Australian Mental Health Care Classification

Mental health phase of care guide

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Australian Mental Health Care Classification – Mental health phase of care guide
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1. Purpose and scope

The purpose of this document is to provide the definitions, guide for use and guiding principles for the application of the mental health phase of care that forms part of the Australian Mental Health Care Classification (AMHCC).

This document provides practical guidance on how to assess the mental health phase of care for a mental health care consumer.

This document should be read in conjunction with the following resource material developed to assist in the implementation of the AMHCC:

1. The Activity Based Funding Mental Health Care Data Set Specifications and the technical specifications and associated metadata on METEOR for the current reporting year.
2. The AMHCC Version 1.0 User Manual which provides additional background to the development of the new classification, explains the data elements and collection protocols, reporting requirements, and how the data is grouped.

2. Background

Overview

The mental health phase of care concept was developed in 2012, through a project commissioned by the Independent Health and Aged Care Pricing Authority (IHACPA). This project identified possible cost drivers for further examination and considered options for a classification architecture. Throughout the project, over 500 stakeholders were consulted on all aspects.

The proposed architecture segregated an episode of care into defined mental health phases 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[1]. The new concept of mental health phase of care was initially tested in the Mental Health Costing Study, a national study that involved 26 hospital service sites across Australia.

The mental health phase of care concept was also tested in the AMHCC pilot in late 2015, at four hospital service sites across Australia. The following guide was originally trialled in the pilot and has since been further refined through additional consultation to ensure mental health phase of care is adequately described.

Within this guide there are also a series of exemplars provided that were developed by experienced clinicians to offer guidance in assigning the mental health phase of care to a consumer. These exemplars are constructed to describe a range of symptoms, behaviours and functional abilities that consumers may experience while in contact with services and bear no relationship to real people or events.

IHACPA would like to acknowledge the Mental Health Working Group (MHWG) members, clinicians, consumer and carer representatives and all state and territory health departments for their guidance and support on the AMHCC development and refinement work.

[1] https://meteor.aihw.gov.au/content/723153 (accessed on 09 February 2023)

3. Definition

The approved definition of a mental health phase of care[2] is:

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.

The four mental health phases of care are:

- *Acute*
- *Functional gain*
- *Intensive extended*
- *Consolidating gain.*

The concept of mental health phase of care forms part of the AMHCC and provides information describing the complexity of the consumer's presentation and the primary goal of care. It is assessed by a healthcare professional directly involved in a consumer's care with the primary goal reflected in the consumer's mental health treatment plan. The mental health phase of care reflects a prospective assessment of the primary goal of care at the time of collection, rather than a retrospective assessment and a new phase of mental health 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 mental health phases of care and 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. There are currently four phases of mental health care, including acute, functional gain, intensive extended, and consolidating gain. The classification also provides for 'unknown phase' which should only be used when a phase is unable to be reported to the primary data collection. Where missing or incomplete data (for example, phase or Health of the Nation Outcome Scales (HoNOS)) is submitted, this will result in an 'unknown' end class.

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[2] Australian Institute of Health and Welfare. (2018). Mental health phase of care. Retrieved 12 January 2023 from http://meteor.aihw.gov.au/content/index.phtml/itemId/682464

[3] Australian Institute of Health and Welfare. (2021). Episode of care – mental health phase of care, code N. Retrieved 9 February 2023 from https://meteor.aihw.gov.au/content/744325

The definition of each mental health phase of care is provided below.

Acute

The primary goals of care are intended to reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk.

Functional gain

The primary goal of care is to improve personal, social or occupational functioning or promote psychosocial adaptation in a consumer 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 consumer 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 (data item)

‘Assessment only’ is a data item and is used when the review outcome does not lead to the consumer being placed in one of the four mental health phases of care immediately after. If the assessment outcome leads to the acute, functional gain, intensive extended or a consolidating gain phase being selected, then the assessment is included as part of the phase chosen.

4. Further development

The classification development work has been undertaken with considerable clinical and stakeholder input including two public consultation processes that were undertaken in January 2015 and December 2015. During the second public consultation process, several submissions proposed the need to further investigate the needs of child and adolescent consumers in relation to the concept of mental health phase of care. The evolving requirements for child and adolescent consumers, the diverse range of services required to satisfy the needs of child and adolescent consumers and the need to coordinate these services during any transfer of care were raised as issues that could have a significant impact on how to apply mental health phase of care within clinical practice.

IHACPA is committed to the further refinement of the mental health phase of care and has commenced a program of work involving child and adolescent mental health services which will inform Version 2.0 of the AMHCC.

In 2016, an inter-rater reliability study was conducted on the mental health phase of care which showed poor to fair reliability in the phase application by clinicians. As a result, IHACPA initiated the Mental Health Phase of Care Clinical Refinement Project in 2017 to refine the mental health phase of care to be more intuitive and to improve the consistency of mental health phase of care application, as a result two alternative definitions were proposed for consideration.

In June 2020, IHACPA undertook the Mental Health Phase of Care Clinical Refinement Testing Project to test the proposed definitions. It was concluded to retain the current mental health phase of care definitions with updates to the “acute” mental health phase of care definition and to change ‘assessment only’ to an administrative data item. These changes came into effect on 1 July 2022.

The project also recommended the development of nationally consistent education materials to assist with mental health phase of care understanding and assignment. The project highlighted that the education materials should include age and setting-specific language and an explanation of AMHCC to ensure clinicians can contextualise the linkage between the mental health phase of care and other variables.

The information contained in this document relates to the implementation of the AMHCC. The Activity based funding: Mental health care national best endeavours data set (ABF MHC NBEDS) is reviewed annually and supports the requirements of the AMHCC. IHACPA continues to align the ABF MHC NBEDS and the AMHCC with the existing National Outcomes and Casemix Collection (NOCC) where possible.

Mental Health Education Materials Development Project

IHACPA commenced the Mental Health Education Materials Development Project in November 2021. The project engaged with mental health clinicians from a diverse range of settings, age groups and professions to ensure the outputs were clinically accurate and relevant for the end users. Consultation was undertaken through the establishment of a Project Steering Group, a

number of workshops and drop-in feedback sessions to derive feedback from numerous methods and a widespread audience.

In collaboration with mental health sector stakeholders, IHACPA developed a suite of education materials. These include a five-minute overview video for clinicians, consumers, families and carers to introduce the purpose of the AMHCC and mental health phase of care, supplemented with an information sheet referencing the mental health phase of care definitions and benefits. There are also eLearning resources to assist jurisdictions with local mental health phase of care training in addition to a six-minute video focusing on the application of the mental health phase of care in clinical practice. The education materials also contain clinical education tools to facilitate discussion of the AMHCC and mental health phase of care in existing meetings and four different consumer journey maps to aid educational sessions. Lastly, the materials contain a one-off IHACPA facilitated webinar to guide jurisdictions to run their own webinars at a local level.

The suite of education materials aims to assist jurisdictions and mental health services with consistent application of the mental health phase of care.

5. Guide for use: mental health phase of care

The following descriptions are to be used as a guide and are not meant to be an exhaustive list.

Assigning a mental health phase of care requires clinical judgement, with active consumer engagement, and should complement and reflect delivery of recovery oriented practice. Understanding differences in the perspectives of consumers and clinicians is integral to clinical conversations and fundamental to personal ownership and responsibility. Therefore, where practical, the consumer should be involved, and aware of, the assignment of a mental health phase of care.

In addition, the consumer's family members, partner or friends should be actively involved (as much as possible) in the consumer's care. The amount of support offered by the clinician will take into account the needs of the family member, partner or friend.

Assigning a mental health phase of care should reflect the primary treating team and/or clinician's judgement.

Phase of care	Goal of care	Consumer's unique characteristics	Clinician activity or expectation	Indicators of phase start	Indicators of phase end
Acute	Reduce high levels of distress, manage complex symptoms, contain and reduce immediate risk.	Consumer has complex symptoms and/or high levels of behavioural disturbance. The consumer's presentation indicates significant risk that requires mitigation.	Consumer may require an increase in intensity of visual observations or increased monitoring by clinician to maintain safety. Need for urgent risk assessment and management. Consumer may require a low stimulus environment. The consumer's family or support network may require additional assistance.	Increasing impact on behaviour, distress associated with psychiatric symptoms. Increased risk of harm to self or others. Change in intensity requiring greater observation and contact with the clinician. Care plan focuses on interventions associated with symptom reduction and/or risk management as well as comprehensive documentation and recovery focused care.	Reduction in symptoms and/or risk, requiring less intensive observation or intervention. The focus of clinical intervention moves from symptoms, distress or risk to improvements in psychosocial functioning in the short term (Functional gain).

Phase of care	Goal of care	Consumer's unique characteristics	Clinician activity or expectation	Indicators of phase start	Indicators of phase end
			Activities undertaken in an acute phase of care are designed to reduce the intensity of symptoms. Recovery/Treatment/ Care or Management plan is highly dynamic. Phase expected to last days to weeks.		The impact of symptoms and/or distress and/or risk and/or improvements in functioning require frequent contact with significant clinical input over the longer term (Intensive extended). Symptoms and/or distress and/or risk along with functioning have all improved requiring regular but less frequent contact with the consumer over the longer term (Consolidating gain).
Functional Gain	Improvement in functioning by gaining confidence and mastery in self-management, psychosocial adaptation and vocational performance through structured training and therapy.	Consumer is less distressed by symptoms and is further seeking or would benefit from greater psychosocial activity.	Assessment is concentrated on psychosocial functioning. Recovery/Treatment/ Care or Management plan is focused on development of the consumer's living and/or interpersonal skills. Phase expected to last weeks to months.	Focus is less on symptom reduction and management, but more directed towards improvement in consumer functioning. Care planning includes group or individual work that focuses on individual, occupational or social functioning as well as comprehensive documentation and recovery focused care.	Increasing need for interventions associated with symptoms and/or risk mitigation requires frequent contact with more intensive clinical input over the shorter term (Acute). The impact of the ongoing symptoms, distress, risk, functional impairment require frequent contact with significant clinical input over the longer term (Intensive extended). Symptoms and/or distress and/or risk along with functioning have all improved requiring regular but less frequent contact with the consumer over the longer term (Consolidating gain).

Phase of care	Goal of care	Consumer's unique characteristics	Clinician activity or expectation	Indicators of phase start	Indicators of phase end
Intensive extended	Symptom mitigation /Functional Improvement/ relapse prevention strategy development.	Prevention/minimisation of further deterioration or risk of harm in circumstances where there are frequent relapses, a severe inability to function independently and/or minimal personal understanding and acceptance.	The mental health care plan is focused on reducing symptoms and improving psychosocial functioning. The consumer's family members, partner or friends are actively involved, as much as possible, in the mental health care plan to establish stability, manage ongoing risk, formulate relapse prevention and to improve functioning. The consumer's symptoms are complex and enduring with intensive psycho-social interventions required to prevent further deterioration. Phase expected to last months to years (indefinite period).	Focus of clinical input includes management of symptoms and functioning. Both symptoms and function require longer term clinical input. Mental health care plan focuses on supporting improvement or preventing deterioration as well as comprehensive documentation and recovery focused care. Significant symptoms and poor psychosocial functioning are an ongoing issue requiring intensive clinical input.	Increasing need for interventions associated with symptoms and/or increasing distress and/or risk mitigation requires frequent contact with more intensive clinical input over the shorter term (Acute). Reduction in symptoms and/or risk, requires less frequent contact. The focus of clinical intervention moves from symptoms, distress or risk to improvements in psychosocial functioning in the short term (Functional gain). Symptoms and/or distress and/or risk along with functioning have all improved requiring regular but less frequent contact with the consumer over the longer term (Consolidating gain).
Consolidating gain	Plateau of symptoms and maintenance of functioning.	Psychiatric symptoms continue but are not distressing nor pose significant risk to consumer or carer.	Monitoring of symptoms and functioning occurs on a regular basis. Optimise level of functioning and promote recovery to assist community integration and independence. Phase expected to last months to years.	Symptoms and functioning are stable but ongoing inputs from services are still required. Mental health care plan incorporates comprehensive documentation and recovery focused care	Increasing need for interventions associated with symptoms and/or increasing distress and/or risk mitigation requires frequent contact with more intensive clinical input over the shorter term (Acute).

Phase of care	Goal of care	Consumer's unique characteristics	Clinician activity or expectation	Indicators of phase start	Indicators of phase end
					Reduction in symptoms and/or risk, requires less frequent contact. The focus of clinical intervention moves from symptoms, distress or risk to improvements in psychosocial functioning in the short term (Functional gain). The impact of symptoms and/or distress and/or risk and/or improvements in functioning require frequent contact with significant clinical input over the longer term (Intensive extended).

Please note that 'assessment only' is now a data item and not a phase of care and has therefore been omitted from the table above, the 'Guide for use: mental health phase of care'.

6. Guiding principles for use in practice

Assigning a mental health phase of care

- The rating of the mental health phase of care should be undertaken by the clinician or group of clinicians with the best understanding of the consumer's presentation and need for intervention. This would typically be the case manager or primary treatment clinician/mental health team.
- The mental health phase of care should be assessed on admission/registration to a service, where there has been a transfer of care between service settings or when there has been a change in the consumer's presentation prompting a change to the mental health care plan.
- The mental health phase of care is not collected at every contact made with the consumer.

Reviewing or changing a mental health phase of care

- The mental health phase of care should be reviewed when there is a substantial and sustained change in the consumer's symptoms and/or psychosocial functioning resulting in a significant change to a consumer's mental health care plan.
- The National Mental Health Standards require regular clinical reviews of the consumer's care. The review and allocation of the mental health phase of care should be incorporated into this clinical review process.
- Clinical reviews do not automatically result in a change in the mental health phase of care. However, if there is a change in the goal of care with a corresponding modification of the mental health care plan, then there is a change in the mental health phase of care.
- Changes in the consumer's presentation and the primary goal of care must be recorded in the consumer's mental health care plan. The mental health care plan will reflect the mental health phase of care.
- At the commencement of, or a change in, a mental health phase of care, an outcome measures collection[4] is required in all mental health service settings.

Timeframes for mental health phases of care

- There is no rating period for the mental health phase of care. The mental health phase of care continues for as long as the goal of care, the consumer's characteristics and the clinician's activity remains unchanged. In other words, if the consumer characteristics do not change and the goal of care remains unchanged and the clinicians' activities do not change as reflected in the mental health care plan then the mental health phase of care does not change.
- Mental health phase of care cannot be changed whilst a consumer is on leave from a health care service.

[4] http://www.amhocn.org/what-collected/nocc-measures (accessed on 09 February 2023)

Numbers of mental health phases of care

- There is no limit on the number of mental health phases of care that can occur within an episode of care.

- A consumer will only have one mental health phase of care at any time. When care is co-managed or provided by multiple mental health services in the same setting, the mental health phase of care should be agreed upon by the various treatment providers. The mental health care plan should include all activity undertaken by all relevant treatment providers in that setting, and the mental health phase of care should align with this mental health care plan. Where a consumer is in a concurrent episode, the goal of care should be consistent amongst providers and thus the phase of care should be the same for each setting.

Outcomes measures and the mental health phase of care

- If a consumer is referred to another setting, the 'assessment only' data item may be reported to capture the work undertaken at the service in conducting the brief triage assessment or initial assessment.
- Although a consumer is reviewed regularly throughout an episode of care, the 'assessment only' data item can only ever be the first or only mental health phase of care data item in an episode.
- The AMHCC does not require the completion of outcome measures for an 'assessment only' data item, however all other mental health phases of care require the completion of outcome measures.
- If outcome measures are completed at the commencement of an 'assessment only' data item, then these can be deemed completed for the first collection of a subsequent mental health phase of care if considered appropriate.

7. Examples of phase of care

The following examples are provided as a guide. They describe adult consumers in different mental health phases of care. They also describe changes in the consumer's presentation, the goal of care or clinician activity that may prompt a change in the reporting of the mental health phase of care.

Acute

Mental Health Phase of Care

Name:
David is a 32 year old single male.

Behaviour:
Your first contact with David is in the Waiting Room, where he has attended with his mother. He appears dishevelled, unkempt and appears to be responding to non-evident stimuli. At times he is quite animated and seems intermittently perplexed and distraught. He is often seen talking to himself and appears distressed by these experiences. His mother reports that she has been very upset by David's recent aggression towards her and states that "every time I try to talk with him he flies off the handle". She says that he will raise his voice and looks like he is going to hit her. "That isn't like him at all", she says. He denies drug and alcohol use except for the "occasional beer" though his mother reports that he has been "drinking a lot lately". He denies thoughts of self-harm.

Physical:
David has gained considerable weight in recent months. He spends most of his time inside, either on the lounge or in his room. He smokes up to 25 cigarettes a day and would smoke more if he had the money. David also repeatedly picks at sores on the back of his hands.

Symptoms:
David received a diagnosis of Schizophrenia when he was aged 19 years. During your interview, David admits to hearing voices that comment aggressively about the behaviour of people around him. He does not believe that medication does anything to help him. During your interview he becomes very animated and is clearly distressed by the non-evident stimuli. David reports that he sometimes has trouble with his memory and working out change when he buys things

Social:
David lives in a small converted garage behind his mother's house. His mother tends to do all the house work as he can't seem to manage it himself. David has two older siblings who are not supportive and criticise their mother for 'babying' him.

Interventions:
David is visited fortnightly by his community Case Manager (CM) who administers Risperdal Consta 50mg IMI. His last dose was given a week ago. At his brothers' insistence, his mother called the CM to discuss his recent behaviour.

Rationale for *Acute* Mental Health Phase of Care:
The primary goal in this phase of care is reduction in the distress caused by the auditory hallucinations and their impact on David's behaviour.

Possible indicators for Mental Health Phase of Care change:

- David is less distressed and preoccupied with Auditory Hallucinations (AH), appears less agitated and expresses an interest in joining a local gym. ***New Phase - Functional Gain***
- The AH's persist and remain troubling and he requires a sustained focus on supporting improved psychosocial functioning. ***New Phase - Intensive Extended***
- Although AH persist, David's response to them appears less pronounced. David continues to accept his medication although he says he doesn't really need it. ***New Phase - Consolidating Gain***

Functional gain

Mental Health Phase of Care

Name:
Lauren is a 35 year old female in a long-term relationship.

Behaviour:
Following an initial referral and assessment, it is decided to register Lauren as a consumer within the service. Lauren reports that she continues to have difficulty attending her workplace and avoids contact with other parents after school. Lauren says that "I know I have to be there for my daughter now that she is at school" and is seeking help with this. Lauren describes having a "glass of wine" of an evening to help her relax. She denies thoughts of self-harm.

Physical:
Lauren says that she is not walking as much as she once did, as she has not been going to work in the past few weeks. She feels that her type 2 Diabetes may not be as well controlled as it once was when she was exercising regularly.

Symptoms:
Lauren reports that she sometimes feels so anxious in social situations that she feels like she might faint. She has tried some basic relaxation techniques with some success but thinks there might be better ways of managing her anxiety. Lauren reports that she finds herself having to make lists to remind her of what to do each day.

Social:
Lauren lives with her husband who claims he is very supportive. Lauren's husband travels a lot for work but has attended one appointment with her assigned case manager to learn how to best support Lauren. Lauren's extended family distanced themselves from Lauren and her husband over a family dispute several years ago. However, Lauren's next door neighbour has committed to walking to school with her and her daughter in the mornings and helping with childcare when Lauren attends appointments.

Interventions:
Lauren is enrolled in a structured CBT program at the community centre which includes individual and group work. Lauren's husband is provided with education. A referral is made to provide carer/family support.

Rationale for *Functional Gain* Mental Health Phase of Care:
Lauren is an active participant in seeking out and engaging in her care. She shows good personal understanding and acceptance about her condition. She identifies appropriate and meaningful goals for her care.

Possible indicators for Mental Health Phase of Care change:

- Lauren is unable to return to work and her symptoms do not improve with the completion of the CBT program. ***New Phase - Intensive Extended***
- Lauren returns to work and reports that she would like to return to her GP for ongoing care and support. ***New Phase - Consolidating Gain***
- Lauren reports that she is experiencing frequent and distressing thoughts of self-harm. ***New Phase - Acute***

Intensive extended

Mental Health Phase of Care

Name:
Peter is a 38 year old single male.

Behaviour:
Peter was diagnosed with a Bipolar Affective Disorder 20 years ago. Peter lives in a shared house with two other men. He is unemployed and struggles financially. He left school before completing Year 10 and has had a series of jobs, ranging from roofing contractor to telesales but has lost them after short periods due to his unpredictable behaviour. His mood and behaviour are erratic. He requires frequent reminders to attend review appointments and to take medication. He has a history of mood swings, and often an inflated sense of his own importance as well as impulsivity and recklessness.

Physical:
For the past few months, Peter has been drinking up to a carton of beer every two days. He is overweight and reports that his girlfriend teases him that he “has a beer belly like her Dad”. Peter smokes ‘roll your own cigarettes’ and has nicotine stained fingers.

Symptoms:
Peter’s mood is changeable and his behaviour is erratic; he blames the mental health service for “making me like this”. Peter’s girlfriend reports that he “argues with everyone” and that the police have been called to his unit when he has been intoxicated. He says that he keeps losing his ATM cards and forgets his PIN.

Social:
Peter’s house-mates are aware of his mental health diagnosis and describe his recent behaviour as “pretty typical.” Although he is behind on his rent, they remain generally supportive. His girlfriend says he likes going to music gigs with her and “it’s the only time he seems happy”.

Interventions:
Peter is seen by his CM on a regular basis. His CM has been actively trying to engage Peter with a local job agency that has a program designed to provide people with supported employment. Peter’s housemates and girlfriend are provided with education and support.

Rationale for *Intensive Extended* Mental Health Phase of Care:
The goal of Peter’s care is to minimise further deterioration and decrease his risk of self-harming behaviours while improving his functional ability over time.

Possible indicators for Mental Health Phase of Care change

- Peter’s mood stabilises with medication and psychological support and he gains casual employment as a furniture removalist which he likes. ***New Phase - Consolidating Gain***
- With the help of his CM, Peter participates in the supported employment program and would like to participate in a financial management program in the near future. ***New Phase - Functional Gain***
- Peter is picked up by police and taken to the Emergency Department after threatening to kill his flatmate while under influence of alcohol. ***New Phase - Acute***

Consolidating gain

Mental Health Phase of Care

Name:
Roberta is a 64 year old woman.

Behaviour:
Roberta presents as an older woman who is quite vibrant and engaging. She is casually and appropriately dressed, though wearing a lot of makeup. She is talking animatedly with the receptionists prior to seeing you and has to be gently reminded to stay on track during your conversation. She denies thoughts of self-harm or drug or alcohol use.

Physical:
Roberta has visible rosacea on her nose and cheeks and has commenced treatment for this by her long standing family GP. Changes to her diet were suggested and she has noted a marked improvement to her eating habits. She has found it a challenge to make dietary changes, as she was brought up eating traditional Italian dishes.

Symptoms:
Roberta was diagnosed with Bipolar Affective Disorder over 30 years ago after a number of hospitalisations for Depression in southern Italy where she was born. She had been unable to work in the family accountancy business for many years. Her mood had stabilised significantly in the previous 12 months and she has been working in the family business as a receptionist. Roberta reports that her mood is stable and that she is sleeping through the night, only getting up once to go to the toilet. She reports that the medication sometimes makes her tired in the mornings. She has also started going to an aqua-aerobics class organised by the local community centre and this has helped with her tiredness. Roberta's son expresses annoyance that she forgets people's names or where things are kept like her shoes or tea bags.

Social:
Roberta lives with her son and his wife, since her husband passed away four years ago and has a large circle of friends. She reports that she gets on well with the other employees of her son's firm as she has known them for many years. Though she reports that it has been "a very big change" to be living with her son, she feels that she has adapted. However, Roberta's son and daughter-in-law do not like that Roberta lives with them as she is becoming increasingly forgetful and her constant reminiscing is annoying.

Interventions:
Roberta attends the local community centre on a regular basis. The family have also been involved with a carer support service for education around Roberta's condition and support. The carer support service suggested that Roberta's son provide his employees with information from the local community centre about Bipolar Affective Disorder. This has not happened to date.

Rationale for *Consolidating Gain* Mental Health Phase of Care:
The prospective goal of care is to promote recovery and to continue to assist Roberta to optimise her level of functioning and to meet her personal goals of continuing to work regularly with her son's business.

Possible indicators for Mental Health Phase of Care change:

- Roberta's mood has been low for over 6 months and is not responding to treatment. She complains that the medication is making her tired at home and she is unable to help her son and daughter-in-law with the housework. She has been reluctant to go to work. ***New Phase - Intensive Extended***
- Roberta reports that she is not able to go to work as her concentration is failing her and she is making too many mistakes with the appointment bookings. ***New Phase - Functional Gain***
- Roberta presents to the Emergency Department after a fight with one of the employees at her son's business. She believes that this woman has been stealing from her purse and also talking about her behind her back. Roberta's son provides conflicting information relating to his mother's recent experience in the workplace. ***New Phase - Acute***

Assessment only

Mental Health Phase of Care

Name:
Peggy is a 28 year old married mother.

Behaviour:
Peggy has been referred to your service by her GP. She has a 3 year history of depression and anxiety. She appears slightly anxious and reports that she sometimes feels sad. In social settings she says she gets “very panicky” and will sometimes leave in a hurry because of this. Her youngest daughter has just started school and she is very worried about meeting with her teachers and other parents. She has had difficulty sleeping and describes a number or strategies her counsellor “told me to try” to help her sleep. She denies thoughts of self-harm. She describes herself as a social drinker, “but I am not really interested”.

Physical:
Peggy has type 2 Diabetes, diagnosed when she was 22. She has changed her diet since her diagnosis and walks to the shops regularly as well as to her work as a receptionist at a local dentist three days a week. She feels that this is helpful in managing her diabetes.

Symptoms:
Peggy reports that she sometimes feels very sad, often for days at a time. She takes any personal criticism to heart and often finds herself withdrawing from conversations and feeling like she is being judged unfairly. She denies psychotic phenomena. Peggy says she is “normally pretty sharp” but finds her attention wandering when she is cooking.

Social:
Peggy lives at home with her husband and two young children. She has a strongly supportive extended family network. Peggy reports that she has been off work for a week due to her anxiety and she feels that her medication is no longer working. Peggy’s husband agrees with this view.

Interventions:
Peggy has been seeing a psychologist following a referral by her GP, but she isn’t sure that this is helping “as he wants to talk about things I don’t think are important”. An anxiety management group offered by a local church is an option that interests Peggy.

Rationale for the data item *Assessment Only*:
The goal of Peggy’s care was to determine what level of mental health care was required and to provide feedback and advice to her referring GP. However, the review outcome did not lead to Peggy being placed in one of the four mental health phases of care immediately after, and therefore the assessment is not included as part of the phase chosen.

8. Frequently asked questions

Assigning a mental health phase of care

Question	Response
Who is responsible for deciding mental health phase of care?	Mental health phase of care should reflect the main aim or goal of the mental health care plan developed by the primary treatment clinician/mental health team in conjunction with the consumer, and as such is assigned in collaboration between clinicians and consumers.
Is the mental health phase of care different in different settings?	No. The types of treatment being offered in different settings may vary but the primary goal will be the same. For example, regardless of setting, an *acute* mental health phase of care has the primary goal of care as reducing the severity of symptoms requiring the intensive input of clinicians with an expectation of change in the short term. An *acute* mental health phase of care may not only require admission to an inpatient unit but also intensive observation. An *acute* mental health phase of care in an ambulatory setting may require the consumer being reviewed by a medical practitioner and visited daily or twice daily to avoid hospitalisation.
Is there a specific hierarchy or order in which mental health phase of care occurs?	No, there is no specific hierarchy or order for the mental health phase of care to occur. For example, a consumer may move from an *acute* mental health phase of care into an *intensive extended* phase of care and then into a *consolidating gain* phase of care.

Question	Response
Does a consumer always have a specific mental health phase of care?	Yes, as a consumer should always have a mental health care plan they would also have an associated mental health phase of care.
A consumer is admitted on a general ward in an acute facility and is under the care of a mental health team but is still an acute care type. Do they need a mental health phase of care reported?	A mental health phase of care is recorded for a consumer with a mental health care type. Where a patient is in an alternate care type (for example, acute), mental health phase of care does not apply and should not be reported for the AMHCC, however it may be required as part of the NOCC process.
Does the person have to be present for an 'assessment only' data item to be identified; sometimes it is only the family or teachers that are part of the assessment process.	In some specialist primarily child and adolescent or consultation liaison services, the consumer is not present during the gathering of information for decisions regarding service suitability. On these occasions, even though the consumer is not present, the mental health phase of care would be best described as assessment only.
How do you determine the mental health phase of care when clinicians have different points of view?	One of the advantages of working as part of a multidisciplinary team is the different perspectives that each discipline can bring to the process of clinical review. These different perspectives need to be considered when rating the mental health phase of care. During the process of clinical review, these different perspectives are discussed and a consensus as to the primary goal of care should be formed. Although each member of the team may be focused on a different aspect of the consumer's care, the primary goal is the overarching goal of the combined team's activities.

Question	Response
I am always looking towards improving a consumer level of functioning, why would I choose any other mental health phase of care?	The interplay between symptoms and functioning is complex. The overall goal of care would be to reduce the distress or risks associated with symptoms and improve individual functioning, regardless of the mental health phase of care. The instrument requires a decision regarding the primary goal of care given the consumer's current presentation.

Reviewing or changing a mental health phase of care

Question	Response
How do I make the decision that a mental health phase of care has changed?	A mental health phase of care change is a clinical decision made following assessment. The decision should not be made by a single clinician after a single event, rather it should be made as part of regular assessment/review processes such as ward rounds or multi-disciplinary reviews where formalised care planning is carried out. You should consider if there is a need to provide more support for a consumer or focus primarily on symptoms or functioning.
How frequently can mental health phase of care change?	Mental health phase of care will change as frequently as the main aim or goal of the mental health care plan. It should be reviewed when there is a significant and sustained change in the consumer's symptoms and/or psychosocial functioning, however it is recommended that this is not changed more than once a day. For example, a consumer's symptoms may fluctuate during an episode of mental health care, however the main goal or aim of the mental health care plan is likely to remain the same, until they are stabilised.

Is there a specific time limit in which a consumer can stay in a specific mental health phase of care? What is the rating period?	No, there is no time limit in which a consumer can stay in a specific mental health phase of care, however it is recommended that it is reviewed on a regular basis to ensure that the current mental health phase of care is still applicable. Consumers stay in the phase that best describes their characteristics, the primary goal of care and the activity of the clinician. There is no rating period for the mental health phase of care.
Can a mental health phase of care be changed whilst a consumer is on leave during an episode of care?	No, the mental health phase of care cannot be changed whilst a consumer is on leave during an episode of care. As the mental health phase of care requires assessment of the consumer and the development of a mental health care plan, this requires the consumer to be present.
Can there be days without a mental health phase of care during an episode of care?	No, every day within an episode of care that has a mental health care type should have an associated mental health phase of care.
A consumer who is managed by a case management team for a long period of time has become rapidly unwell during the course of their care, requiring closer supervision. While the consumer will still be managed by the case management team, care has been temporarily transferred to the acute care team over the weekend, due to lack of staff resourcing to provide appropriate care. The consumer will return to the case management team when there is more staffing available after the weekend. Is this a change in phase of care over a two day period and would this warrant a completion of additional outcome measures?	This would not require a change to the phase of care. The collection of an outcome measure is not mandated; however as part of clinical practice, outcome measures may be collected anytime as clinically indicated.
I am the person making the rating of the mental health phase of care but other people are involved in providing intensive input. I only see	You are rating the consumer’s primary goal of care. Although you may not be delivering the service, you have been responsible for mobilising a range of other service providers to support improvements in symptoms or

the consumer once a month. How should I rate intensive extended or consolidating gain?	functioning or prevent deterioration in an individual with an enduring presentation. The mental health phase of care should be rated as intensive extended.
Someone is in a consolidating gain mental health phase of care and becomes unwell; do they go to an acute or an intensive extended?	People can move between the different mental health phases of care and there is no set or expected progression between the different mental health phases of care.

Timeframes for mental health phases of care

Question	Response
What happens if a consumer has a long stay episode of mental health care (i.e. the episode of mental health care is longer than the reference period or a year) and the mental health phase of care does not change?	If a consumer's mental health phase of care does not change during the entire episode (and it has been reviewed regularly), then more than one mental health phase of care should not be reported.

Numbers of mental health phases of care

Question	Response
Can there be more than one mental health phase of care at a time?	Mental health phase of care should be reflective of the mental health care plan. As the mental health care plan is usually developed in consideration of a multidisciplinary team, it may consist of multiple goals or aims of treatment. There is however usually an overarching or main goal of care This is what mental health phase of care should reflect. In instances where the patient is in a concurrent episode, the goal of care should be consistent amongst providers and thus there will only be one phase of care which should be the same across settings.

Outcomes measures and the mental health phase of care

Question	Response
In an encounter, the usual first point of contact is the acute care team. After receiving services from the acute care team, consumers may be transferred to a case management team where the phase of care may be the same or different. If the phase of care is the same does an outcome measure need to be completed?	An additional outcome measure is not required as it is about the consumer and not the treatment provider. However, if the phase of care is changed, an outcome measure will be required. For example, when a consumer becomes rapidly unwell and the main goal or aim of care has changed.
Some consumers may be seen by a primary case management team and a secondary team (for example, rehabilitation, working with families, transition teams and Clozapine clinics). In accordance with the outcome measure protocols, responsibility for completing outcome measures rest with the primary team. Secondary teams are not required to complete an additional set of outcome measures. If the secondary team is a rehabilitation team and the phase of care of the rehabilitation team is different to the phase of care of the primary team should an additional set of outcome measures be completed?	The phase of care should align with the mental health care plan for the consumer. The mental health care plan for the consumer would normally reflect the activity that was being undertaken by all relevant teams therefore the phase of care should not be different for the various treatment providers. As a result the additional outcome measures would not need to be collected.
How do the other assessment tools or service measures relate to the mental health phase of care?	The Mental Health Costing Study conducted by IHACPA found that outcome measures such as the HoNOS and mental health phase of care were significant variables for predicting cost across settings and ages. At the commencement of, or a change in, a mental health phase of care, an outcome measures collection is required in all mental health service settings as per clinical guidelines. At present, the AMHCC does not require the completion of outcome measures for an ‘assessment only’ data item, however all other mental health phases of care require the completion of outcome measures.

	With the implementation of the AMHCC, there will be an opportunity to gather more data to better understand the impact of other assessment tools or service measures as the collection proceeds. Work is also being undertaken to align the mental health phase of care and the NOCC, via the National Mental Health Information Strategy Standing Committee. This work is essential to the ongoing refinement of information collection in the mental health sector.
What is the difference between focus of care and mental health phase of care?	There are a number of differences between the two instruments. The mental health phase of care is a prospective rating and indicates the current and future primary goal of care. Focus of care is retrospective. There have also been changes in the definitions and the addition of an 'assessment only' category.

Other questions

Question	Response
A consumer in the admitted setting may be followed-up by their case manager from the ambulatory setting. Similarly, a consumer may be admitted to a general ward and followed-up by their treatment provider/case manager from the ambulatory mental health unit. In both scenarios, how is the 'secondary' provider acknowledged?	The consumer's mental health care plan should reflect the activity undertaken by all relevant teams and the phase of care should not be different for the various treatment providers. In this scenario, the secondary provider contact (i.e. the ambulatory case manager) may be counted through service contacts.
When a consumer is in a consolidating gain mental health phase of care, does that indicate that their recovery has reached a plateau?	Research indicates that recovery can include a moratorium phase during which consumers consolidate their experience. The identification of someone in a consolidating gain phase of care does not mean that clinicians have stopped actively engaging with the consumer in the work of change. This mental health phase of care acknowledges that some change can take an

	extended period of time, and that consumers may require the ongoing support of clinicians.
How do you deal with comorbidities, what if for one disorder the consumer has no problems but for another they are very distressed?	There can only be one mental health phase of care at a time and while the consumer may have various comorbid conditions the clinician must choose the primary goal of care for the current mental health phase of care.

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