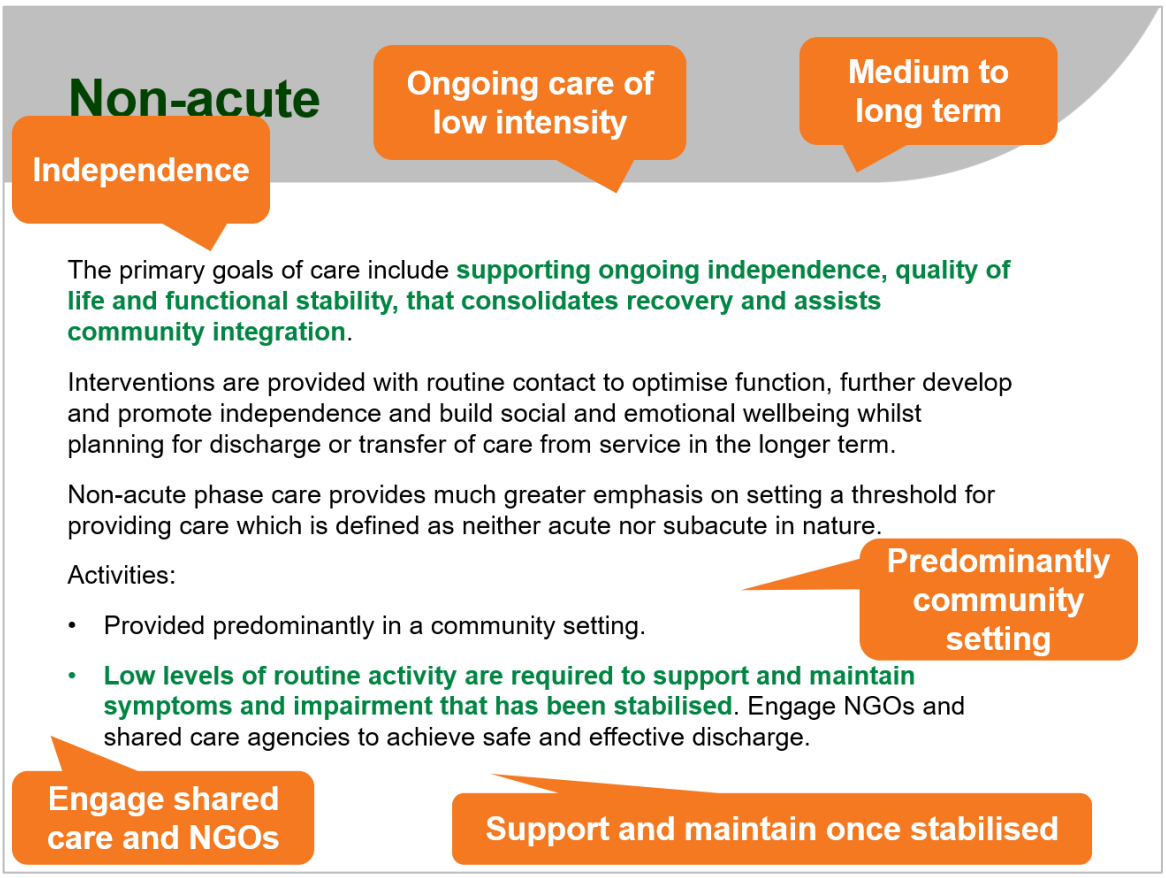

Non-acute
Ongoing care of low intensity
Medium to long term
Independence
The primary goals of care include supporting ongoing independence, quality of life and functional stability, that consolidates recovery and assists community integration.
Interventions are provided with routine contact to optimise function, further develop and promote independence and build social and emotional wellbeing whilst planning for discharge or transfer of care from service in the longer term.
Non-acute phase care provides much greater emphasis on setting a threshold for providing care which is defined as neither acute nor subacute in nature.
Activities:
• Provided predominantly in a community setting.
• Low levels of routine activity are required to support and maintain symptoms and impairment that has been stabilised. Engage NGOs and shared care agencies to achieve safe and effective discharge.
Predominantly community setting
Engage shared care and NGOs
Support and maintain once stabilised

Assessment only

The goal is to **obtain information, including collateral information where possible, in order to determine the consumer complexity and need for intervention**.

Activities:

- Includes brief history, risk assessment, clinical screening and information gathering.

For this to be applicable the outcome would result in no further intervention or a referral on or into a new care episode

May include brief interventions

Acute	Subacute	Non-acute	Assessment only
The primary goals of care are intended to **reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk**.	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to **mitigate or prevent relapse into acute mental health** ('**stepping up in care**'). *or* The primary goals of care are to restabilise recovery and promote a return to previously observed function. To **increase independence and social/vocational integration** via a program of skills acquisition ('**stepping down in care**').	The primary goals of care include **supporting ongoing independence, quality of life and functional stability** that consolidates recovery and assists community integration.	The goal is to **obtain information**, including collateral information where possible, in order to determine the consumer complexity and need for intervention.

Example 1

Makayla is 16. Three months ago she was assessed as depressed and anxious.

She was concerned about “germs” being “everywhere”.

She has had a good response to medication and cognitive behaviour therapy.

Her case manager wants some additional sessions with Makayla and her family to reinforce her positive gains.

Non-acute

Example 2

Patricia has a long history of anxiety.

She was an avid member of the Rotary; however, she stopped attending meetings because her feelings of anxiety became overwhelming.

Her medication regiment was modified with good effect.

She is currently working on different relaxation techniques with her case manager with a view to returning to Rotary meetings.

Subacute

Example 3

Ross has been experiencing auditory hallucinations for many years which he finds distressing.

He presents with severe lack of motivation even to undertake simple activities of daily living.

He has regular contact with his case manager because of concerns about a possible deterioration in his presentation.

Ross is engaged with an NGO to improve his functioning and a psychiatrist to manage his symptoms.

Subacute

Quiz (1/4)

The primary goal of an 'acute' mental health phase of care is:

a. improving medication adherence

b. focused on improving the consumer's level of functioning

c. the short term reduction of symptoms

d. all of the above

Quiz (2/4)

'Assessment only' is:

a. the active treatment of the consumer's symptoms
b. collection of collateral information to support assessment and referral
c. focused on improving the consumer's level of functioning
d. all of the above

Quiz (3/4)

The mental health phase of care 'subacute' is:

a. monitoring warning signs to prevent relapse of an acute phase
b. the development of skills to increase independence
c. supporting independence through routine activities
d. containing and reducing immediate risk
e. all of the above

Quiz (4/4)

When identifying the 'non-acute' mental health phase of care you should consider:

a. the primary goal of care

b. consumer characteristics

c. your expectations of the rate of change in the consumer's presentation

d. all of the above

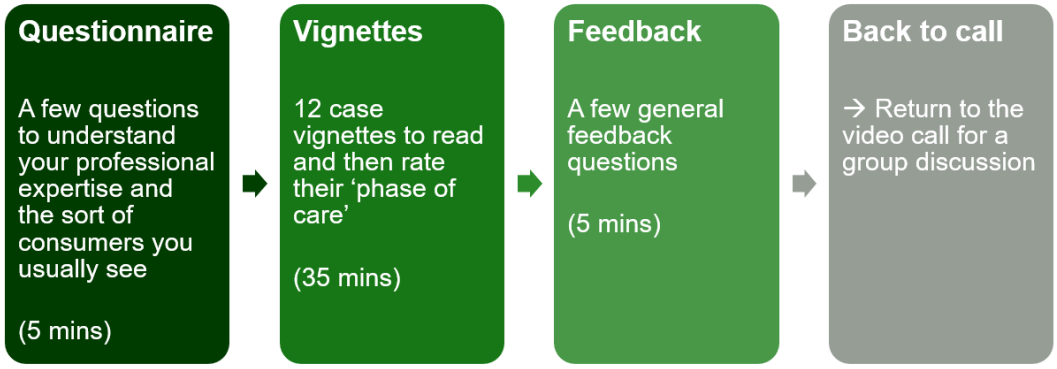
Acute	Subacute	Non-acute	Assessment only
The primary goals of care are intended to **reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk**.	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to **mitigate or prevent relapse into acute mental health** ('**stepping up in care**'). *or* The primary goals of care are to restabilise recovery and promote a return to previously observed function. To **increase independence and social/vocational integration** via a program of skills acquisition ('**stepping down in care**').	The primary goals of care include **supporting ongoing independence, quality of life and functional stability** that consolidates recovery and assists community integration.	The goal is to **obtain information**, including collateral information where possible, in order to determine the consumer complexity and need for intervention.

Questions on the phases?

What happens now?

1. **As a group:** training (1 hour)
   - background
   - training
   - worked examples and discussion – ask questions and test ideas
2. **On your own:** survey (45 mins)
   - quick demographic questionnaire
   - rating of case vignettes
   - provide feedback
3. **As a group:** feedback and discussion (15 mins)

Survey



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Rating the case vignettes

Each case vignette is about a page long

It describes a consumer in a **single phase of care**

You will be asked to:

- identify the phase
- rate how confident you were in assigning that phase of care

At the end of the survey you can make further comments

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Instructions

You have 45 minutes to complete the survey

Please keep the Zoom call open in the background (you can turn off camera/microphone)

If you need to leave the Zoom call you can return via the same weblink

If you have any questions during the survey, switch back to Zoom and send me a message using the chat function, or email me at jennifer@jennifernobbsconsulting.com

When you have completed the survey please click 'submit' and return to the Zoom call

Instructions

It is important that you do not communicate with your colleagues on your interpretation of, or response to the survey questions during the time you or your colleagues are completing the survey

There will be a session following the survey completion in which we can discuss interpretations and provide feedback

Please take note that you are participating in the **GROUP A** training session

You will be asked which session at the beginning of the survey, and it is important that you enter **GROUP A** for this question

Please refer to the mental health phase of care diagram included in the training handout, to assist with rating the case vignettes

Welcome back!

Subacute phase: alternative approach

An alternative approach is being considered for ‘subacute’

The subacute phase could be split into **two separate phases**

- Subacute (alternative definition)
- Rehabilitation and recovery

There is **no change** to the language in the description

There are **no changes to any of the other phases**

Subacute: alternative approach

Subacute (alternative definition)

The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. **This phase is primarily intended to mitigate or prevent relapse into acute mental health** ('stepping up in care').

Activities:

- Provided predominantly in a hospital setting but may also be provided in an assertive community setting.
- Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.

Rehabilitation and recovery

Or

The primary goals of care are to **restabilise recovery** and **promote a return to previously observed function**.

To increase **independence and social/vocational integration via a program of skills acquisition** ('stepping down in care').

Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.

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Previous subacute definition

Acute	Subacute	Rehabilitation and recovery	Non-acute	Assessment only
The primary goals of care are intended to **reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk**.	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to **mitigate or prevent relapse into acute mental health** ('**stepping up in care**').	The primary goals of care are to restabilise recovery and promote a return to previously observed function. To **increase independence and social/vocational integration** via a program of skills acquisition ('**stepping down in care**').	The primary goals of care include **supporting ongoing independence, quality of life and functional stability** that consolidates recovery and assists community integration.	The goal is to **obtain information**, including collateral information where possible, in order to determine the consumer complexity and need for intervention.

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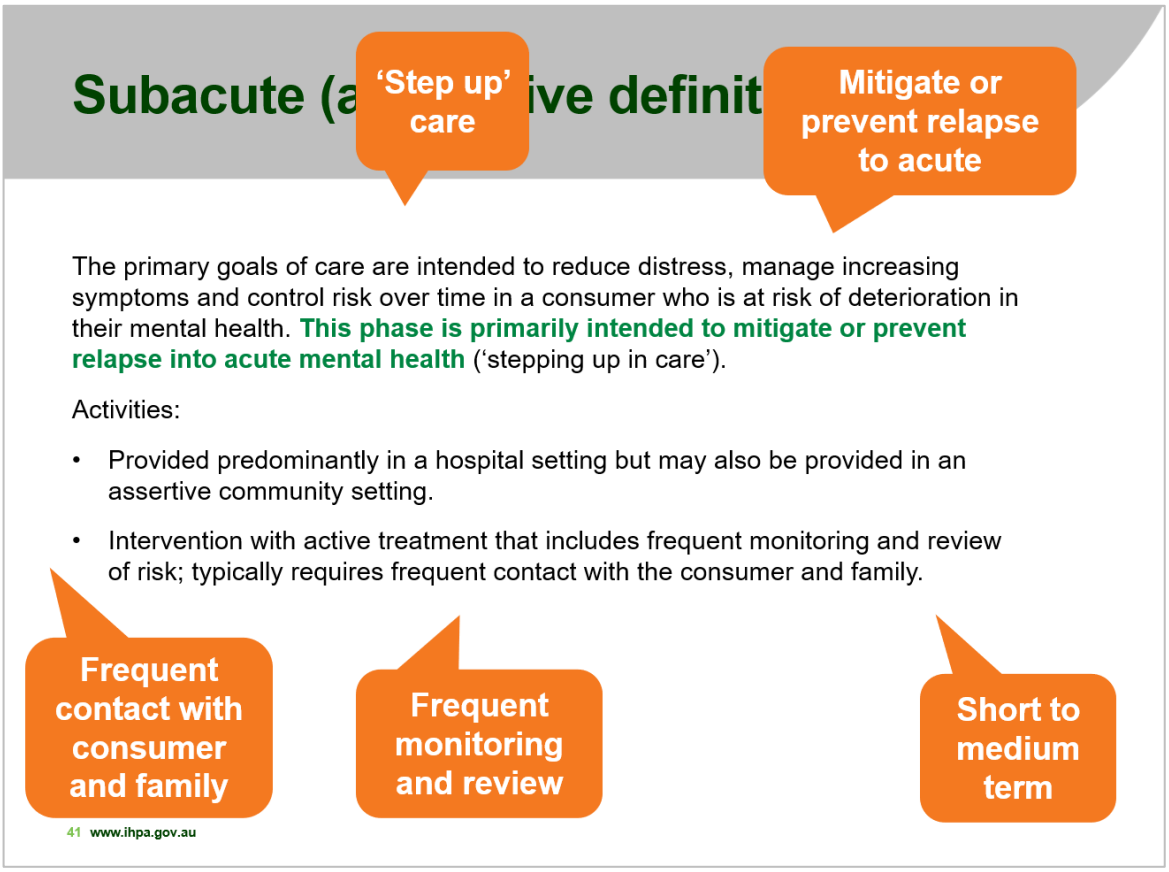
Subacute (a
ive definit
'Step up' care
Mitigate or prevent relapse to acute
The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to mitigate or prevent relapse into acute mental health ('stepping up in care').
Activities:
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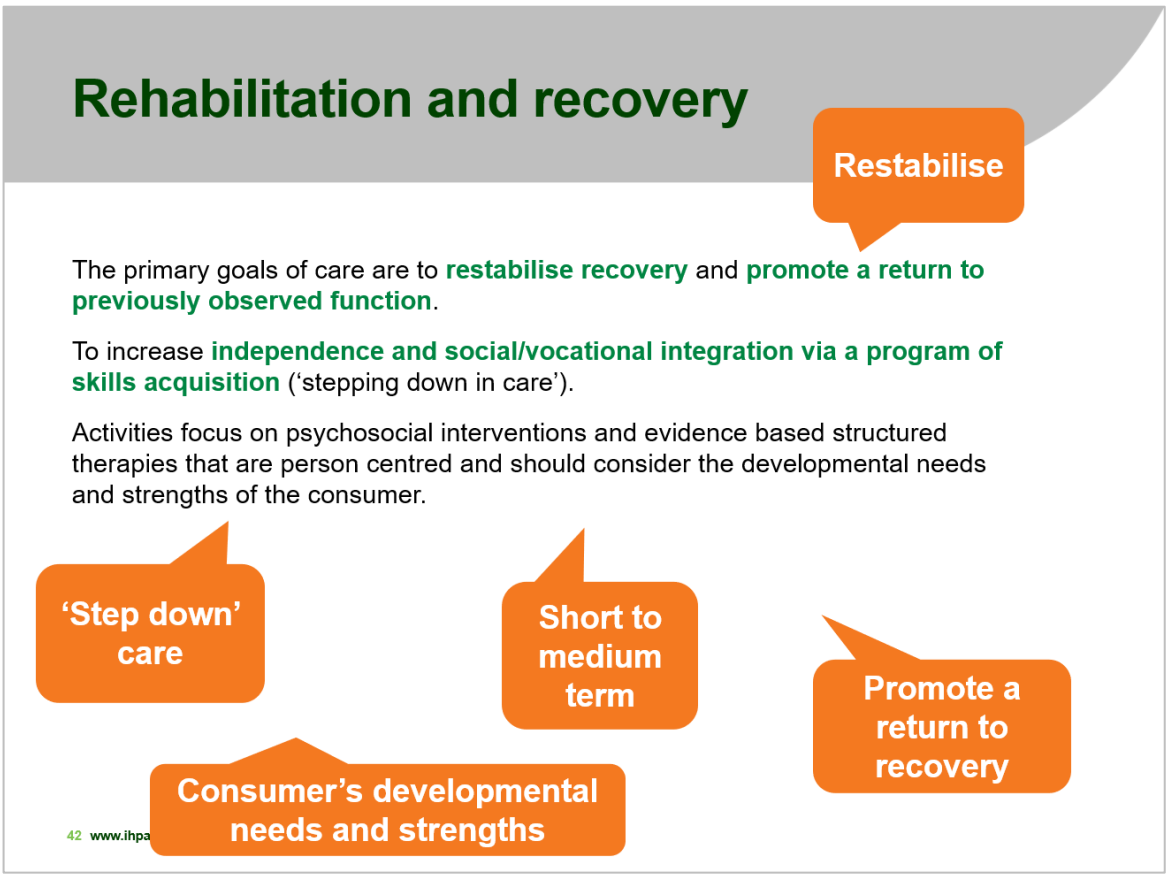
Frequent contact with consumer and family
Frequent monitoring and review
Short to medium term
41 www.ihpa.gov.au


Rehabilitation and recovery
Restabilise
The primary goals of care are to restabilise recovery and promote a return to previously observed function.
To increase independence and social/vocational integration via a program of skills acquisition ('stepping down in care').
Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.
'Step down' care
Short to medium term
Promote a return to recovery
Consumer's developmental needs and strengths
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Subacute (alternative definition): example

Ross has been experiencing auditory hallucinations for many years which he finds distressing.

He is amotivated and has difficulty undertaking simple and complex activities of daily living.

He has regular contact with his case manager because of concerns about a possible deterioration in his condition.

Ross is engaged with an NGO to improve his functioning and a psychiatrist to manage his symptoms.

Rehabilitation and recovery: example

Patricia has a long history of anxiety.

She was an avid member of the Rotary; however, she stopped attending meetings because her feelings of anxiety became overwhelming.

Her medication regiment was modified with good effect.

She is currently working on different relaxation techniques with her case manager with a view to returning to Rotary meetings.

Voting on the following slides

You may sign in to Poll Everywhere as a guest so that your response is anonymised. You do **not** need to register your name.

If you do choose to sign in with your name, your vote will be recorded against your name. **IHPA will remove your name prior to analysis**.

We will only use the number of votes for each option in the session, and not names.

Vignette 1

Name: Gary, 38. Gary is a single male who has lived with his mother his whole life. He has been case managed across a range of service settings for some years. He has been managed almost exclusively by an acute care team for two years due to the treatment resistant nature of his symptoms. Gary is a challenge to engage. He is currently reporting that he is adherent with his medications but there is some doubt as to the veracity of this claim.

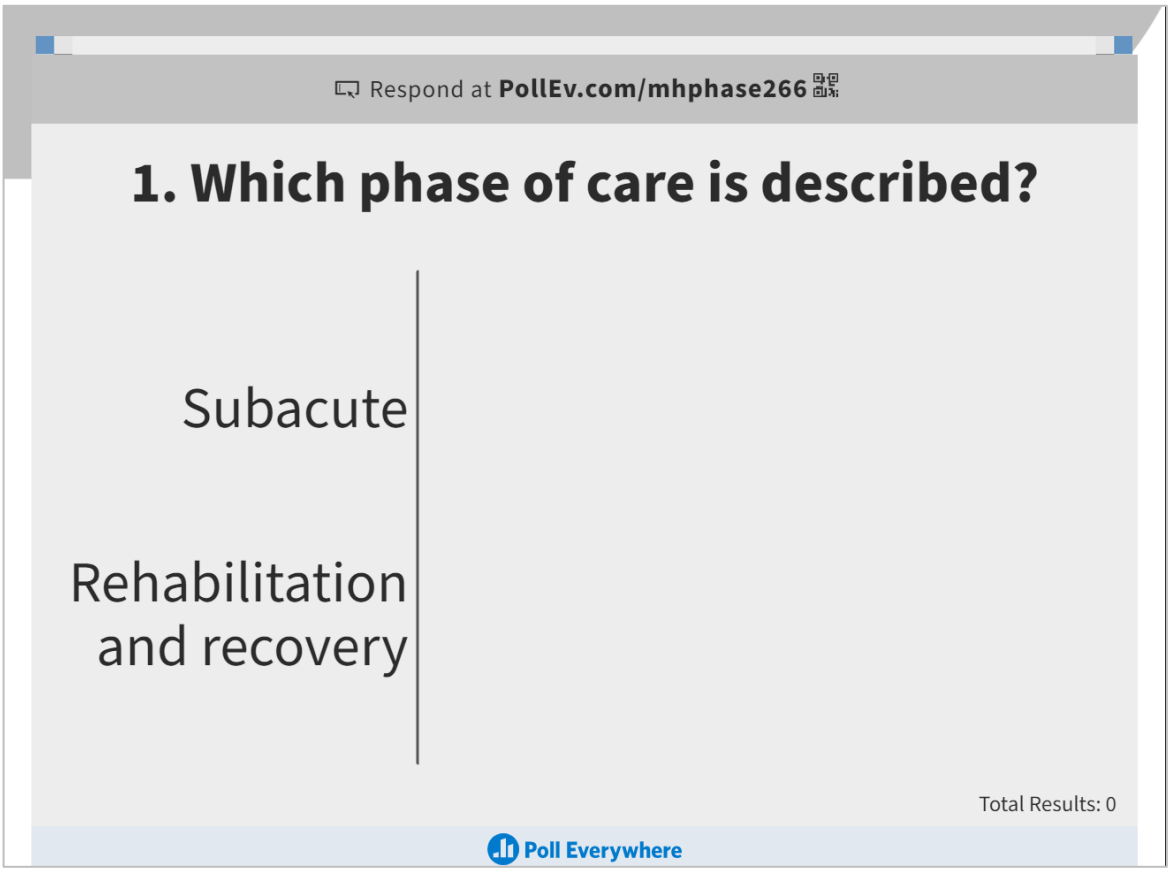
Behaviour: Gary has a diagnosis of Schizophrenia and has been on a Community Treatment Order in the past but is not at present. He is very reluctant to speak with you and will only do so on the front veranda of his family home, as he says he does not want his mother 'listening in'. Gary makes little eye contact and he seems guarded. He says that the medication is making him 'slow' and that people 'look at me like I'm a zombie'. He reports that the only thing he likes to do is watch DVDs and smoke. He says he cannot listen to music because it makes him 'sad'.

Physical: Gary is overweight and his GP has advised that he is in danger of developing Type 2 diabetes. Gary says that he feels hungry all the time. He also worries that he needs glasses as he has trouble seeing the TV unless he 'sits on top of it'. He says that he feels like he has to burp all the time, so he drinks a lot of soft drinks which he says helps with this.

Symptoms: Gary appears, as is usual, to be responding to non-evident stimuli and mumbles to himself frequently, at times he appears distressed but denies that he is. He says his mood is 'OK' but he has felt better before. He sleeps during the day and is awake at night. He feels that his neighbours joke about him when he comes outside to smoke.

Social: Gary is not able to identify any friends and is socially isolated. He says that his sister sometimes comes to take him out for a meal if he asks. He is worried that his mother is getting old and what will happen to her if she gets sick. Gary has never worked and his siblings want him to move out as their mother is elderly; but they are also worried what will happen to Gary if she doesn't look after him.

Interventions: Gary is engaged with the local community Rehab service for social skills development. An appointment is made for him to speak to a dietician about his weight. His mother is engaged with carer support services and encouraged to support Gary to live more independently with the view to gaining his own accommodation.



Vignette 2

Name: Mara, 69. Mara is a 69 year old, recently widowed woman of Italian heritage. Her husband of 48 years, Roberto, has died 8 months ago after battling a long illness. She lives alone, around the corner from her youngest daughter.

Behaviour: Mara is a current client of the Older Persons Community MH team and is under active case management. Mara has a long history of Bipolar Affective Disorder (BPAD), first diagnosed when she arrived in Australia from Sicily. During her husband's illness, Mara was hospitalised for mania three times and her treatment is now made more challenging as she has developed chronic renal failure. Mara is a friendly, somewhat overfamiliar woman who looks older than her stated age. She is dressed in black and smiles often when questioned. She claims that she cannot understand English very well (though her daughter disputes this). For over a month she has been seen walking in the very early hours of the morning, muttering to herself. More recently, she struck her youngest grandson as she claims he 'disrespected' her. She says she often 'wishes for death' so she could be with her beloved husband.

Physical: Mara is a small statured woman, slim build but has been putting on weight since she was diagnosed with 'the kidney troubles' about which she appears to have a poor understanding. She frequently feels nauseous in the mornings and blames this on her change of medications in the past few months. She has refused out-right to alter her diet to control her kidney disease. She likes to drink wine with dinner every night.

Symptoms: Mara is slightly elevated in mood and is very talkative. Her daughter reports that since her husband died, she is not sure if Mara is taking her tablets or not. Mara dismisses the concerns of her daughter. She says three months ago she was 'very depressed' but now feels fine. She is sleeping with the aid of hypnotics at night. She denies suicidal thoughts as 'it is a sin' and she has strong religious beliefs.

Social: Mara's daughter has also been diagnosed with BPAD. Mara lives about 500 metres from her daughter's house, in her own home. She has a large circle of friends from the local Italian community and plays cards each Saturday afternoon at the local club. Mara and her daughter 'clash' often to the point where Mara will refuse to speak to her for weeks at a time over some perceived slight.

Interventions: The Case Manager with the Older Persons' Community Team has been closely monitoring of Mara's mental state and physical health status. Her medication regime requires close monitoring due to her renal disease. Mara is visited at home weekly due to her high likelihood of relapse.

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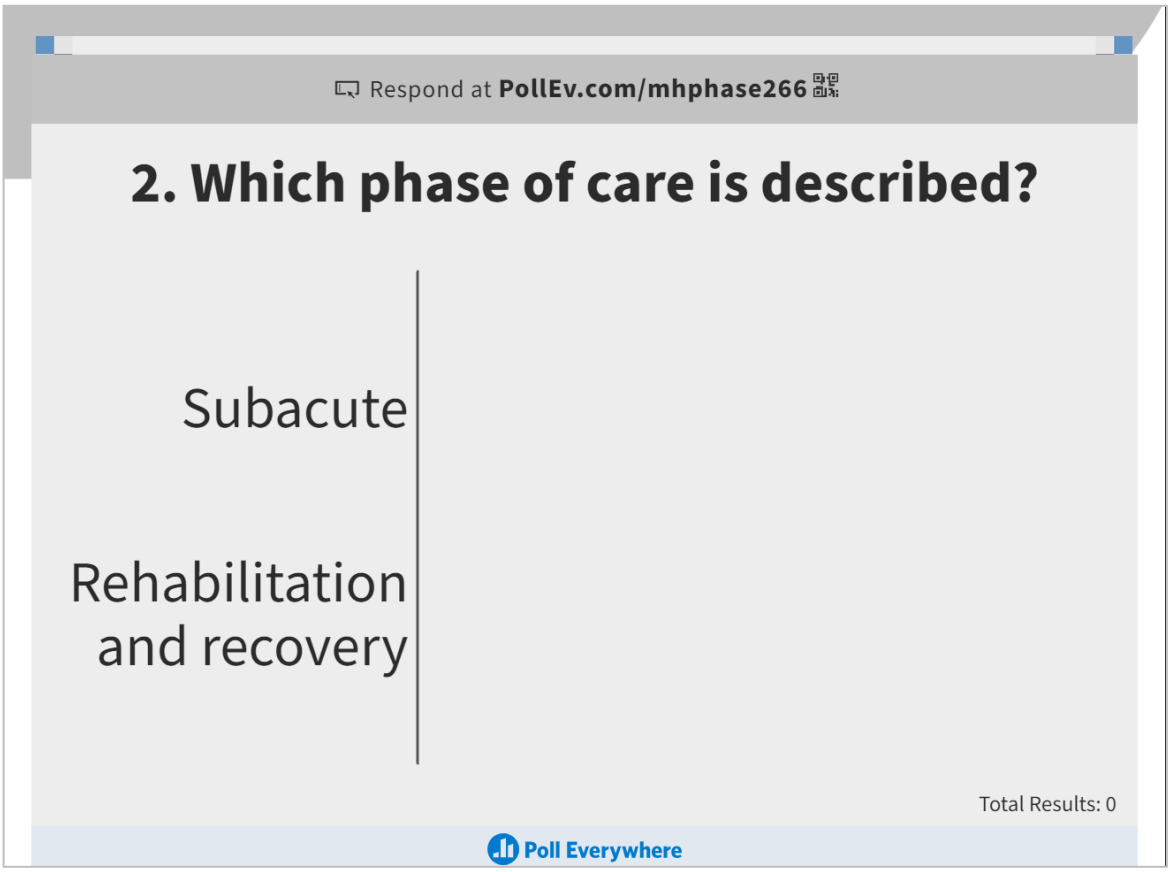


Vignette 3

Name: Sumaya, 11. Sumaya is an 11 year old girl who lives at home with her mother and two older sisters in rental accommodation. They arrived in Australia as settled refugees from Somalia 18 months ago. Her father is deceased, killed in the war seven years previously. He is barely remembered by Sumaya as he had been away fighting for 18 months before his death. She has been seeing you for some months after an initial referral from her primary school. You have a good rapport.

Behaviour: Sumaya is somewhat withdrawn and hides her face in the side of her mother's clothing. She appears shy and is hard to engage. She has had several episodes at home where she will refuse to leave her mother's side when her mother tries to breastfeed Sumaya's younger sister and has also smacked her other sister when she refuses to go to school with her.

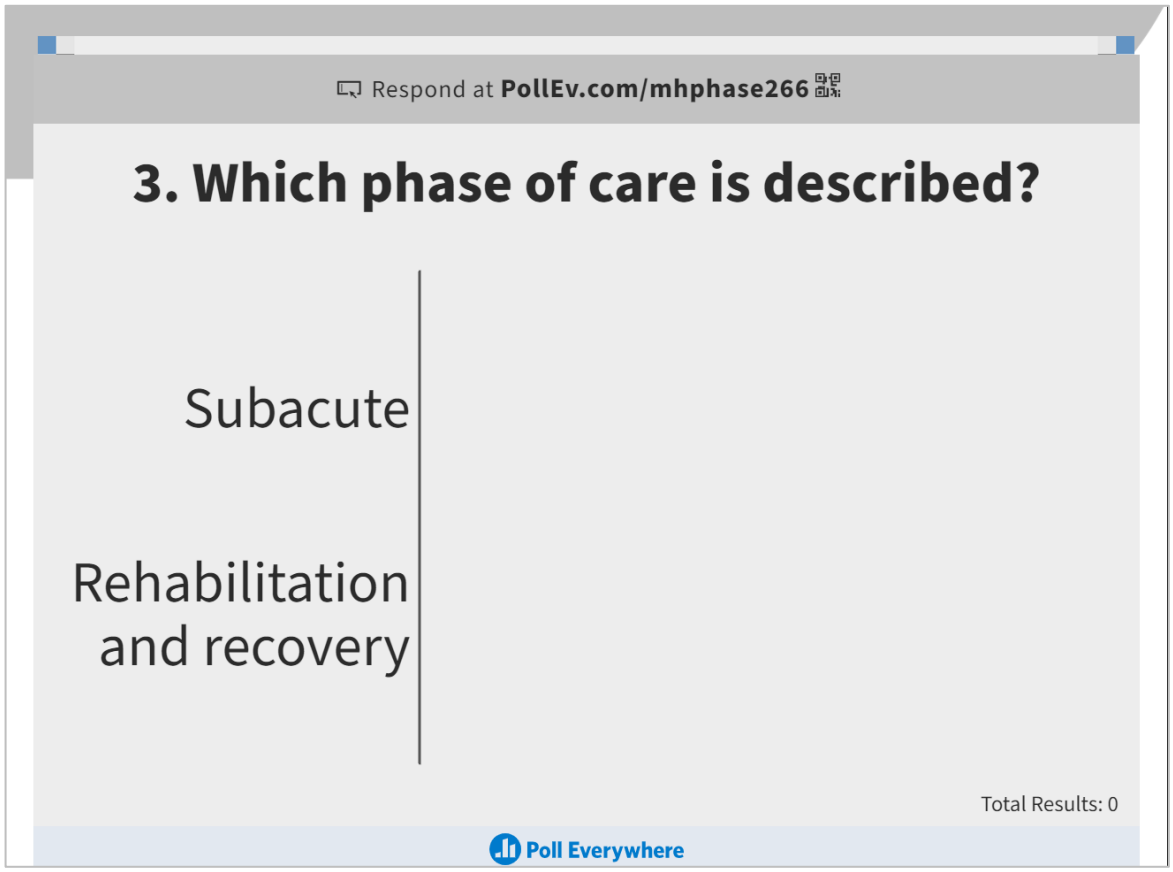
Physical: Sumaya is a slim young girl who appears underweight. Her mother reports that she will only eat broccoli, cherry tomatoes, cheese and plain pasta and she is worried about her health. For the past six months, Sumaya has been pulling out strands of her hair when she is at the school gates.

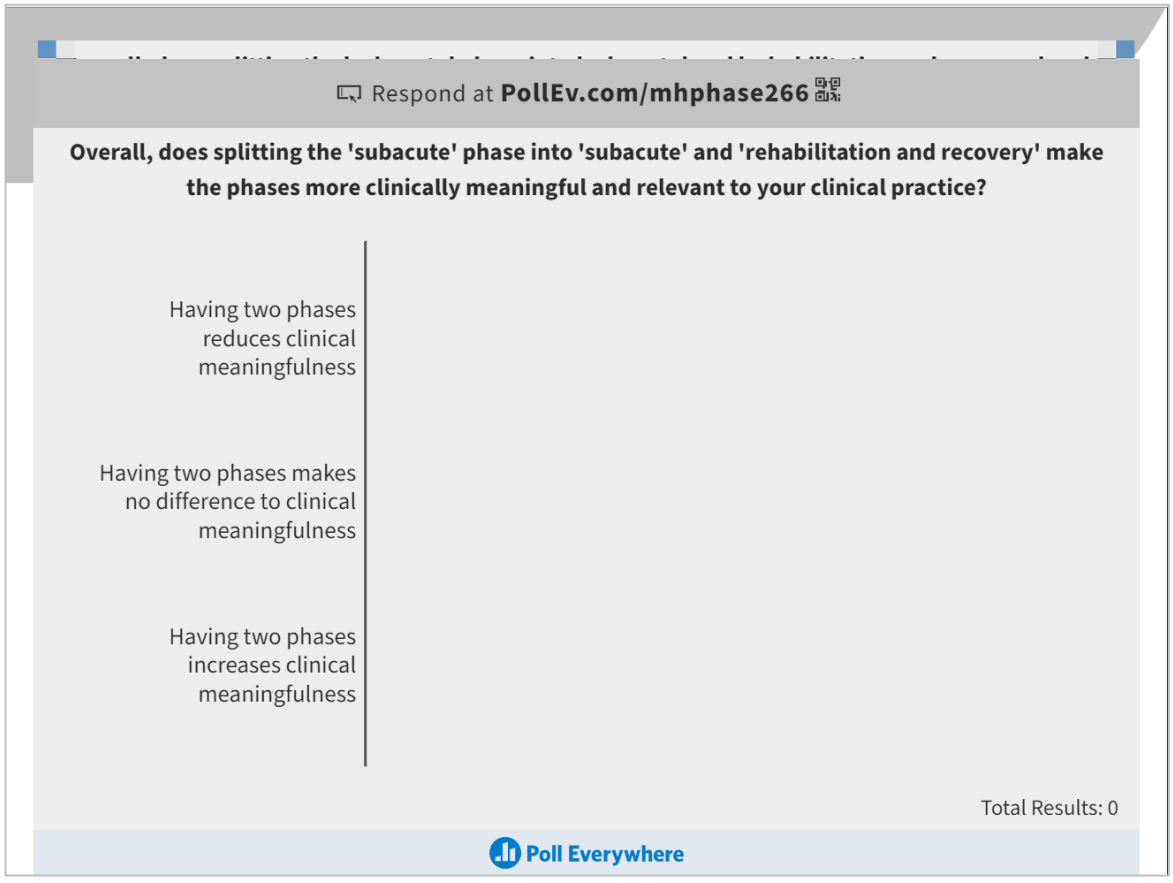
Symptoms: Sumaya is reported to seem anxious when she has to go to school in the morning and expresses a fear that she is not 'smart like the other girls'. She has developed a number of odd vocalisations when her mother tries to talk to her about her school work. Sumaya sometime wakes in the middle of the night and goes to her mother's bed to sleep.

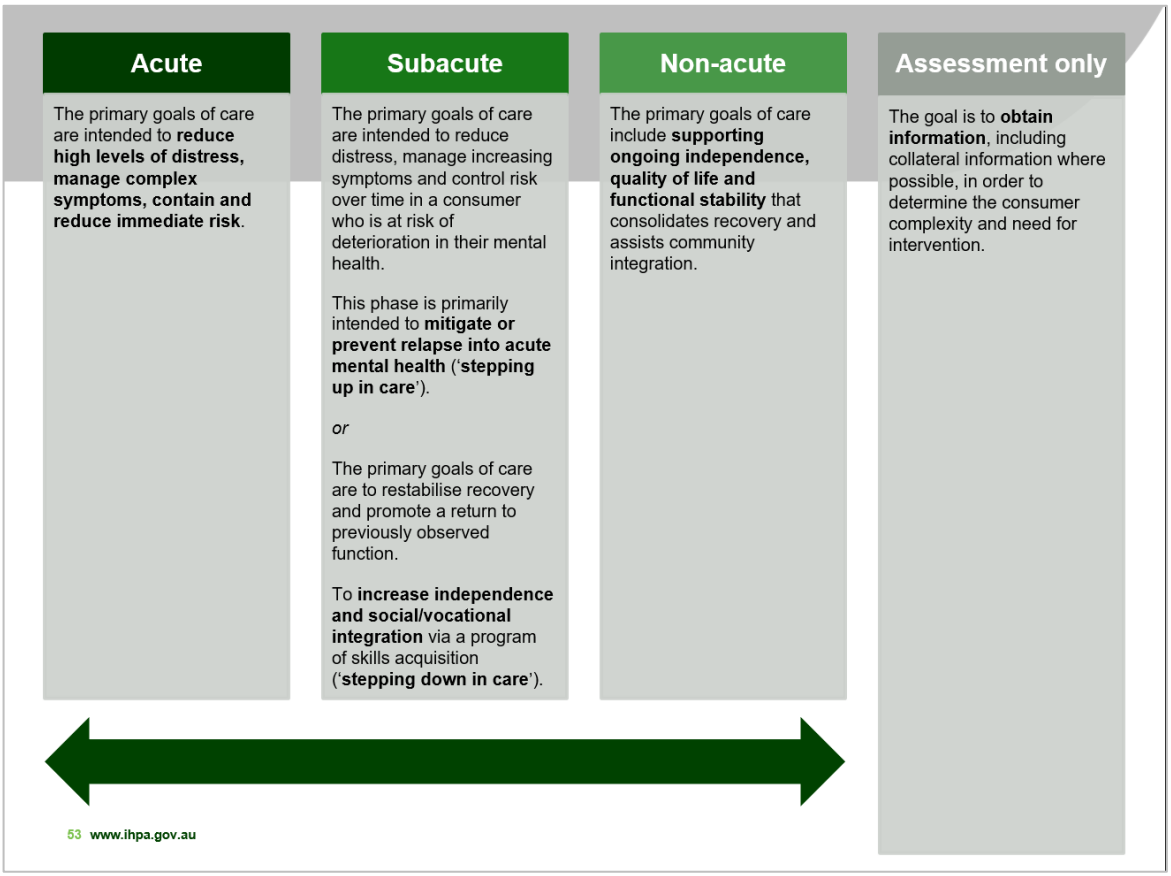
Social: Sumaya is a talented guitar player and enjoys playing with her two female friends after school. She is somewhat excluded from her larger peer group.

Family/carer: Her mother has expressed the belief that Sumaya may have been cursed by her grandmother when she left Somalia because she did not approve of her father when he was alive.

Interventions: Sumaya is enrolled in a day program with a focus on addressing her anxiety and confidence in the school setting. Sumaya expresses the wish to be able to walk to school by herself, as it is only 5-minute walk from her home, so a graduated program is planned. Her mother is also engaged in some education and support around assisting Sumaya with her anxiety. Sumaya is also referred to a dietician to discuss her current food preferences.


Respond at PollEv.com/mhphase266
3. Which phase of care is described?
Subacute
Rehabilitation and recovery
Total Results: 0
Poll Everywhere


Respond at PollEv.com/mhphase266
Overall, does splitting the 'subacute' phase into 'subacute' and 'rehabilitation and recovery' make the phases more clinically meaningful and relevant to your clinical practice?
Having two phases reduces clinical meaningfulness
Having two phases makes no difference to clinical meaningfulness
Having two phases increases clinical meaningfulness
Total Results: 0
Poll Everywhere



What's next?

IHPA ran a similar study in 2016-17 which tested different phase definitions

We will compare the results from the studies to see which definitions:

- make most sense to clinicians
- are more consistently applied by clinicians

This will inform phase of care refinement and future AMHCC development

State health departments will contribute to this through IHPA's Mental Health Working Group

Thank you

IHPA will provide site coordinators with high-level results and outcomes from the project in early 2021

More information is also available at:

www.ihpa.gov.au/what-we-do/mental-health-care

email: enquiries.ihpa@ihpa.gov.au

Slide deck – Group 2B

Objectives for today

1. Understand the proposed ‘mental health phases of care’ definitions

2. Apply them to some case vignettes so we can test if:
   - they make sense to clinicians
   - they are applied consistently by clinicians

Structure of today

1. **As a group:** training (1 hour)
   - background
   - training
   - worked examples and discussion – ask questions and test ideas

2. **On your own:** survey (45 mins)
   - quick demographic questionnaire
   - rating of case vignettes
   - provide feedback

3. **As a group:** feedback and discussion (15 mins)

4

Where are we in the development process?

We are now on Step 5: review and refinement

Version 1 of the AMHCC has been built

We are refining it with clinical input, so that it is:

- easier to use
- better describes the different costs of care across the system

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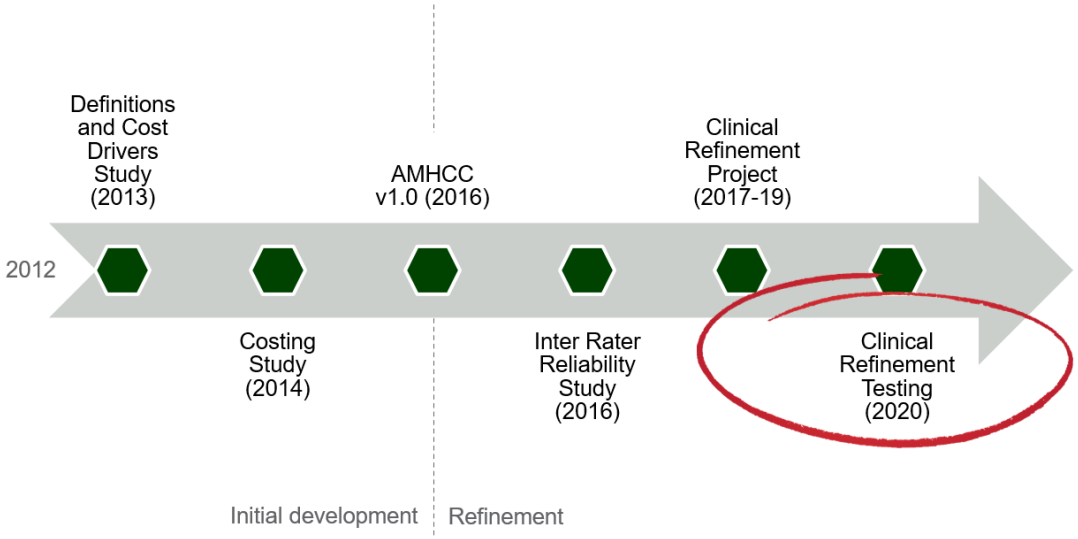
Where are we in the development process?



Clinical refinement testing project

Testing ‘phase of care’ definitions with clinicians from a range of different mental health services and specialties across Australia

Results will inform possible updates to the AMHCC

State health departments are involved through IHPA’s Mental Health Working Group

What are we testing today?

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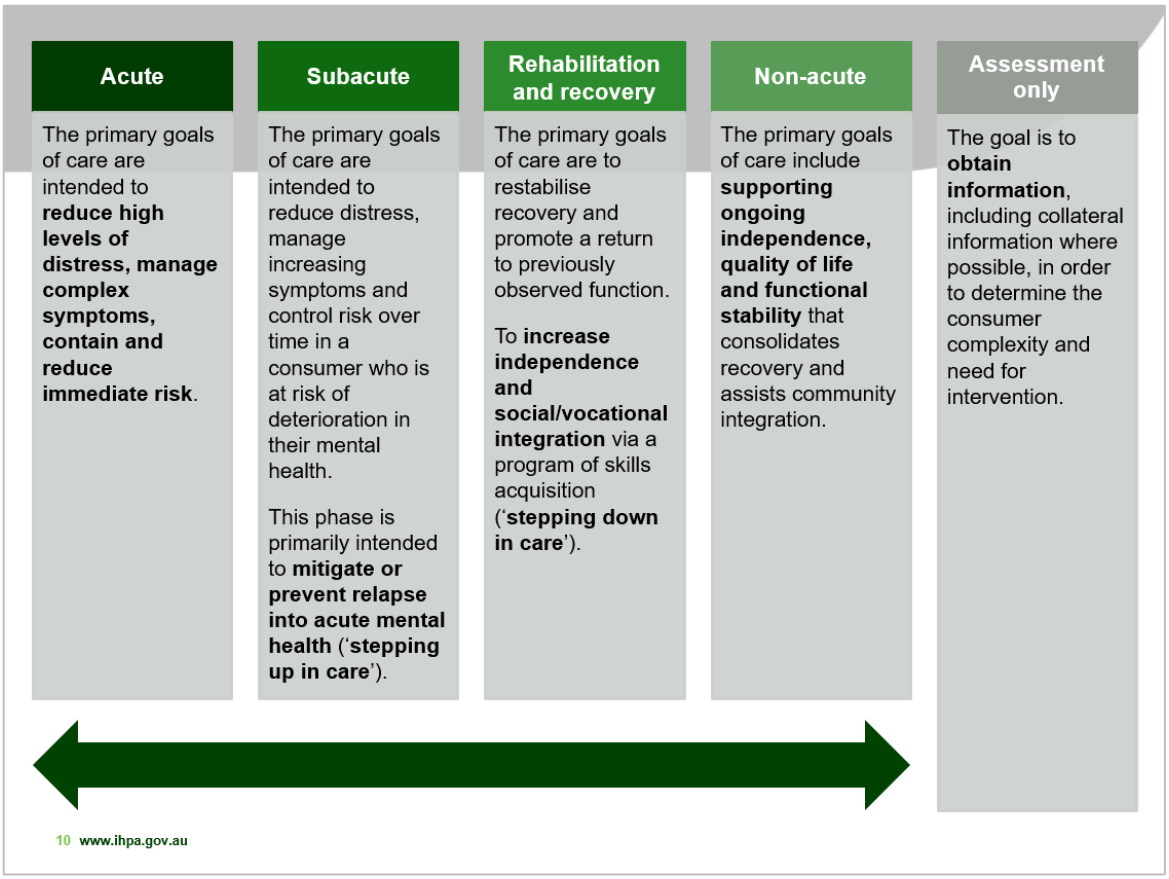
The names of the phases and their descriptions are different to those in the current AMHCC

You don't need any knowledge of the AMHCC to participate

This is **not** training on how to use the AMHCC

Prospective 'phase of care' is **not** the same as **retrospective** 'focus of care'

Mental health phase of care



What is ‘phase of care’?

Overall, your goal as a clinician may be to reduce symptoms, improve functioning and support the consumer in their journey of recovery… but what is their mental health phase of care?

Phase of care describes one part of that journey

It is a consumer-focused **prospective** assessment

It is independent of:

- discipline
- service unit
- type of treatment
- diagnosis

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What is 'phase of care'?

Phase of care is based on:
✓goal of care ✓consumer characteristics ✓clinical decision

Phase is assessed at the **start of an episode** of care

A change of phase can occur **within an episode** when there is a substantial or sustained change in the consumer's clinical condition, their requirements for care change or your treatment plan changes

It is completed by **clinicians** on assessment, review or in a multidisciplinary meeting

How is phase of care used?

Used together with other variables in the AMHCC to explain resource consumption (cost) at the consumer level

The other variables are:

- service setting (admitted or community)
- consumer age
- HoNOS score (except for 'assessment only')
- *for some groups of consumers:* mental health legal status, or LSP-16

What are we testing today?

We are reviewing the AMHCC and testing **new phase types** to see if the AMHCC should be updated to include them

The names of the phases and their descriptions are different to those in the current AMHCC

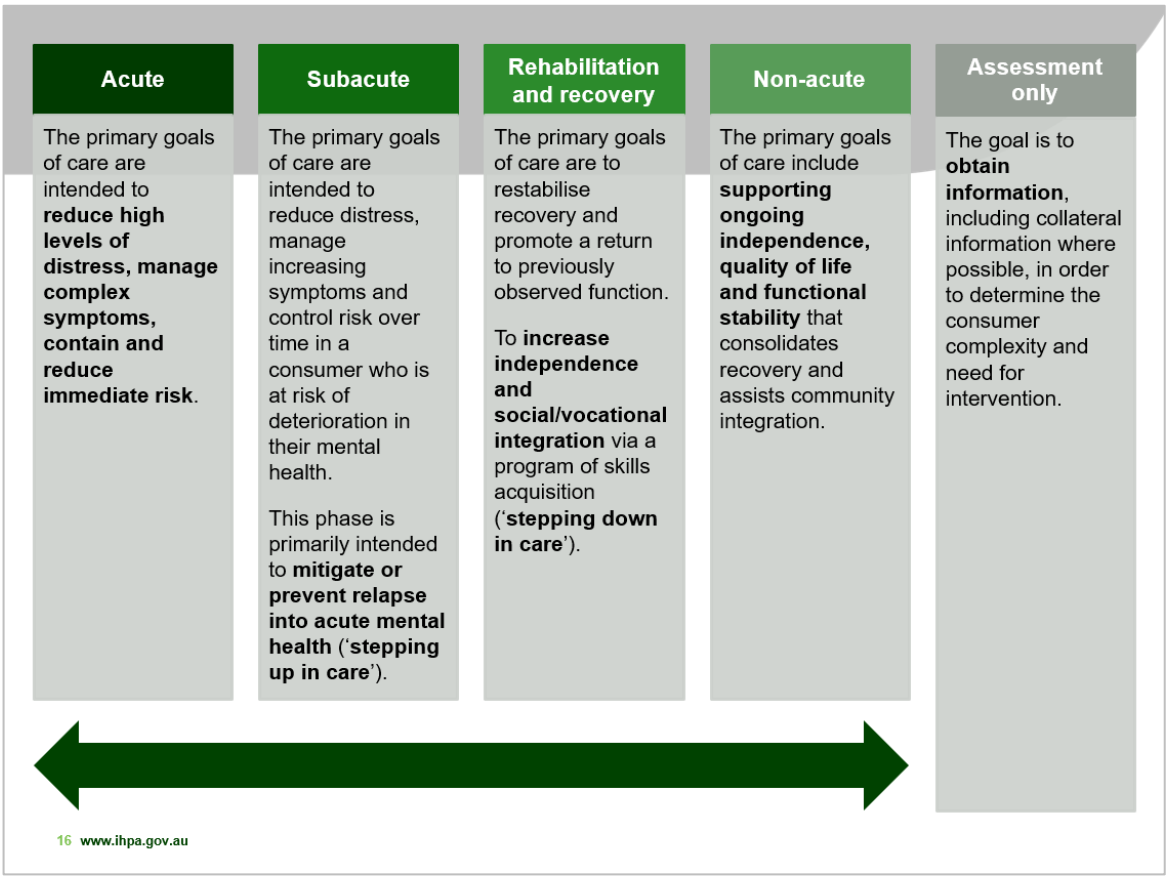
You don't need any knowledge of the AMHCC to participate

This is **not** training on how to use the AMHCC

Prospective 'phase of care' is **not** the same as **retrospective** 'focus of care'

Training approach

1. Overview of the phases
2. Discuss each phase definition in detail
3. Work through some examples
4. Quiz questions for group discussion


Acute
The primary goals of care are intended to **reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk**.
Subacute
The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health.
This phase is primarily intended to **mitigate or prevent relapse into acute mental health** (‘**stepping up in care**’).
Rehabilitation and recovery
The primary goals of care are to restabilise recovery and promote a return to previously observed function.
To **increase independence and social/vocational integration** via a program of skills acquisition (‘**stepping down in care**’).
Non-acute
The primary goals of care include **supporting ongoing independence, quality of life and functional stability** that consolidates recovery and assists community integration.
Assessment only
The goal is to **obtain information**, including collateral information where possible, in order to determine the consumer complexity and need for intervention.
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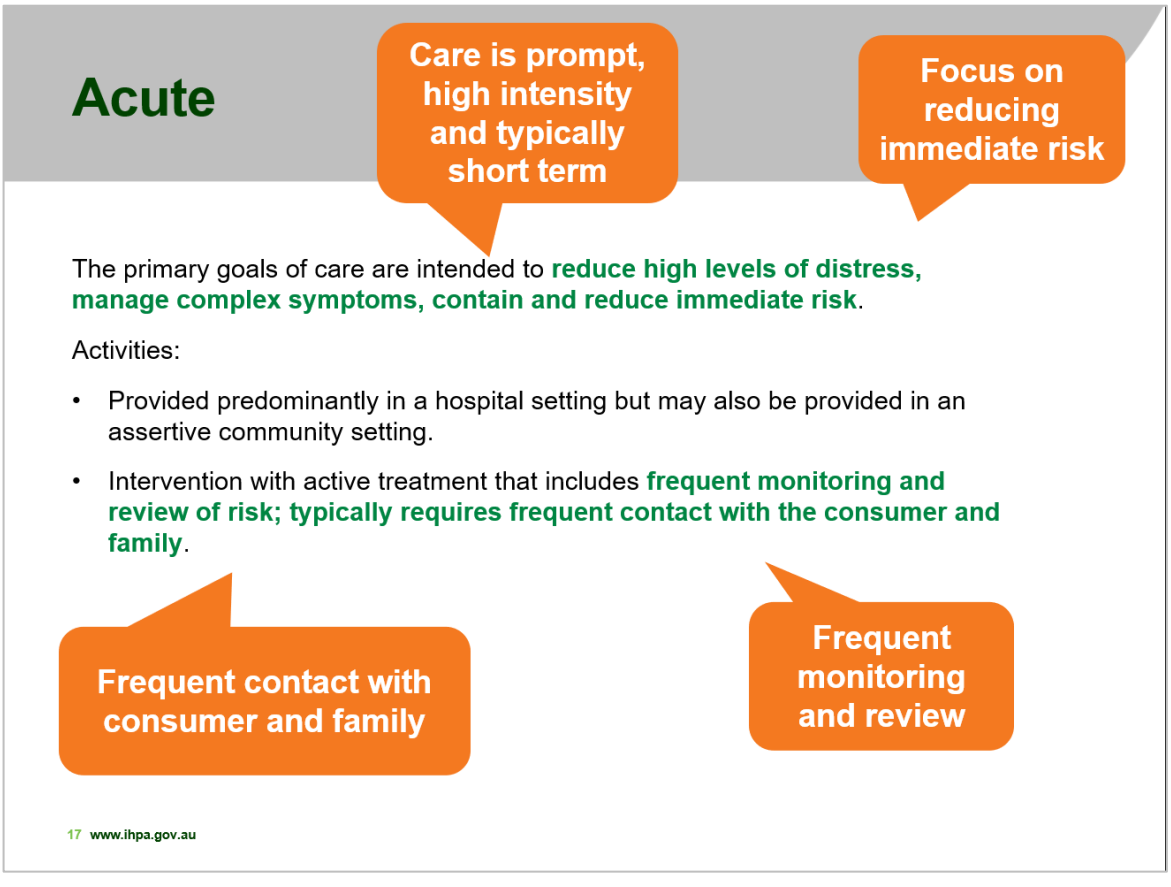
Acute
Care is prompt, high intensity and typically short term
Focus on reducing immediate risk
The primary goals of care are intended to reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk.
Activities:
• Provided predominantly in a hospital setting but may also be provided in an assertive community setting.
• Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.
Frequent contact with consumer and family
Frequent monitoring and review
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Subacute

'Step up' care

Mitigate or prevent relapse to acute

The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. **This phase is primarily intended to mitigate or prevent relapse into acute mental health** ('stepping up in care').

Activities:

- Provided predominantly in a hospital setting but may also be provided in an assertive community setting.
- Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.

Frequent contact with consumer and family

Frequent monitoring and review

Short to medium term

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Rehabilitation and recovery

Restabilise

The primary goals of care are to **restabilise recovery** and **promote a return to previously observed function**.

To increase **independence and social/vocational integration via a program of skills acquisition** ('stepping down in care').

Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.

'Step down' care

Short to medium term

Promote a return to recovery

Consumer's developmental needs and strengths

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Non-acute

Ongoing care of low intensity

Medium to long term

Independence

The primary goals of care include **supporting ongoing independence, quality of life and functional stability, that consolidates recovery and assists community integration**.

Interventions are provided with routine contact to optimise function, further develop and promote independence and build social and emotional wellbeing whilst planning for discharge or transfer of care from service in the longer term.

Non-acute phase care provides much greater emphasis on setting a threshold for providing care which is defined as neither acute nor subacute in nature.

Activities:

- Provided predominantly in a community setting.
- **Low levels of routine activity are required to support and maintain symptoms and impairment that has been stabilised**. Engage NGOs and shared care agencies to achieve safe and effective discharge.

Predominantly community setting

Engage shared care and NGOs

Support and maintain once stabilised

Assessment only

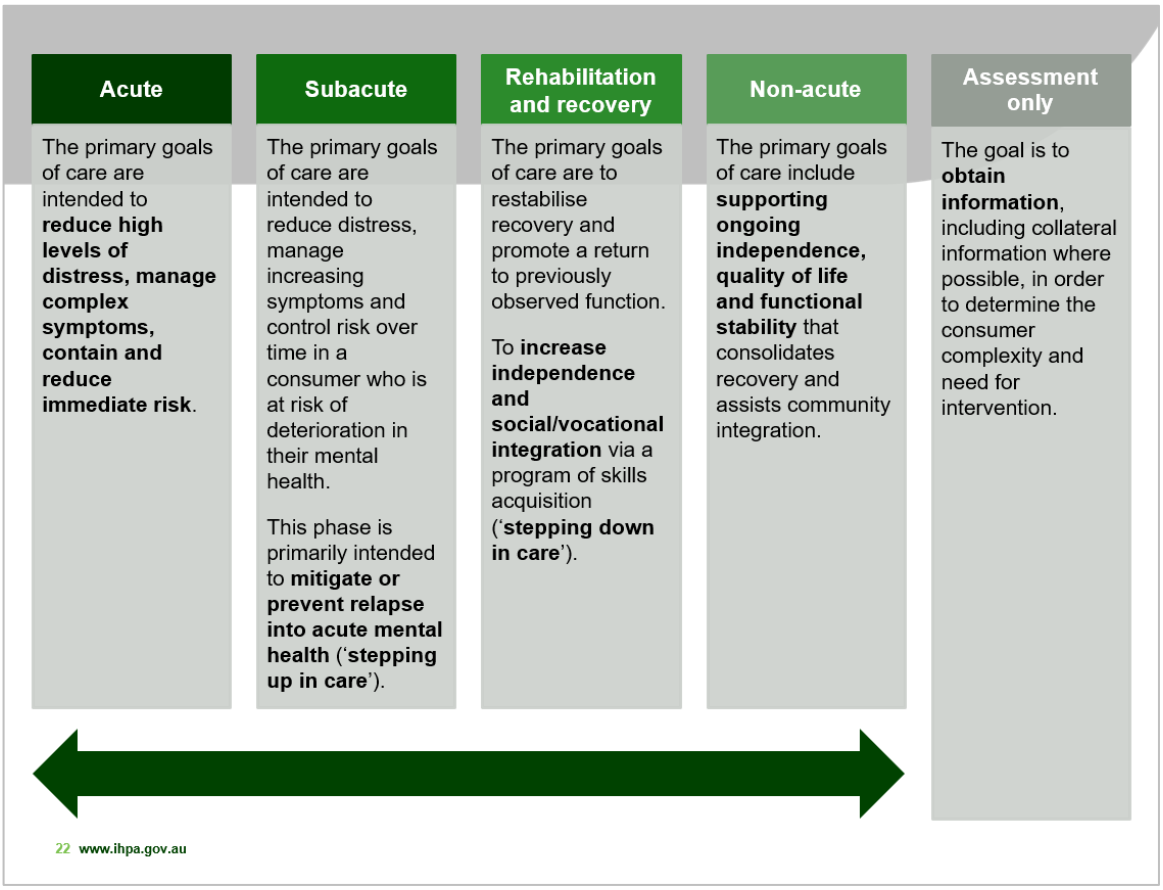
The goal is to **obtain information, including collateral information where possible, in order to determine the consumer complexity and need for intervention**.

Activities:

- Includes brief history, risk assessment, clinical screening and information gathering.

For this to be applicable the outcome would result in no further intervention or a referral on or into a new care episode

May include brief interventions



Example 1

Makayla is 16. Three months ago she was assessed as depressed and anxious.

She was concerned about “germs” being “everywhere”.

She has had a good response to medication and cognitive behaviour therapy.

Her case manager wants some additional sessions with Makayla and her family to reinforce her positive gains.

Non-acute

Example 2

Patricia has a long history of anxiety.

She was an avid member of the Rotary; however, she stopped attending meetings because her feelings of anxiety became overwhelming.

Her medication regiment was modified with good effect.

She is currently working on different relaxation techniques with her case manager with a view to returning to Rotary meetings.

Rehabilitation and recovery

Example 3

Ross has been experiencing auditory hallucinations for many years which he finds distressing.

He presents with severe lack of motivation even to undertake simple activities of daily living.

He has regular contact with his case manager because of concerns about a possible deterioration in his presentation.

Ross is engaged with an NGO to improve his functioning and a psychiatrist to manage his symptoms.

Subacute

Quiz (1/5)

The primary goal of an 'acute' mental health phase of care is:

a. improving medication adherence

b. focused on improving the consumer's level of functioning

c. the short term reduction of symptoms

d. all of the above

Quiz (2/5)

'Assessment only' is:

a. the active treatment of the consumer's symptoms

b. collection of collateral information to support assessment and referral

c. focused on improving the consumer's level of functioning

d. all of the above

Quiz (3/5)

The mental health phase of care 'subacute' is:

a. monitoring warning signs to prevent relapse of an acute phase

b. the development of skills to increase independence

c. supporting independence through routine activities

d. containing and reducing immediate risk

e. all of the above

Quiz (4/5)

The primary goal of a 'rehabilitation and recovery' mental health phase of care:

a. is to prevent relapse into acute care

b. includes skills acquisition

c. focuses on returning to previously observed function

d. none of the above

Quiz (5/5)

When identifying the 'non-acute' mental health phase of care you should consider:

a. the primary goal of care

b. consumer characteristics

c. your expectations of the rate of change in the consumer's presentation

d. all of the above

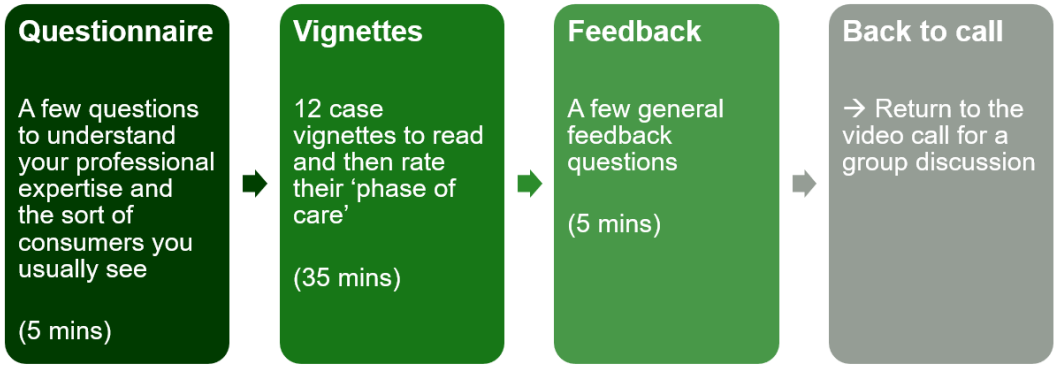
Acute	Subacute	Rehabilitation and recovery	Non-acute	Assessment only
The primary goals of care are intended to **reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk**.	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to **mitigate or prevent relapse into acute mental health** ('**stepping up in care**').	The primary goals of care are to restabilise recovery and promote a return to previously observed function. To **increase independence and social/vocational integration** via a program of skills acquisition ('**stepping down in care**').	The primary goals of care include **supporting ongoing independence, quality of life and functional stability** that consolidates recovery and assists community integration.	The goal is to **obtain information**, including collateral information where possible, in order to determine the consumer complexity and need for intervention.

Questions on the phases?

What happens now?

1. **As a group:** training (1 hour)
   - background
   - training
   - worked examples and discussion – ask questions and test ideas
2. **On your own:** survey (45 mins)
   - quick demographic questionnaire
   - rating of case vignettes
   - provide feedback
3. **As a group:** feedback and discussion (15 mins)

Survey



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Rating the case vignettes

Each case vignette is about a page long

It describes a consumer in a **single phase of care**

You will be asked to:

- identify the phase
- rate how confident you were in assigning that phase of care

At the end of the survey you can make further comments

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Instructions

You have 45 minutes to complete the survey

Please keep the Zoom call open in the background (you can turn off camera/microphone)

If you need to leave the Zoom call you can return via the same weblink

If you have any questions during the survey, switch back to Zoom and send me a message using the chat function, or email me at jennifer@jennifernobbsconsulting.com

When you have completed the survey please click 'submit' and return to the Zoom call

Instructions

It is important that you do not communicate with your colleagues on your interpretation of, or response to the survey questions during the time you or your colleagues are completing the survey

There will be a session following the survey completion in which we can discuss interpretations and provide feedback

Please take note that you are participating in the **GROUP B** training session

You will be asked which session at the beginning of the survey, and it is important that you enter **GROUP B** for this question

Please refer to the mental health phase of care diagram included in the training handout, to assist with rating the case vignettes

Welcome back!

Subacute/ rehabilitation and recovery phases: alternative approach

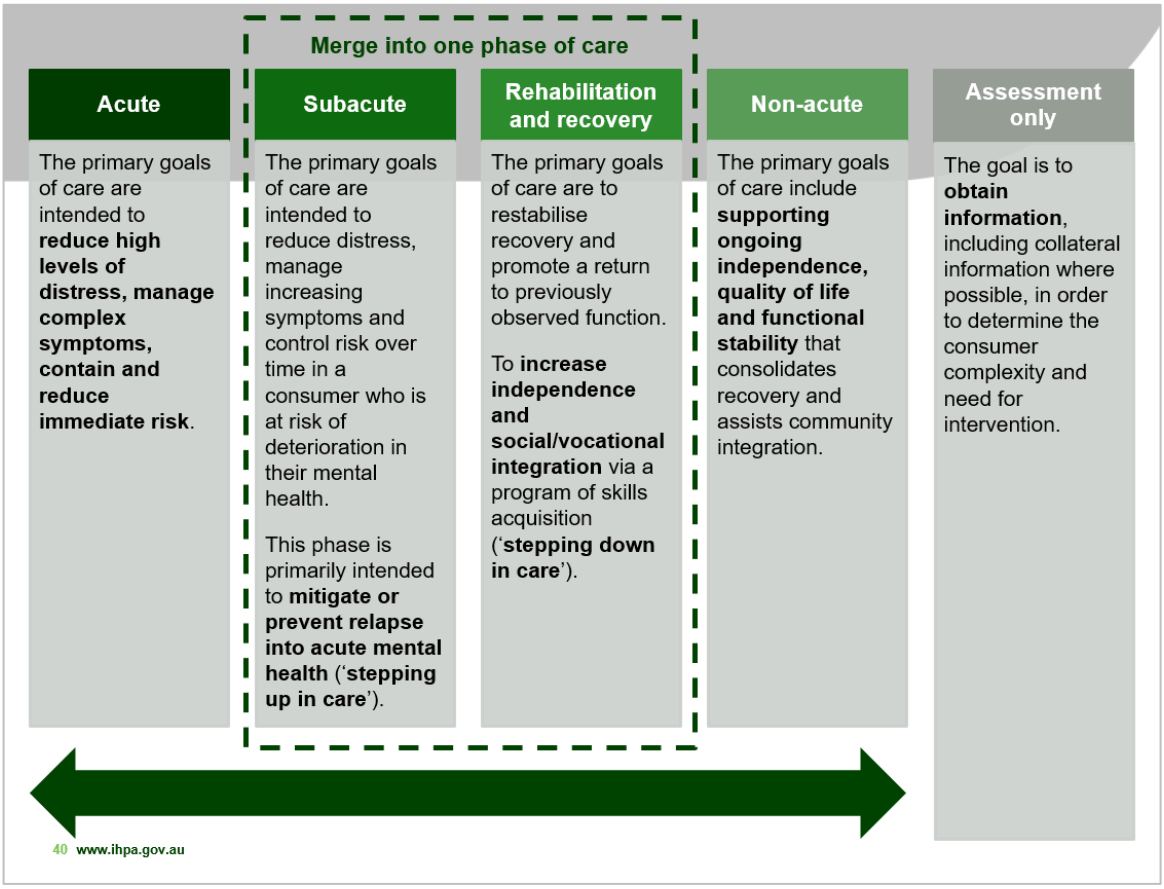
An alternative approach is being considered for ‘subacute’ and ‘rehabilitation and recovery’

These phases could be **merged into one phase**

- Subacute (alternative definition)

There is **no change** to the language in the description

There are **no changes to any of the other phases**



Subacute (alternative approach): two definitions merged

The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. **This phase is primarily intended to mitigate or prevent relapse into acute mental health** ('stepping up in care').

Activities:

- Provided predominantly in a hospital setting but may also be provided in an assertive community setting.
- Intervention with active treatment that includes frequent monitoring and review of risk; typically requires frequent contact with the consumer and family.

Or

The primary goals of care are to **restabilise recovery** and **promote a return to previously observed function**.

To increase **independence and social/vocational integration via a program of skills acquisition** ('stepping down in care').

Activities focus on psychosocial interventions and evidence based structured therapies that are person centred and should consider the developmental needs and strengths of the consumer.

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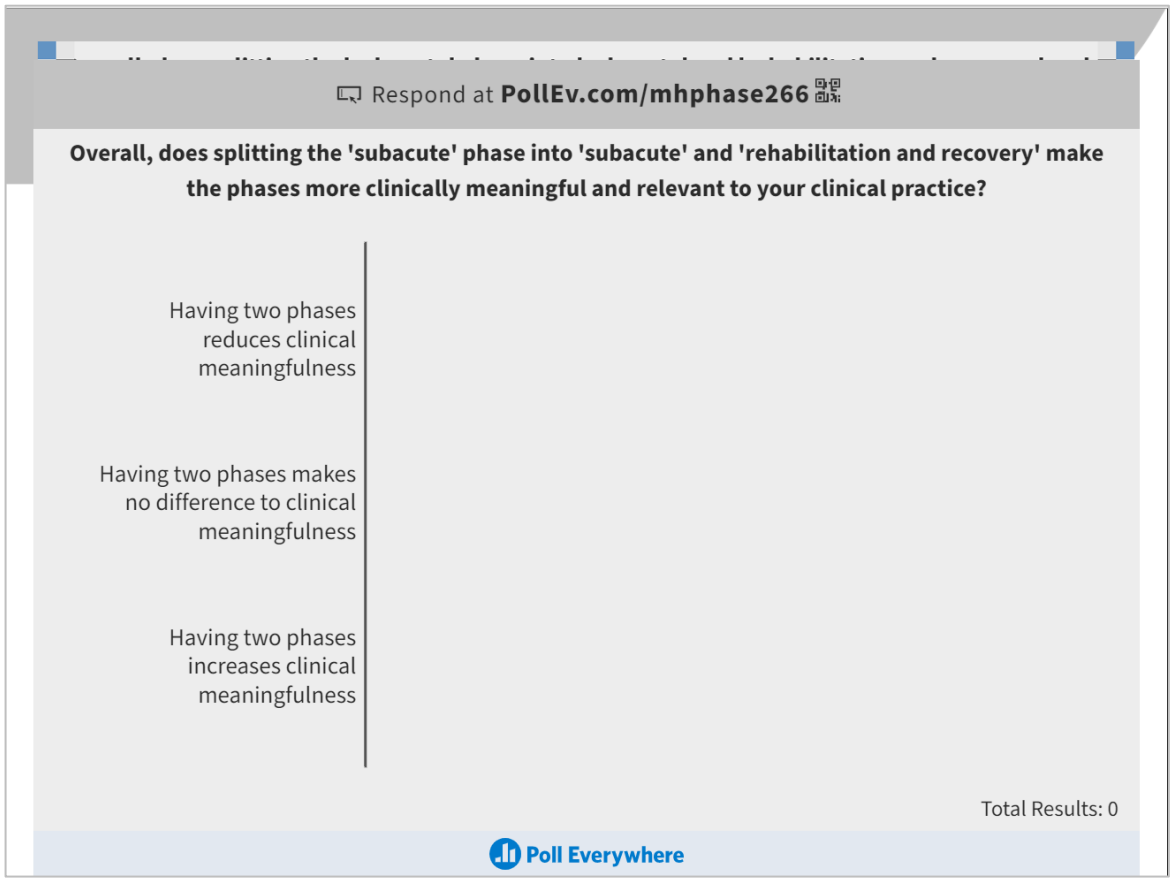
Voting on the following slide

You may sign in to Poll Everywhere as a guest so that your response is anonymised. You do **not** need to register your name.

If you do choose to sign in with your name, your vote will be recorded against your name. **IHPA will remove your name prior to analysis**.

We will only use the number of votes in the session, and not names.



Acute	Subacute	Rehabilitation and recovery	Non-acute	Assessment only
The primary goals of care are intended to **reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk**.	The primary goals of care are intended to reduce distress, manage increasing symptoms and control risk over time in a consumer who is at risk of deterioration in their mental health. This phase is primarily intended to **mitigate or prevent relapse into acute mental health** (‘**stepping up in care**’).	The primary goals of care are to restabilise recovery and promote a return to previously observed function. To **increase independence and social/vocational integration** via a program of skills acquisition (‘**stepping down in care**’).	The primary goals of care include **supporting ongoing independence, quality of life and functional stability** that consolidates recovery and assists community integration.	The goal is to **obtain information**, including collateral information where possible, in order to determine the consumer complexity and need for intervention.

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What’s next?

IHPA ran a similar study in 2016-17 which tested different phase definitions

We will compare the results from the studies to see which definitions:

- make most sense to clinicians
- are more consistently applied by clinicians

This will inform phase of care refinement and future AMHCC development

State health departments will contribute to this through IHPA’s Mental Health Working Group

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Thank you

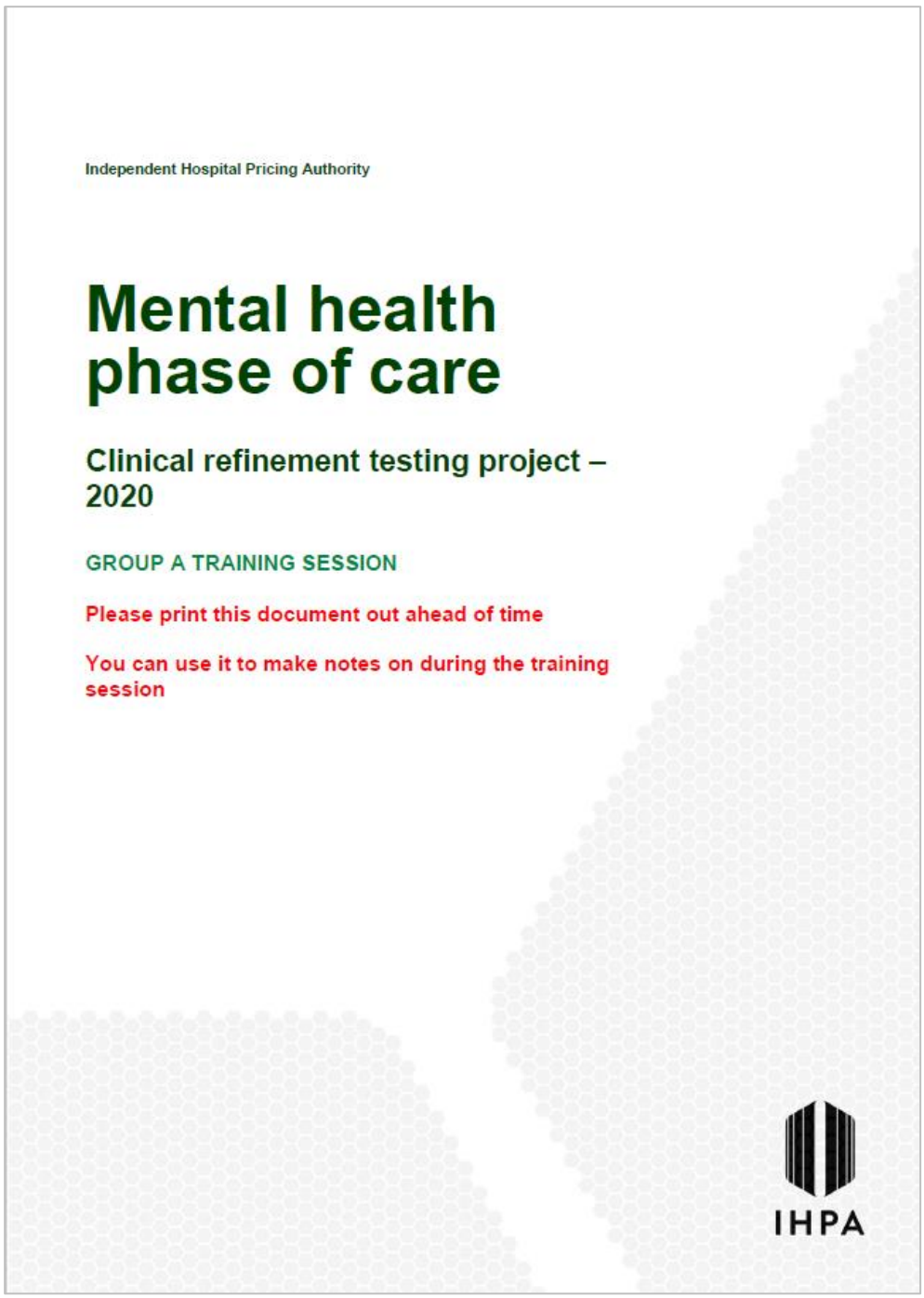
IHPA will provide site coordinators with high-level results and outcomes from the project in early 2021

More information is also available at:

www.ihpa.gov.au/what-we-do/mental-health-care

email: enquiries.ihpa@ihpa.gov.au

Handout


Independent Hospital Pricing Authority
Mental health phase of care
Clinical refinement testing project – 2020
GROUP A TRAINING SESSION
Please print this document out ahead of time
You can use it to make notes on during the training session
IHPA

Mental health phase of care – clinical refinement testing project 2020

Instructions

Please read the following before the training session

The session will last approximately two hours. It is interactive and you will **not** be able to 'pause' and complete any part of it later. Please ensure you have sufficient time scheduled in your diary.

You may dial in on your own, or as a group of colleagues in the same room.

There will be three parts to the session:

1. A group interactive video call and presentation (via the video conferencing platform advised by email)
2. An online survey which you will complete on your own
3. A group interactive feedback session (via video conferencing)

Please ensure that you have access to a quiet space and an internet-enabled device for the full session. This should preferably be a laptop or larger screen as the slides will include text-heavy information. You may share a screen with colleagues, but you will need to be close enough to the screen to read the detailed slides.

As Parts 1 and 3 are interactive video calls, you will need to be able to access the video conferencing platform advised in your email and your device's camera and microphone functions.

If you are dialling in as group, please ensure you have access to your own device for Part 2, the online survey (laptop, tablet, smartphone, etc).

There is no pre-reading required.

Please contact your local site coordinator if you have any questions prior to the training session.

Connecting to the call

Please access the video call via the link provided to you in advance **by email**.

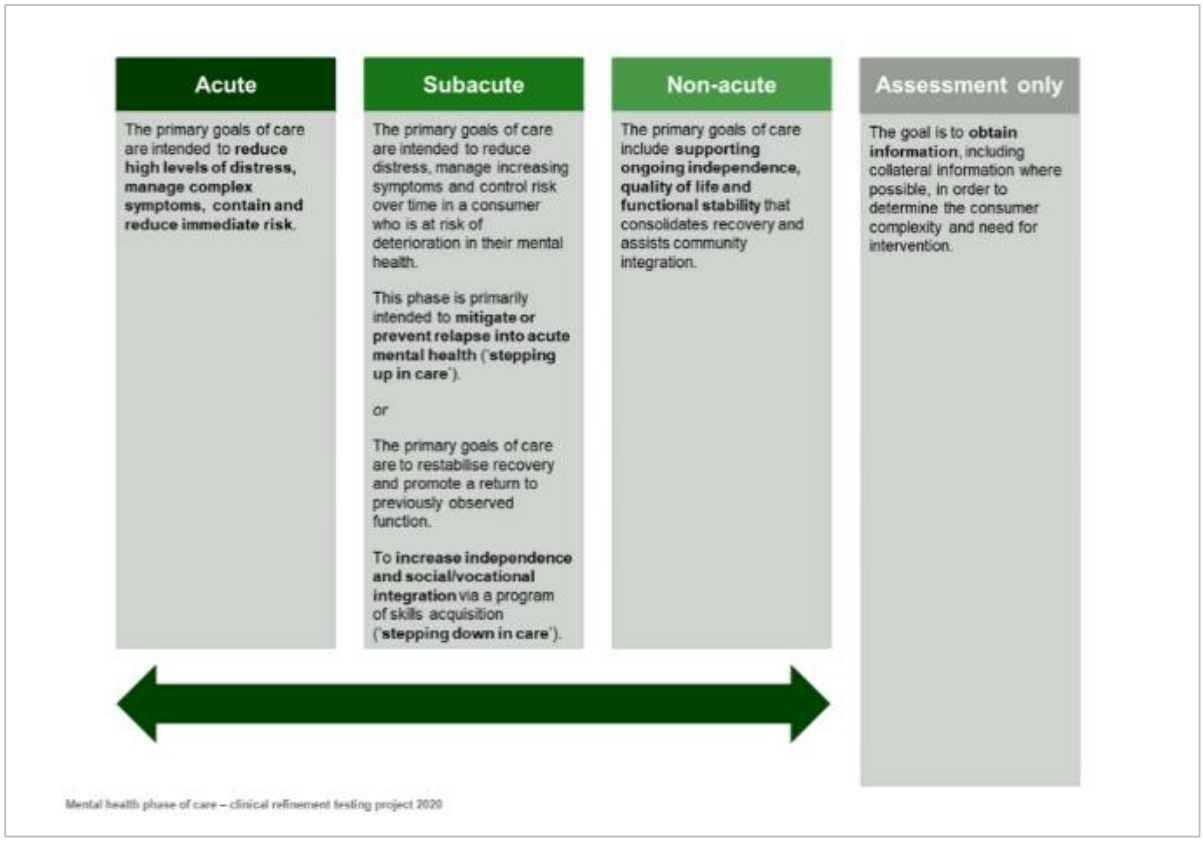
If you have problems connecting on the day, please contact jennifer@jennifernobbsconsulting.com

Diagram on next page

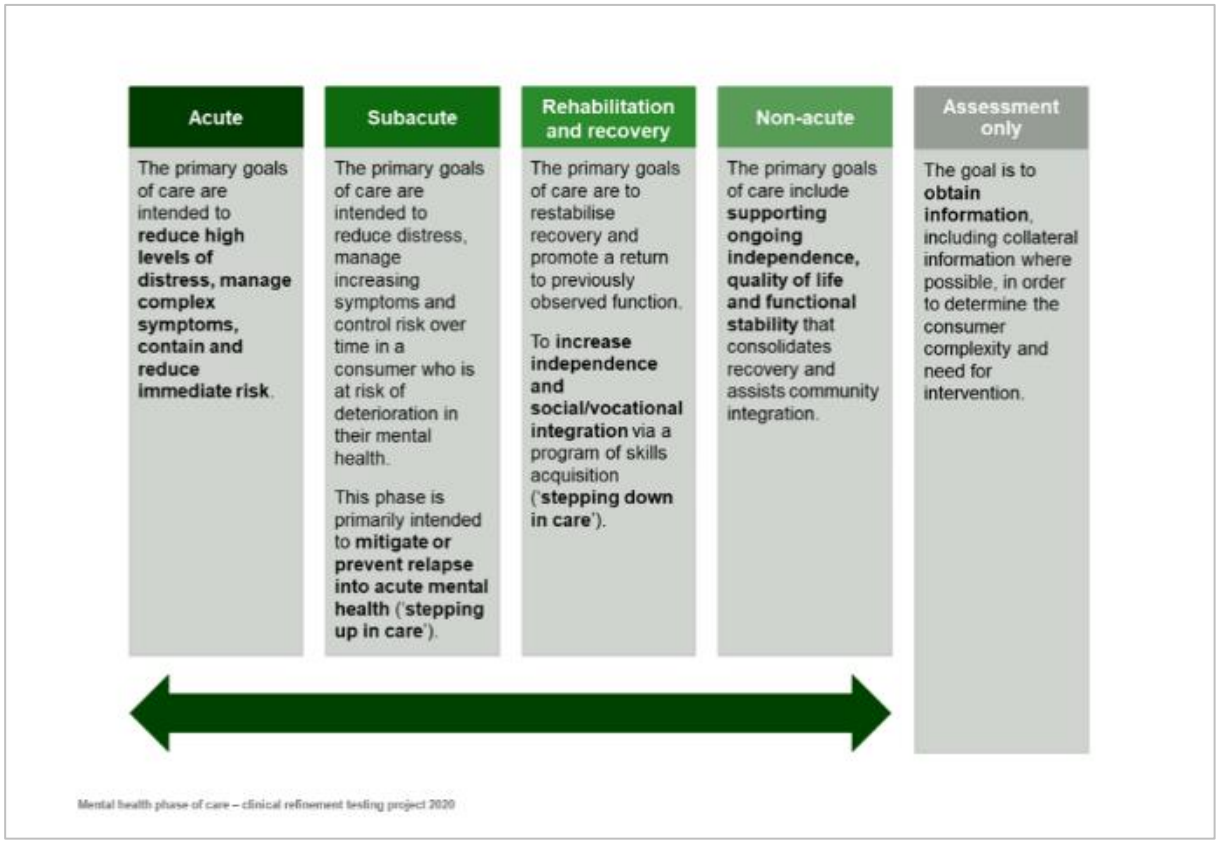
The diagram on the next page is provided as an accompaniment to the presentation. You do **not** need to read it ahead of time.

It is provided for you to make notes on during the session and refer to throughout.

Page 3: Group 2A



Page 3: Group 2B



Appendix E. Detailed analysis

Table 44: List of Study 2 session and survey respondent counts by survey group (prior to data exclusions)

No.	Date	Group 2A	Group 2B
1	28 August 2020		8
2	31 August 2020	10	
3	1 September 2020	5	
4	3 September 2020	8	
5	4 September 2020	7	
6	7 September 2020		13
7	8 September 2020		7
8	9 September 2020	20	
9	9 September 2020	11	
10	10 September 2020		5
11	10 September 2020		9
12	14 September 2020	8	
13	14 September 2020		21
14	16 September 2020	11	
15	16 September 2020	8	
16	17 September 2020		8
17	18 September 2020		8
18	22 September 2020		6
19	24 September 2020		14
20	28 September 2020	2	
21	29 September 2020		4
22	30 September 2020	10	
23	5 October 2020		4
24	7 October 2020	9	
25	8 October 2020		4
26	15 October 2020	8	
27	16 October 2020		3

No.	Date	Group 2A	Group 2B
28	19 October 2020		4
29	20 October 2020		10
30	20 October 2020	6	
31	22 October 2020		12
32	22 October 2020	14	
Total respondents by Group (prior to data exclusions)		**137**	**140**

Table 45: Summary of unweighted and weighted ratings by vignette and study

		Ratings Sample Size			% Ratings Unweighted			% Ratings Weighted		
Age Group	Name	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B	Group 1	Group 2A	Group 2B
Children and adolescents	Jordan	31	20	20	1.5%	2.2%	2.1%	4.5%	4.5%	4.5%
	Tameka	34	20	20	1.6%	2.2%	2.1%	4.5%	4.5%	4.5%
	Marcus	33	20	20	1.6%	2.2%	2.1%	4.5%	4.5%	4.5%
	Llubica	35	20	20	1.7%	2.2%	2.1%	4.5%	4.5%	4.5%
	Jade	34	20	20	1.6%	2.2%	2.1%	4.5%	4.5%	4.5%
	Bryce	59	20	20	2.8%	2.2%	2.1%	4.5%	4.5%	4.5%
	Sumaya	61	20	20	2.9%	2.2%	2.1%	4.5%	4.5%	4.5%
Adults	Gary	239	77	86	11.3%	8.5%	8.9%	4.5%	4.5%	4.5%
	Ashley	254	77	86	12.0%	8.5%	8.9%	4.5%	4.5%	4.5%
	Jason	157	88	98	7.4%	9.8%	10.1%	4.5%	4.5%	4.5%
	Fang	116	88	98	5.5%	9.8%	10.1%	4.5%	4.5%	4.5%
	Barry	152	77	86	7.2%	8.5%	8.9%	4.5%	4.5%	4.5%
	Vivian	248	88	98	11.7%	9.8%	10.1%	4.5%	4.5%	4.5%
	Jo Beth	255	77	86	12.1%	8.5%	8.9%	4.5%	4.5%	4.5%
	Malcolm	251	77	86	11.9%	8.5%	8.9%	4.5%	4.5%	4.5%
Older persons	Agnes	29	16	15	1.4%	1.8%	1.5%	4.5%	4.5%	4.5%
	Eric	17	16	15	0.8%	1.8%	1.5%	4.5%	4.5%	4.5%
	Jo	17	16	15	0.8%	1.8%	1.5%	4.5%	4.5%	4.5%
	Mara	17	16	15	0.8%	1.8%	1.5%	4.5%	4.5%	4.5%
	Peter	15	16	15	0.7%	1.8%	1.5%	4.5%	4.5%	4.5%
	Antonina	29	16	15	1.4%	1.8%	1.5%	4.5%	4.5%	4.5%
	Edward	30	16	15	1.4%	1.8%	1.5%	4.5%	4.5%	4.5%
Total		**2113**	**901**	**969**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table 46: Comparison of alternative agreement statistics across studies

Agreement statistic	Group 1	Group 2A	Group 2B
Kappa	0.396	0.495	0.441
Gwet's AC1	0.400	0.515	0.446

Table 47: Summary of vignette ratings by phase of care and age group – Group 1

				% Ratings by Phase					
Phase	Age Group	Name	Ratings	AC	FG	IE	CG	AO	Total
Acute	Children and adolescents	Jordan	31	61.3%	6.5%	32.3%	0.0%	0.0%	100%
		Jade	34	70.6%	8.8%	14.7%	0.0%	5.9%	100%
	Adults	Ashley	254	76.8%	5.9%	3.9%	0.8%	12.6%	100%
	Older persons	Jo	17	88.2%	11.8%	0.0%	0.0%	0.0%	100%
		Edward	30	66.7%	20.0%	10.0%	3.3%	0.0%	100%
Functional gain	Children and adolescents	Marcus	33	0.0%	39.4%	33.3%	24.2%	3.0%	100%
		Sumaya	61	6.6%	50.8%	27.9%	6.6%	8.2%	100%
	Adults	Barry	152	16.4%	63.2%	2.6%	7.9%	9.9%	100%
	Older persons	Peter	15	6.7%	66.7%	20.0%	6.7%	0.0%	100%
		Antonina	29	6.9%	65.5%	13.8%	13.8%	0.0%	100%
Intensive extended	Children and adolescents	Llubica	35	2.9%	25.7%	68.6%	2.9%	0.0%	100%
	Adults	Gary	239	2.1%	15.1%	69.9%	11.7%	1.3%	100%
		Jason	157	8.3%	24.8%	49.0%	17.8%	0.0%	100%
	Older persons	Mara	17	0.0%	5.9%	94.1%	0.0%	0.0%	100%
Consolidating gain	Children and adolescents	Tameka	34	0.0%	2.9%	2.9%	94.1%	0.0%	100%
	Adults	Fang	116	0.9%	22.4%	5.2%	65.5%	6.0%	100%
		Jo Beth	255	1.6%	22.4%	4.7%	53.7%	17.6%	100%
	Older persons	Eric	17	0.0%	29.4%	5.9%	52.9%	11.8%	100%
Assessment only	Children and adolescents	Bryce	59	6.8%	11.9%	13.6%	1.7%	66.1%	100%
	Adults	Vivian	248	9.3%	2.8%	9.7%	16.1%	62.1%	100%
		Malcolm	251	6.8%	3.2%	2.4%	4.0%	83.7%	100%
	Older persons	Agnes	29	48.3%	0.0%	0.0%	0.0%	51.7%	100%

Key: AC acute, FG functional gain, IE intensive extended, CG consolidating gain, AO assessment only

Table 48: Summary of vignette ratings by phase of care and age group – Group 2A

				% Ratings by Phase				
Phase	Age Group	Name	Ratings	AC	SA	NA	AO	Total
Acute	Children and adolescents	Jordan	20	85.0%	15.0%	0.0%	0.0%	100%
		Jade	20	55.0%	30.0%	5.0%	10.0%	100%
	Adults	Ashley	77	74.0%	10.4%	1.3%	14.3%	100%
	Older persons	Jo	16	100.0%	0.0%	0.0%	0.0%	100%
		Edward	16	12.5%	75.0%	0.0%	12.5%	100%
Subacute	Children and adolescents	Marcus	20	0.0%	45.0%	50.0%	5.0%	100%
		Llubica	20	5.0%	80.0%	15.0%	0.0%	100%
		Sumaya	20	0.0%	50.0%	45.0%	5.0%	100%
	Adults	Gary	77	0.0%	62.3%	37.7%	0.0%	100%
		Jason	88	1.1%	60.2%	37.5%	1.1%	100%
		Barry	77	6.5%	57.1%	23.4%	13.0%	100%
	Older persons	Mara	16	0.0%	100.0%	0.0%	0.0%	100%
		Peter	16	0.0%	56.3%	37.5%	6.3%	100%
		Antonina	16	0.0%	37.5%	62.5%	0.0%	100%
Non-acute	Children and adolescents	Tameka	20	0.0%	0.0%	100.0%	0.0%	100%
	Adults	Fang	88	0.0%	4.5%	86.4%	9.1%	100%
		Jo Beth	77	0.0%	6.5%	72.7%	20.8%	100%
	Older persons	Eric	16	0.0%	0.0%	93.8%	6.3%	100%
Assessment only	Children and adolescents	Bryce	20	5.0%	15.0%	10.0%	70.0%	100%
	Adults	Vivian	88	3.4%	12.5%	17.0%	67.0%	100%
		Malcolm	77	0.0%	2.6%	7.8%	89.6%	100%
	Older persons	Agnes	16	25.0%	0.0%	0.0%	75.0%	100%

Key: AC acute, SA subacute, NA non-acute, AO assessment only

Table 49: Summary of vignette ratings by phase of care and age group – Group 2B

				% Ratings by Phase					
Phase	**Age Group**	**Name**	**Ratings**	**AC**	**SA**	**RR**	**NA**	**AO**	**Total**
Acute	Children and adolescents	Jordan	20	50.0%	50.0%	0.0%	0.0%	0.0%	**100%**
		Jade	20	65.0%	25.0%	5.0%	0.0%	5.0%	**100%**
	Adults	Ashley	86	66.3%	24.4%	3.5%	0.0%	5.8%	**100%**
	Older persons	Jo	15	86.7%	0.0%	0.0%	0.0%	13.3%	**100%**
		Edward	15	33.3%	60.0%	0.0%	0.0%	6.7%	**100%**
Subacute	Children and adolescents	Llubica	20	0.0%	15.0%	75.0%	5.0%	5.0%	**100%**
	Adults	Jason	98	1.0%	34.7%	34.7%	28.6%	1.0%	**100%**
	Older persons	Mara	15	6.7%	86.7%	0.0%	6.7%	0.0%	**100%**
Rehabilitation and recovery	Children and adolescents	Marcus	20	0.0%	5.0%	40.0%	40.0%	15.0%	**100%**
		Sumaya	20	5.0%	5.0%	70.0%	15.0%	5.0%	**100%**
	Adults	Gary	86	0.0%	26.7%	55.8%	17.4%	0.0%	**100%**
		Barry	86	4.7%	34.9%	47.7%	10.5%	2.3%	**100%**
	Older persons	Peter	15	0.0%	6.7%	73.3%	20.0%	0.0%	**100%**
		Antonina	15	0.0%	6.7%	26.7%	53.3%	13.3%	**100%**
Non-acute	Children and adolescents	Tameka	20	0.0%	5.0%	10.0%	85.0%	0.0%	**100%**
	Adults	Fang	98	0.0%	0.0%	16.3%	80.6%	3.1%	**100%**
		Jo Beth	86	0.0%	2.3%	15.1%	72.1%	10.5%	**100%**
	Older persons	Eric	15	0.0%	0.0%	13.3%	86.7%	0.0%	**100%**
Assessment only	Children and adolescents	Bryce	20	0.0%	0.0%	5.0%	10.0%	85.0%	**100%**
	Adults	Vivian	98	0.0%	13.3%	5.1%	14.3%	67.3%	**100%**
		Malcolm	86	1.2%	9.3%	0.0%	8.1%	81.4%	**100%**
	Older persons	Agnes	15	20.0%	0.0%	0.0%	0.0%	80.0%	**100%**

Key: AC acute, SA subacute, RR rehabilitation and recovery, NA non-acute, AO assessment only

Table 50: Phase of care raw agreement ratings by vignette – child and adolescent vignettes

	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Jordan	1	Acute	31	61.3%	6.5%	32.3%	0.0%	0.0%
				AC	SA	NA	AO	
	2A	Acute	20	85.0%	15.0%	0.0%	0.0%	
				AC	SA	RR	NA	AO
	2B	Acute	20	50.0%	50.0%	0.0%	0.0%	0.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Tameka	1	Consolidating gain	34	0.0%	2.9%	2.9%	94.1%	0.0%
				AC	SA	NA	AO	
	2A	Non-acute	20	0.0%	0.0%	100.0%	0.0%	
				AC	SA	RR	NA	AO
	2B	Non-acute	20	0.0%	5.0%	10.0%	85.0%	0.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Marcus	1	Functional gain	33	0.0%	39.4%	33.3%	24.2%	3.0%
				AC	SA	NA	AO	
	2A	Subacute	20	0.0%	45.0%	50.0%	5.0%	
				AC	SA	RR	NA	AO
	2B	Rehab. and recovery	20	0.0%	5.0%	40.0%	40.0%	15.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Llubica	1	Intensive extended	35	2.9%	25.7%	68.6%	2.9%	0.0%
				AC	SA	NA	AO	
	2A	Subacute	20	5.0%	80.0%	15.0%	0.0%	
				AC	SA	RR	NA	AO
	2B	Subacute	20	0.0%	15.0%	75.0%	5.0%	5.0%

	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Jade	1	Acute	34	70.6%	8.8%	14.7%	0.0%	5.9%
				AC	SA	NA	AO	
	2A	Acute	20	55.0%	30.0%	5.0%	10.0%	
				AC	SA	RR	NA	AO
	2B	Acute	20	65.0%	25.0%	5.0%	0.0%	5.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Bryce	1	Assessment only	59	6.8%	11.9%	13.6%	1.7%	66.1%
				AC	SA	NA	AO	
	2A	Assessment only	20	5.0%	15.0%	10.0%	70.0%	
				AC	SA	RR	NA	AO
	2B	Assessment only	20	0.0%	0.0%	5.0%	10.0%	85.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Sumaya	1	Functional gain	61	6.6%	50.8%	27.9%	6.6%	8.2%
				AC	SA	NA	AO	
	2A	Subacute	20	0.0%	50.0%	45.0%	5.0%	
				AC	SA	RR	NA	AO
	2B	Rehab. and recovery	20	5.0%	5.0%	70.0%	15.0%	5.0%

Key: AC acute, FG functional gain, IE intensive extended, CG consolidating gain, AO assessment only, SA subacute, RR rehabilitation and recovery, NA non-acute

Table 51: Phase of care raw agreement ratings by vignette – adult vignettes

	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Gary	1	Intensive extended	239	2.1%	15.1%	69.9%	11.7%	1.3%
				AC	SA	NA	AO	
	2A	Subacute	77	0.0%	62.3%	37.7%	0.0%	
				AC	SA	RR	NA	AO
	2B	Rehab. and recovery	86	0.0%	26.7%	55.8%	17.4%	0.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Ashley	1	Acute	254	76.8%	5.9%	3.9%	0.8%	12.6%
				AC	SA	NA	AO	
	2A	Acute	77	74.0%	10.4%	1.3%	14.3%	
				AC	SA	RR	NA	AO
	2B	Acute	86	66.3%	24.4%	3.5%	0.0%	5.8%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Jason	1	Intensive extended	157	8.3%	24.8%	49.0%	17.8%	0.0%
				AC	SA	NA	AO	
	2A	Subacute	88	1.1%	60.2%	37.5%	1.1%	
				AC	SA	RR	NA	AO
	2B	Subacute	98	1.0%	34.7%	34.7%	28.6%	1.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Fang	1	Consolidating gain	116	0.9%	22.4%	5.2%	65.5%	6.0%
				AC	SA	NA	AO	
	2A	Non-acute	88	0.0%	4.5%	86.4%	9.1%	
				AC	SA	RR	NA	AO
	2B	Non-acute	98	0.0%	0.0%	16.3%	80.6%	3.1%

	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Barry	1	Functional gain	152	16.4%	63.2%	2.6%	7.9%	9.9%
				AC	SA	NA	AO	
	2A	Subacute	77	6.5%	57.1%	23.4%	13.0%	
				AC	SA	RR	NA	AO
	2B	Rehab. and recovery	86	4.7%	34.9%	47.7%	10.5%	2.3%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Vivian	1	Assessment only	248	9.3%	2.8%	9.7%	16.1%	62.1%
				AC	SA	NA	AO	
	2A	Assessment only	88	3.4%	12.5%	17.0%	67.0%	
				AC	SA	RR	NA	AO
	2B	Assessment only	98	0.0%	13.3%	5.1%	14.3%	67.3%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Jo Beth	1	Consolidating gain	255	1.6%	22.4%	4.7%	53.7%	17.6%
				AC	SA	NA	AO	
	2A	Non-acute	77	0.0%	6.5%	72.7%	20.8%	
				AC	SA	RR	NA	AO
	2B	Non-acute	86	0.0%	2.3%	15.1%	72.1%	10.5%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Malcolm	1	Assessment only	251	6.8%	3.2%	2.4%	4.0%	83.7%
				AC	SA	NA	AO	
	2A	Assessment only	77	0.0%	2.6%	7.8%	89.6%	
				AC	SA	RR	NA	AO
	2B	Assessment only	86	1.2%	9.3%	0.0%	8.1%	81.4%

Key: AC acute, FG functional gain, IE intensive extended, CG consolidating gain, AO assessment only, SA subacute, RR rehabilitation and recovery, NA non-acute

Table 52: Phase of care raw agreement ratings by vignette – older person vignettes

	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Agnes	1	Assessment only	29	48.3%	0.0%	0.0%	0.0%	51.7%
				AC	SA	NA	AO	
	2A	Assessment only	16	25.0%	0.0%	0.0%	75.0%	
				AC	SA	RR	NA	AO
	2B	Assessment only	15	20.0%	0.0%	0.0%	0.0%	80.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Eric	1	Consolidating gain	17	0.0%	29.4%	5.9%	52.9%	11.8%
				AC	SA	NA	AO	
	2A	Non-acute	16	0.0%	0.0%	93.8%	6.3%	
				AC	SA	RR	NA	AO
	2B	Non-acute	15	0.0%	0.0%	13.3%	86.7%	0.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Jo	1	Acute	17	88.2%	11.8%	0.0%	0.0%	0.0%
				AC	SA	NA	AO	
	2A	Acute	16	100.0%	0.0%	0.0%	0.0%	
				AC	SA	RR	NA	AO
	2B	Acute	15	86.7%	0.0%	0.0%	0.0%	13.3%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Mara	1	Intensive extended	17	0.0%	5.9%	94.1%	0.0%	0.0%
				AC	SA	NA	AO	
	2A	Subacute	16	0.0%	100.0%	0.0%	0.0%	
				AC	SA	RR	NA	AO
	2B	Subacute	15	6.7%	86.7%	0.0%	6.7%	0.0%

	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Peter	1	Functional gain	15	6.7%	66.7%	20.0%	6.7%	0.0%
				AC	SA	NA	AO	
	2A	Subacute	16	0.0%	56.3%	37.5%	6.3%	
				AC	SA	RR	NA	AO
	2B	Rehab. and recovery	15	0.0%	6.7%	73.3%	20.0%	0.0%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Antonina	1	Functional gain	29	6.9%	65.5%	13.8%	13.8%	0.0%
				AC	SA	NA	AO	
	2A	Subacute	16	0.0%	37.5%	62.5%	0.0%	
				AC	SA	RR	NA	AO
	2B	Rehab. and recovery	15	0.0%	6.7%	26.7%	53.3%	13.3%
	Group	Vignette Phase	Ratings	% Ratings				
				AC	FG	IE	CG	AO
Edward	1	Acute	30	66.7%	20.0%	10.0%	3.3%	0.0%
				AC	SA	NA	AO	
	2A	Acute	16	12.5%	75.0%	0.0%	12.5%	
				AC	SA	RR	NA	AO
	2B	Acute	15	33.3%	60.0%	0.0%	0.0%	6.7%

Key: AC acute, FG functional gain, IE intensive extended, CG consolidating gain, AO assessment only, SA subacute, RR rehabilitation and recovery, NA non-acute

Table 53: Percentage of correct phase of care ratings by respondent's confidence in assigning phase – Study 2

	Ratings		% Correct Phase	
Rating Confidence	Group 2A	Group 2B	Group 2A	Group 2B
0 - 4	50	84	58.3%	56.3%
5	117	104	64.7%	36.7%
6	111	167	54.6%	54.0%
7	203	211	67.2%	65.7%
8	201	243	74.7%	67.9%
9	110	76	83.0%	82.5%
10	109	84	80.1%	82.8%

The results in Table 54 to Table 57 are not weighted, as they report on respondent statistics rather than rating statistics.

Table 54: Responses to the survey question, 'Overall, how confident were you in assigning a phase to the vignettes?'

	Respondents		% Respondents	
Confidence level	Group 2A	Group 2B	Group 2A	Group 2B
0	0	1	0.0%	0.8%
1	0	0	0.0%	0.0%
2	3	4	2.4%	3.0%
3	3	5	2.4%	3.8%
4	6	6	4.8%	4.5%
5	16	18	12.9%	13.5%
6	23	36	18.5%	27.1%
7	46	42	37.1%	31.6%
8	22	18	17.7%	13.5%
9	2	3	1.6%	2.3%
10	3	0	2.4%	0.0%
Total	**124**	**133**	**100%**	**100%**

Table 55: Responses to the survey question, 'How well do the phases of care describe the consumers that you see at your service?'

	Respondents		% Respondents	
Phase Alignment	Group 2A	Group 2B	Group 2A	Group 2B
Very poorly	3	2	2.4%	1.5%
Poorly	10	11	8.1%	8.3%
Adequately	60	57	48.4%	42.9%
Well	38	47	30.6%	35.3%
Very well	13	16	10.5%	12.0%
Total	**124**	**133**	**100%**	**100%**

Table 56: Summary of respondent perception of phase meaningfulness

	Respondents		% Respondents	
Phase Meaningfulness	Group 2A	Group 2B	Group 2A	Group 2B
Not at all meaningful or relevant	1	0	0.8%	0.0%
Not so meaningful or relevant	5	11	4.0%	8.3%
Somewhat meaningful and relevant	55	50	44.4%	37.6%
Very meaningful and relevant	53	58	42.7%	43.6%
Extremely meaningful and relevant	10	14	8.1%	10.5%
Total	**124**	**133**	**100%**	**100%**

Table 57: Summary of respondent perception of training length

	Respondents		% Respondents	
Training length	Group 2A	Group 2B	Group 2A	Group 2B
Too short	14	9	11.3%	6.8%
The right length of time	106	117	85.5%	88.0%
Too long	4	7	3.2%	5.3%
Total	**124**	**133**	**100%**	**100%**

Table 58: Group 2A question: 'Which phase of care is described?'

Vignette	Correct phase of care	Responses: subacute	Responses: rehabilitation and recovery	Total responses
Gary	Rehabilitation and recovery	18	86	104
Mara	Subacute	91	13	104
Sumaya	Rehabilitation and recovery	18	86	104

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