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Development of a prototype Australian Mental Health Intervention Classification: a working paper

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Authoritative information and statistics to promote better health and wellbeing

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Contents

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Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACHI	Australian Classification of Health Interventions
AIHW	Australian Institute of Health and Welfare
AMHOCN	Australian Mental Health Outcomes and Classification Network
BEACH	Bettering the Evaluation and Care of Health
CAMHIDEAP	Child and Adolescent Mental Health Information Development Expert Advisory Panel
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive behavioural therapy
DoHA	Australian Government Department of Health and Ageing
ECT	Electroconvulsive therapy
FMHIDEAP	Forensic Mental Health Information Development Expert Advisory Panel
FTE	full-time equivalent
ICD-10-AM	International statistical classification of diseases and related health problems, 10th revision, Australian modification
ICD-10-PCS	International statistical classification of diseases and related health problems, 10th revision, procedure coding system.
ISC	Information Strategy Committee
MHIC	Mental Health Intervention Classification
MHISS	Mental Health Information Strategy Subcommittee
NHDD	National health data dictionary
NCCC	National Casemix and Classification Centre
NCCH	National Centre for Classification in Health
NMDS	National Minimum Data Set
NSW	New South Wales
Qld	Queensland
SA	South Australia

Tas	Tasmania
Vic	Victoria
WA	Western Australia

Summary

This report presents a brief history of the development of the Mental Health Intervention Classification (MHIC) that has been designed for use in Australian health-care settings, and details the most recent iteration of the classification scheme.

The rationale for developing a MHIC is to allow collection of mental health intervention information using a standard classification scheme that enables nationally comparable and consistent reporting of trends, patterns and best practice in the provision of mental health services.

Work towards a nationally consistent scheme for mental health interventions for use in Australian health care settings was agreed by the Australian Health Ministers' Advisory Council National Mental Health Working Group Information Strategy Committee (now known as the Mental Health Information Strategy Subcommittee, or MHISS) in 2005.

The development of a MHIC has been an iterative process, extending over several years, and has been guided by the MHISS.

The first iteration, known as MHIC 06, was developed by the National Centre for Classification in Health in 2006. Following the development of this proposed classification scheme, the MHISS agreed to undertake a reappraisal of the MHIC 06.

As part of the reappraisal, a revised classification scheme was developed, which became known as MHIC 09.

In 2011, the MHIC 09 was piloted at a number of trial sites. After feedback from participating sites, further refinements have been made. This report presents the 2012 revision of the MHIC.

1 Introduction

The collection of national information on mental health interventions is identified as a priority in the second edition of the National Health Information Priorities report (DoHA 2005). However, there is currently no national approach to the collection of mental health intervention information in Australia, and the adoption of a standardised classification is seen as an important development in this area. Such a classification would enable national reporting of trends, patterns, and best practice in the provision of mental health interventions and make a substantial contribution to the body of evidence available for this identified health information priority area.

Aim

The aim of this report is to document the historical development of the Mental Health Intervention Classification 2009 (MHIC 09) and to present the latest iteration of this classification, which has been designed for use by a wide range of mental health professionals, including admitted patient care (hospital-admitted patients), ambulatory care (community health facilities) and residential (home) care settings across Australia.

Background

In 1989, the United States (US) National Institute of Health and Services released a report that proposed that the central questions to be addressed by its mental health statistics improvement program were: '*Who* receives *what* services from *whom* at what *cost* and with what *effect*?' (Leginski et al. 1989). Subsequently, these questions were adopted by the Australian National Mental Health Strategy as the key ones to be answered by the mental health-care National Minimum Data Sets (NMDSs) (DoHA 1999).

One of the specific initiatives identified as part of the improvement work for the NMDSs was the development of a system of nationally consistent mental health intervention codes. The purpose of such a system would be to allow the compilation of accurate and consistent information on the number and types of services provided to mental health consumers in Australia.

At its April 2005 meeting, the Australian Health Ministers' Advisory Council National Mental Health Working Group Information Strategy Committee (ISC)[1] agreed that the Australian Institute of Health and Welfare (AIHW) would be the lead agency to progress the Mental Health Intervention Classification (MHIC) project, with the assistance of ISC representatives from New South Wales, Queensland and Western Australia.

The aim of the project was to design a MHIC that could be used in all mental health intervention settings and could answer the questions:

> *What services are provided to consumers of mental health services? That is, what programs, activities or interventions are delivered to consumers of mental health services?*

[1] As of July 2006, the ISC has been known as the Mental Health Information Strategy Subcommittee (MHISS)

The development of a MHIC has been an iterative process, extending over several years (Figure 1). During this period, its development has been guided by the Mental Health Information Standards Subcommittee (MHISS).

Figure 1: Mental Health Intervention Classification project history overview

2 MHIC 06

Defining mental health interventions

In 2005, the process of developing the first iteration of a national mental health intervention classification, known as MHIC 06, began with an agreed working definition for the term 'intervention', as it is applied to mental health services. This definition was used to specify which interventions would be included in the classification. This process of arriving at an agreed definition included an evaluation of the *National health data dictionary's* (NHDD) definition of 'clinical intervention', the Admitted Patient Care NMDS's definition of 'procedure', the 'treatment type' definition from the Alcohol and Other Drug Treatment Services NMDS, and 'management' of problems from the Bettering the Evaluation and Care of Health (BEACH) survey. From this process the following draft definition of 'mental health intervention' was constructed:

> *Activities carried out during a service contact to improve, maintain or assess the health of a person. If not therapeutic or diagnostic, an intervention will nevertheless contribute materially to the improvement of a client's health, alter the course of a health condition or promote wellness. Interventions include invasive and non-invasive procedures, cognitive interventions and other interventions (including psychosocial interventions).*

Stocktake of existing mental health intervention codes

Following the development of a working definition of a mental health intervention, the AIHW undertook a 'stocktake' of Australian and international examples of mental health intervention codes currently in use.

The following Australian classification schemes were reviewed in this process:

- National Health and Medical Research Council's Clinical Practice Improvement Network for Early Psychosis.
- Australian Classification and Terminology of Community Health.
- Allied health activity hierarchy and Indicators for Intervention.
- Medicare Benefits Schedule.
- BEACH.
- International Classification of Primary Care.

In addition, several international coding systems were also considered:

- Canadian Classification of Health Interventions.
- Anatomical Therapeutic Chemical (ATC) classification system.
- United States Healthcare Common Procedure Coding System.
- United States ICD-10-PCS.
- New Zealand Mental Health Information National Collection.

Also, to gain a better understanding of the amount and type of mental health intervention information available in Australia in 2006, the AIHW reviewed the data from a number of different data sets, including:

- Mental Health Classification and Service Costs.
- Admitted patient data from the National Hospital Morbidity Database.
- Other data presented in the AIHW's *Mental Health Services in Australia 2003–04* that described reported interventions at that time.

The AIHW review found that the level of detail in the data was generally inadequate for describing the type of care provided, or what the intent of such care was.

Finally, using the information gleaned from the stocktake, a 'directions' document was prepared by the AIHW (and subsequently endorsed by MHISS at its July 2006 meeting). This document specified a number of parameters for the MHIC, including its purpose, scope, statistical units and number of axes.

Development of the MHIC 06

The AIHW contracted the National Centre for Classification in Health (NCCH) to develop the first draft of the MHIC. The development was informed by the *Stocktake* report and by the directions and specifications outlined by the AIHW. In addition, a Mental Health Intervention Classification Project Clinical Reference Group—which included clinicians, clinical coders and other stakeholders—was established to provide advice to the NCCH. Members of the NCCH Clinical Classification and Coding Group for Mental Health were also contacted and invited to participate in the project. In addition, three members of the ISC were nominated to represent the recommended participating jurisdictions of New South Wales, Queensland and Western Australia. The ISC also nominated four expert mental health clinicians to join the group.

A draft of the first iteration of the MHIC (known as MHIC 06) was completed by NCCH in November 2006, with a review undertaken from mid-November 2006 to mid-February 2007. The review consisted of both a 'pilot test' and a 'desktop review'. The pilot test involved volunteer staff at participating facilities piloting the MHIC 06; that is, the newly developed classification was used to code mental health interventions for up to 50 cases, drawn from the inpatient, residential and community mental health settings. A total of 742 cases were coded as part of the pilot test and participating staff completed a feedback questionnaire.

A total of 47 facilities participated in the pilot test, of which 45 were state-funded and two were private facilities. The test was conducted in admitted, community mental health-care and residential mental health-care facilities, across a range of sub-speciality areas (adult/general, child/adolescent, older persons and drug/alcohol). The majority of participants who undertook MHIC 06 coding were clinicians (for example, psychologists, psychiatrists, nurses and allied health workers), while other participants included clinical coders, health information managers and administrators.

The desktop review involved nine committees (including the MHISS and the NMDS Sub-committee) and 20 individuals and/or organisations. Participants were sent a copy of the draft classification and asked to provide comment, either via a feedback questionnaire, email or letter. A total of 28 responses were received.

After the pilot testing and desktop review were completed, NCCH revised the draft MHIC 06 and submitted it to AIHW for consideration by the MHISS at its meeting in April 2007.

MHISS members provided broad-ranging views regarding the proposed classification. Their comments included:

- Collection and coding was too ambitious, difficult to do and, if implemented initially in admitted patient settings, as proposed, would impose a collection burden that was likely to be substantially beyond the capacity of all jurisdictions.
- The coding was ambiguous and overlapping in several areas. Examples included: inadequate differentiation between components of the category 'Education, Counselling and Skills Training Related to Psychological or Psychosocial Issues' and 'Psychological Skills Training'; the various categories of 'Psychotherapeutic Programs' were not sufficiently differentiated and largely rested on opinion rather than being tied to objective criteria.
- The coding needed to be further specified in areas that were critical from a clinical perspective. For example, medication coding did not differentiate atypical antipsychotics from older generation antipsychotics, there was no differentiation between the various classes of antidepressant medications, and that unilateral and bilateral electroconvulsive therapy (ECT) were not differentiated.
- The inclusion of non-patient attributable activities confused the core objective—that is, to specify interventions rather than comprehensively record what staff did with their time.

Overall, MHISS members expressed concern that the MHIC 06, in aiming for comprehensiveness, was now too fine-grained and 'overly inclusive'. Feedback received as to the implications of implementing MHIC 06 included:

> *'if implemented, clinical staff would be required to record a wide range of 'day to day' interventions that are provided to all consumers (e.g., assistance with medication) that are not differentiated from the more significant interventions that we should aim to focus the collection upon'.*

The AIHW presented a paper to the August 2007 MHISS meeting that both canvassed the issues that had been identified with respect to the MHIC 06, and explored options for its progression. The AIHW recommended that it would be both 'prudent and timely' for a period of consolidation on the MHIC project and for the MHISS to review the original intent of the project, as well as its interdependencies with the other mental health information data collection activities.

MHISS considered that it needed to fundamentally rethink the project, in particular to resolve whether the industry would gain more benefit from the fine-grained, comprehensive approach that coded every intervention, or whether including in the classification only those interventions considered to be the most clinically significant would be of greater benefit.

After this decision by MHISS, the NCCH ceased work on the MHIC 06, pending further guidance about the future direction of the project.

Reappraisal of the MHIC 06

In August 2007, the MHISS agreed that there was a need to review the original intent of the MHIC project and the AIHW was subsequently commissioned by the Department of Health

and Ageing (DoHA) to undertake the 'reappraisal project'. This involved further investigation and consideration of the following:

- The original intent of the MHIC project.
- Interdependencies with the other mental health information data collection activities.
- The range and importance of interventions to be included.
- International and jurisdictional experience with mental health intervention classifications.
- The scale and future direction of the project.
- Previously identified implementation practicalities, including resource implications alternative data sources and data analysis issues.

The reappraisal project consisted of four stages:

1. Scoping the study and engaging stakeholders. This involved scoping the parameters of the reappraisal study by delineating substantive issues that required further investigation and consideration. A consultative approach was used, whereby advice and information was sought from stakeholders and other interested parties including, but not limited to, DoHA, states and territories, MHISS, the Australian Mental Health Outcomes and Classification Network, and NMDS subcommittee.
2. Preliminary investigation of intervention and counting issues. Information gathered in the first stage of the study was used to inform the investigation and further assessment of the already identified issues of interventions ('should' versus 'could') and counting ('summary' versus 'contact').
3. Conceptualisation and development of MHIC project options. A conceptual model of proposed MHIC data collection options was developed based on the investigation and assessments undertaken in the second stage of the project. MHIC project plan options based on the conceptual model were developed and progressed with stakeholders.
4. Final report and presentation of MHIC Project Plan options to MHISS. A report detailing the options for a revised MHIC project plan was prepared for consideration by MHISS at its April 2008 meeting.

Given the previously documented concerns with MHIC 06, and the results of the reappraisal study, the AIHW concluded that the project's original purpose and scope was overly ambitious. Overall, the feedback received by the AIHW during the consultation process confirmed the desire for a smaller and more consolidated intervention classification system containing detailed descriptions of interventions that could be used by health professionals across inpatient, ambulatory and residential settings.

3 MHIC 09

Development of the MHIC 09

As a part of the reappraisal project, the AIHW undertook the development of a 'prototype' revised classification scheme for mental health interventions—known at the time as MHIC 08—which was presented to the MHISS in December 2008.

After consideration by MHISS members, it was agreed that, with appropriate refinement, the MHIC 08 prototype was a suitable vehicle to advance the future development of an MHIC.

After further consultation with mental health Expert Advisory Panels and interested MHISS members, the MHISS further refined the MHIC 08 structure, content and definitions at the February 2009 meeting and the prototype was renamed MHIC 09.

The MHIC 09 is a multi-axial intervention scheme that was designed to capture 'significant' mental health interventions. Interventions were selected for collection on the basis that:

- they were evidence based
- they were highly valued by consumers, carers or clinicians
- they had potential for high impact or risk
- there was evidence of significant variation in practice
- they were high cost.

The MHIC 09 was developed to be a provider-neutral, logical, and pragmatic system for routine data collection.

MHISS decided to conduct a 'proof-of-concept' trial within a single community mental health-care service, before further refinement of the classification and, potentially, a wider piloting of the classification across all jurisdictions and service settings.

MHIC 09 proof of concept trial

The Australian Capital Territory MHISS representative volunteered to participate in the proof-of-concept trial. The trial was conducted with ACT Health's Tuggeranong Mental Health Team. A presentation and information session for trial participants was held on 7 April 2010 at the Tuggeranong Health Centre. The trial began on 12 April 2010 and ended on 7 May 2010. The trial aimed to determine the extent to which the MHIC 09 prototype:

- adequately covered the significant mental health interventions provided to mental health consumers
- provided adequate descriptions of the significant mental health interventions included in the MHIC 09
- was easy to use
- imposed a minimal coding burden on staff
- was feasible for routine collection
- could be used by mental health providers from all pertinent professions

- provided a way of consistently describing the significant mental health interventions provided to consumers.

Overall, participant feedback indicated that the MHIC was:

- generally user-friendly
- suitable for use by a wide range of mental health professionals
- clear and had adequate intervention descriptions.

Based on the feedback gained from clinicians involved in the proof-of-concept study, the MHIC 09 was further refined before a widespread pilot study was conducted.

MHIC 09 pilot study

The MHIC 09 pilot study, undertaken in May 2011, provided an opportunity for operational and 'real world' testing of the classification system to determine whether it was a valid, effective and practicable tool for use within the Australian mental health-care context.

The objective of the pilot study was to address the following research questions:

- Were the MHIC 09 codes sufficiently broad and transferable for use in different jurisdictions and mental health settings?
- Did the MHIC 09 allow for the effective coding and description of the significant mental health interventions being provided to mental health consumers?
- Were there significant mental health interventions that could not be classified using MHIC 09?
- What proportions of contacts/interventions/separations reviewed were not allocated an MHIC 09 code?
- What were the time/workload implications for mental health practitioners using MHIC 09?
- Was MHIC 09 appropriate for national implementation, either in its current form or with minor refinements?

Planning

MHISS, in conjunction with Expert Advisory Panel members, identified and confirmed a sufficient number of trial sites for participation in the MHIC 09 pilot study. A total of 34 mental health service sites participated in the pilot study, with representation from all jurisdictions except the Northern Territory. Participant sites included public and private sector mental health services in the admitted and community mental health service settings. Despite considerable effort, the AIHW was unable to secure participation from a residential mental health service. Further feasibility testing of the classification scheme in the residential mental health service setting may therefore be considered warranted before any national implementation of the MHIC 09 protocol.

Data collection

The participating mental health service sites were then contacted by the AIHW to ascertain the numbers of clinicians and clinical coders who would be involved in the trial. A training and support package for each participant, tailored to the type of participant (coders/clinicians), was sent to each site. Each package contained an information brief,

MHIC 09 guidelines, MHIC 09 training compact disc, data response booklet (including the survey instrument and feedback questionnaire) and an online survey address.

Sites participating in the pilot had three data collection methods available to them: paper survey, online survey or direct data transfer from existing data collections.

A total of 537 clinician, and 10 clinical coder paper survey response booklets were sent to the nominated mental health service sites. Paper surveys were sent regardless of whether the site had nominated to conduct the survey online or not. AIHW staff used a commercial online survey provider (Survey Gizmo™) to develop an online version of the survey. Individual online survey addresses were supplied to each participating service site. Apple iPads™, with pre-loaded individual links to the online survey, were made available for use by some clinicians at a subset of participating sites. The option for jurisdictions to supply data directly from their current data collection systems was also made available. The Australian Capital Territory was the only jurisdiction to agree to this form of data supply, with data provided from its mental health information system. The ACT only supplied data from individual clinicians who had agreed to participate in the pilot study.

The data collection processes used in community and residential health-care settings differ from those used in a hospital-admitted setting.

Community/Residential setting: In community and residential settings, client information is usually coded during the contact or clinical intervention. Clinicians in the community setting were asked to use the MHIC 09 to code significant interventions for each contact provided to their mental health clients during the pilot period. In the residential setting, clinicians were asked to use the MHIC 09 to code each client intervention.

Admitted setting: Admitted settings employ clinical coders to code all separations, including, diagnoses and procedures, using ICD-10-AM. In the pilot, clinical coders were requested to code mental health-related separations in public acute, public and private psychiatric facilities using MHIC 09 in addition to the ICD-10-AM codes.

Pilot study time frames

To increase the diversity of pilot participants, flexible pilot study time frames were negotiated with participants. Clinical coders were limited to the month of May 2011. Clinician participation was staggered over three periods: 16 May to 27 May 2011, 23 May to 3 June 2011, and 20 June to 1 July 2011.

Training and support

A support telephone number and email address were set up to provide guidance to trial participants before, during or after the pilot study. An MHIC 09 reference group, comprising interested MHISS members, was also established for the duration of the pilot study. This group assisted with questions as they arose during the course of the study.

Outcomes

A total of 6,084 surveys were completed for the MHIC 09 pilot study, comprising 5,272 clinician and 812 coder survey responses. Multiple collection methodologies allowed participants to choose the method that would most suit their individual work arrangements. Despite the availability of iPads and the online survey methodologies, paper responses (4,716 or 77.5%) were by far the most used survey response mechanism. Of the 5,272 clinician

surveys (which resulted in 9,401 significant interventions), 747 were online responses, 3,967 were paper responses and 558 were responses directly from the ACT jurisdictional information system. For coders, 63 responses were provided via the online survey and 749 were paper responses.

Clinical coder surveys

Clinical coder data was comprised of surveys from public and private hospital services from two jurisdictions only. While this sample was not considered to be representative of hospital services nationally, it did provide valuable insights into the coder experience. The coder survey data comprised 812 surveys, with 1,207 significant interventions being coded.

On completion of the pilot study, participants completed a feedback questionnaire based on the research questions as stated above. Results for each question are discussed in Table 1.

Table 1: Responses to feedback questionnaire

Question	Response
Are the MHIC 09 codes broad and transferable for use in different jurisdictions and mental health settings?	• MHIC 09 codes described the majority (87.8%) of significant interventions, provided by clinicians from a broad range of professions to clients/patients of public and private admitted patient mental health services and community mental health-care services, across a broad range of client demographics. Additional pilot testing of the protocol in the residential service setting may be required. • MHIC 09 codes could be assigned by coders in the admitted patient setting using clinical files of patients with a mental health-related separation. Feedback from coders supports the need for targeted workforce education as part of any national implementation strategy of an MHIC.
Does the MHIC 09 allow for the effective coding and description of the significant mental health interventions being provided to consumers?	• The MHIC 09 protocol was used by clinicians to describe nearly 90% of significant interventions. Also, MHIC 09 codes distinguished differences between interventions provided by clinicians of varying professions working in different mental health service settings. Refinement of the supporting guidelines may be necessary to further specify the intervention descriptions for individual codes. • The MHIC 09 protocol in its current form could be used by coders to describe interventions provided in the admitted patient setting, including identifying differences in the proportions of intervention groups between service settings. However, the volume of interventions may not have been effectively recorded. The coding of interventions in the admitted patient setting may require additional conceptual work to address this issue.
Are there significant mental health interventions which cannot be classified using MHIC 09?	• Clinicians most commonly reported that interventions involving consultation with others, for example, case conferencing, were significant interventions not covered by the MHIC 09. This may have been influenced by the demographic of the sample data, with more than half of the surveys completed for clients under the age of 25. However, pilot study data supports the position of the Child and Adolescent Mental Health Information Development Expert Advisory Panel that provision for this type of intervention should be included as part of any refinement of MHIC 09. • In addition, the development of a non-specific intervention option, for example ‘Other intervention not elsewhere specified’, may be considered warranted to capture highly specialised interventions.

What proportions of contact/interventions/separations reviewed were not allocated a MHIC 09 code?	• About 6.6% of contacts between clinicians and clients were considered by trial participants to not involve a significant intervention. For clinicians, this is considered an underestimation due to two factors. Firstly, some trial sites were of the view that coding all contacts would be too burdensome for trial participants; therefore, some sites only recorded significant interventions. Secondly, not all of the additional significant interventions specified by clinicians would meet the definition of significant, as specified in the MHIC 09 guidelines. • About 38% of surveys completed by coders for mental health-related separations could not be assigned an MHIC 09 code. This is considered an overestimation of the activity that did not include a significant intervention, with coders noting their frustration with the lack of matching terminology in the patient files. In summary, almost 7% of clinician activity and 38% of coded mental health-related separations were not considered to include a significant intervention. As described above, there are issues with these estimates that prevent accurate analysis of this objective.
What are the time/workload implications for mental health practitioners using MHIC 09?	• The average survey response time of 1.1 minutes for clinicians to code MHIC 09 interventions translates to about 2% of the average contact duration in the sample data. On average, coders completed an MHIC 09 survey for a mental health-related separation in 2.5 minutes. However, it is expected that the average time to code an intervention would decrease with increased familiarity. • These results can be used to estimate the number of full-time equivalent (FTE) working years required for an annual national collection of the MHIC 09, for the admitted hospital mental health-related separations and community mental health client contacts. The estimated total for national implementation of the MHIC 09 would be about 73.5 FTE working years, comprising about 65 FTE working years for the community mental health setting and about 8.5 FTE working years for the admitted patient service setting. • Analysis of the balance between the workload costs of implementation compared to the need for the data is beyond the scope of this report. However, the results from the pilot study could be used to for more detailed modelling of the national cost of implementing MHIC 09.
Is MHIC 09 appropriate for national implementation, either in its current form or with minor refinements?	• The pilot study supports the proposition that the protocol is usable in its current form and has enough specificity to measure differences across the mental health sector. The MHIC 09 protocol could be implemented in its current form or could proceed with either minor, or indeed major, refinements. • Support for the implementation of the MHIC 09 in its current form is evidenced by the high proportion of interventions that were coded using MHIC 09. Despite this, the majority of clinician respondents (from 191 feedback surveys) did not agree that the MHIC 09 was ready for national implementation. • Refinements to the MHIC 09 were suggested by participants, ranging from improvement to the guidelines through to addition of codes to capture liaison activities. Additional suggestions appear to imply an appetite for a more detailed classification scheme. This would imply that the MHIC 09 may not yet have achieved the right balance between a more generic classification protocol and the highly specific nature of the MHIC 06. However, it is unclear whether the participating clinicians were aware of the history of MHIC 06 when suggesting modifications to the MHIC 09 protocol. • Notwithstanding respondents ratings captured in the feedback survey, the merit in taking the MHIC 09 forward is supported by the high proportion of interventions in the pilot study sample data that could be described using an MHIC 09 code.

Refinements to the MHIC 09

Findings gleaned from the analysis of the MHIC 09 pilot study and feedback data, support the need for the following refinements:

- Replace the term 'significant' with an alternate, less emotive, term such as 'selected' to describe the intervention classification.
- Improving the guidelines through more detailed descriptions of the individual interventions.
- Including additional codes and/or new groups for case conferencing/liaison interventions, to meet the needs of the Child and Adolescent Mental Health Services (CAMHS) setting.
- Adding a generic 'Other intervention not elsewhere specified' code for highly specialised interventions. Alternatively, develop specific codes for interventions provided by specialised segments of the workforce, for example occupational therapists.
- Creating strong business rules for data reporting when more than one client and/or clinician is present during the intervention.
- Creating a 'volume' aspect to the MHIC codes for interventions provided to admitted patients, to cover the possibility of one or more of the same intervention being provided during a single separation. Note that this type of coding concept currently exists for the Australian Classification of Health Interventions (ACHI) coding of ECT.
- Including more detailed codes for pharmacotherapy prescription to glean additional information on dosage, whether the prescription is a new or ongoing treatment, and whether the prescription is a one-off or repeat.

Next steps

The findings of the MHIC 09 pilot study supported the proposition that the classification scheme was usable (in the form piloted) and that it had sufficient specificity to measure differences across the mental health sector. Further refinements have been made after feedback from pilot participants and, as a result, it is expected that the usability and specificity have been further improved. The MHIC 09 was subsequently renamed MHIC 1.0.

At the 84th MHISS meeting, held in October 2012, it was agreed that the feasibility of MHIC being integrated into the ACHI, in its current form, for potential routine use needed to be assessed.

The AIHW has sought and received feedback from the National Casemix and Classification Centre (NCCC) regarding the incorporation of MHIC into the ACHI. The AIHW was advised that consideration would need to be given to the most appropriate level of integration and where and how the MHIC would be used. Two options were suggested:

1. The code sets were completely integrated and all ACHI codes (including those included from the MHIC set) were available for the coding of all services.
2. A separate mental health intervention chapter was created within ACHI and this contained interventions that were only used for coding mental health services.

In addition to this advice, the NCCC also advised that there was a requirement to define the standards and business rules for the MHIC if it was to be used across different care settings, specifically:

- The use of codes for case conferencing and non-patient-attributable interventions may be suitable for settings where coded data was used to assess workload and professional development activities, as well as patient interventions. These codes would not fit well with the conventions of coding for acute inpatient collections and therefore required specific instructions for appropriate use.

- Regarding the use of a 'volume aspect' for when interventions were delivered multiple times during a patient care episode and for the inclusion of more detailed codes for specific interventions (for example, further detail about the nature of a drug prescription). This constituted a level of reporting that was not in line with the inpatient collection in which ACHI was traditionally used, but which could be supported by separate coding business rules.

The AIHW is further exploring these and governance issues, in conjunction with DoHA, with a view to incorporating MHIC 1.0 in a future version of the ACHI at the earliest opportunity.

References

DoHA (Australian Government Department of Health and Ageing) 1999. National Information Strategies and Priorities under the Second National Mental Health Plan, 1998–2003. 1st edn. Canberra: Commonwealth of Australia.

DoHA 2005. National Mental Health Information Priorities. 2nd edn. Canberra: Commonwealth of Australia.

Leginski W, Croze C, Driggers J, et al. 1989. Data standards for mental health decision support systems: a report of the task force to revise the data content and system guidelines of the mental health statistics improvement program. Washington, DC: US Department of Health and Human Services.

Annex A: The MHIC 1.0 classification

Broadly, the findings of the MHIC 09 pilot study suggested that further refinements of the prototype MHIC 09 would improve its usefulness. These refinements have now been largely incorporated into the revised MHIC 1.0 classification scheme.

Guiding principles for the MHIC 1.0

Purpose of the classification

To describe and capture information on selected mental health interventions provided to mental health consumers in Australia.

If mental health interventions can be described accurately and consistently, analyses examining the relationship between service delivery and best practice can be made, which allow areas of improvement in service quality to be identified.

Provider and setting neutral

The MHIC 1.0 has been developed to be neutral with respect to both service provider and service setting. As a result, neither provider profession nor mode of practice is reflected in the structure. The same classification codes are intended to be used regardless of the particular speciality of the mental health professional involved in delivering the particular intervention(s). In addition, the MHIC 1.0 has been designed to be used across the various mental health service settings in Australia: admitted, community and residential care.

Consumer-centred not activity-based

The MHIC 1.0 is intended to capture information on 'selected' interventions provided to consumers rather than as a measure of a particular mental health professional's activity.

'Selected' interventions

Feedback received through the MHIC 09 pilot study suggests that the use of the term 'significant' may have been a barrier to the perceived effectiveness of the MHIC 09 in describing mental health interventions. This was due to some clinicians perceiving the use of the term 'significant' as a value judgement on their work, potentially causing undue negative reaction to the prototype classification scheme.

As a result, in the revised MHIC 1.0 classification scheme 'significant' interventions was replaced with 'selected' interventions.

As with 'significant' interventions in the prototype scheme, 'selected' interventions for inclusion in the MHIC 1.0 will satisfy one or more of the following criteria:

- evidence-based
- highly valued either by consumers, carers or clinicians (or all)
- has the potential for high impact or risk
- evidence of significant variation in practice is available
- high cost.

In addition, other factors, such as major changes in health policy and priorities, or the introduction of a new treatment modality of particular interest to clinicians, may result in particular mental health interventions being selected for inclusion in the classification.

The intention of the MHIC 1.0 also allows for selected interventions to be either added or removed as required.

It should be noted that the MHIC 1.0 is not designed to capture information on each and every intervention which is provided to mental health consumers. Nor is it designed to capture clinician activity levels or case-loads. Its purpose is to capture a specific set of interventions provided to mental health consumers.

Figure 2a: MHIC 1.0 - selected interventions diagrammatic overview

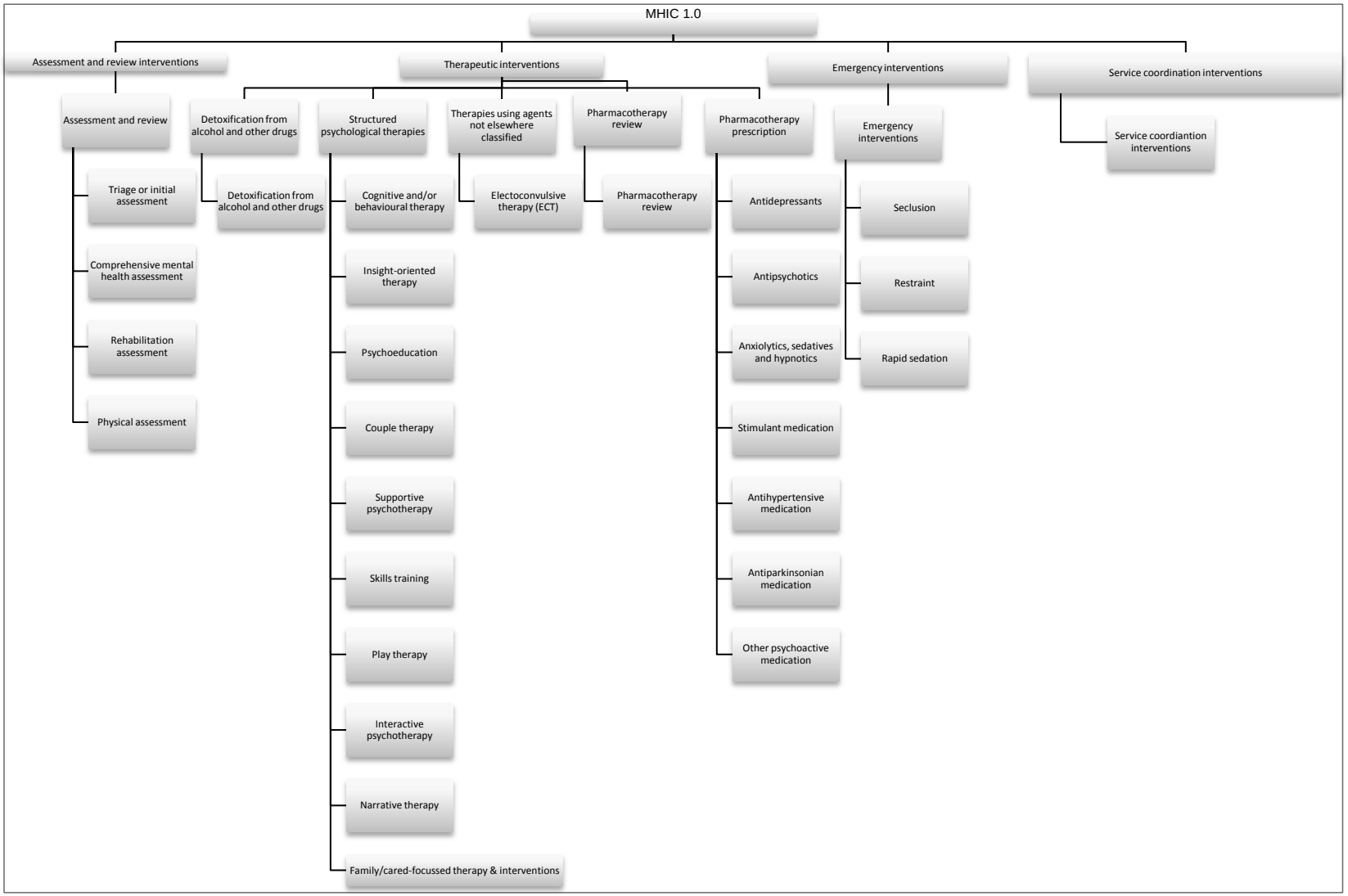


Table 2: Summary of MHIC 1.0 selected intervention classification codes

Group	Code	Intervention
Assessment and review	1011.00	Triage or initial assessment
	1021.xx	Comprehensive mental health assessment
	1031	Rehabilitation assessment
	1041	Physical assessment
Detoxification from alcohol and other drugs	2011	Non-medicated detoxification
	2012	Medicated detoxification
Structured psychological therapies	3011	Cognitive and/or behavioural therapies; individual
	3012	Cognitive and/or behavioural therapies; group
	3012	Insight-oriented therapies; individual
	3022	Insight-oriented therapies; group
	3031	Psychoeducation; individual
	3032	Psychoeducation; group
	3041	Couple therapy; individual
	3042	Couple therapy; group
	3051	Supportive psychotherapy; individual
	3052	Supportive psychotherapy; group
	3061	Skills training; individual
	3062	Skills training; group
	3071	Play therapy; individual
	3072	Play therapy; group
	3081	Interpersonal therapy; individual
	3082	Interpersonal therapy; group
	3091	Narrative therapy; individual
	3092	Narrative therapy; group
	3101	Family/carer-focussed therapy and interventions; individual
	3102	Family/carer-focussed therapy and interventions; group
Therapies using agents not elsewhere classified	4011	Electroconvulsive therapy; unilateral
	4012	Electroconvulsive therapy; bilateral
Pharmacotherapy review	5011	Pharmacotherapy review
Pharmacotherapy prescription	See appendix table 1	Antidepressants
		Antipsychotics
		Anxiolytics, sedatives and hypnotics
		Mood stabilisers and anticonvulsants
		Stimulant medication
		Antihypertensive medication
		Antiparkinsonian medication
		Other psychoactive medication
Emergency interventions	7011	Seclusion

	7021	Physical restraint
	7022	Direct mechanical restraint
	7023	Indirect mechanical restraint
	7031	Rapid sedation
Service coordination interventions	8011	Case conferencing
	8021	Liaison with other professionals
	8031	Secondary consultations
	8041	Service coordination for consumers with severe, persistent mental illness and complex care needs involving care facilitator
	8051	Other service coordination
Other interventions not elsewhere specified	9011	

Assessment and review interventions

A mental health assessment is a determination of a consumer's mental health status and need for mental health services, made by a suitably trained mental health professional or mental health team (which may consist of a psychiatrist, psychologist, mental health nurse and/or allied health professional), based on the collection and evaluation of data obtained through interview and observation, of a consumer's mental history and presenting problem(s). The assessment may include consultation with the consumer's family and concludes with formation of problems/issues, documentation of a preliminary diagnosis or diagnosis, and a written treatment plan supported by the assessment and interview data.

The following section provides a detailed view of the various sub-categories within the MHIC 1.0.

Triage or initial assessment

MHIC code 1011.00

Definition

This occurs when contact with a mental health service is first made in relation to a consumer. The contact may be either direct via a face-to-face interview, or via telephone. It involves a mental health professional conducting an initial assessment of the consumer's presenting mental health status, including whether mental illness is present, the nature of the mental illness, risk and impact. Demographic and social information may also be collected as well as information on a consumer's mental health and family history. The information gathered is used to assess:

- the need for mental health services
- urgency
- the most appropriate service for referral.

Comprehensive mental health assessment

MHIC code 1021.xx

Definition

This involves the gathering, evaluation and recording of information by a mental health professional relative to the consumer's problem(s), strengths, functional status or situation and must include (but is not limited to) at least *four* of the following assessment components:

- Mental status assessment (MHIC code 1021.01)
- Mental health history assessment (MHIC code 1021.02)
- Triage/emergency assessment (MHIC code 1021.03)
- Risk assessment (MHIC code 1021.04)
- Medication assessment (MHIC code 1021.05)
- Social and environmental assessment (MHIC code 1021.06)
- Assessment summary and clinical formulation (MHIC code 1021.07)
- Development of a further action plan (even if the plan includes provision of no further services) (MHIC code 1021.08)
- Developmental or observational assessment (MHIC code 1021.09)
- Home assessment (MHIC code 1021.10).

Rehabilitation assessment

MHIC code 1031.00

Definition

This involves a mental health professional undertaking an assessment of the impact of mental illness on a mental health consumer's ability to perform day-to-day activities of living. In addition, the rehabilitation assessment may have a specialised focus on a consumer's employment and vocational capacity.

Physical assessment

MHIC code 1041.00

Definition

This involves the collection and assessment of information relating to a mental health consumer's physical state. A physical assessment is usually conducted as part of the general mental health assessment because it is important to assess a mental health consumer's physical state to determine appropriate interventions, especially those involving medications. Some physical conditions may create the appearance of mental health conditions.

Therapeutic interventions

Detoxification from alcohol and other drugs

MHIC code 2011.xx

Definition

This intervention is defined as involving interaction(s) between a consumer(s) and a mental health professional(s) where an intervention is aimed at the management of withdrawal from a drug of dependence so that the associated risks are minimised. Detoxification is managed by monitoring the withdrawal process and may include medical interventions as appropriate. This intervention type includes the administration of medications which are used to control withdrawal symptoms, observation and supportive care.

It should be noted that interventions for relapse prevention activities are to be coded under structured psychological therapies.

Detoxification from alcohol and other drugs may include:

- Non-medicated detoxification (MHIC code 2011.01)
- Medicated detoxification (MHIC code 2011.02).

Structured psychological therapies

Definition

Those interventions which include a structured interaction between a mental health consumer and a qualified mental health professional(s) using a recognised, psychological method, for example, cognitive behavioural techniques, family therapy or psychoeducation counselling. Psychological interventions are designed to alleviate psychological distress or emotional disturbance, change maladaptive behaviour and foster mental health.

These interventions embrace the following three approaches:

Psychosocial therapy: Recognised, structured or published method or techniques for the treatment of mental and emotional disorders. It occurs through discussion about the condition and related issues between a consumer(s) and a mental health professional(s). Psychosocial therapies can be delivered on either an individual or group basis, typically in an office or outpatient facility.

***Education*:** Instruction and guidance with the aim of enhancing a consumer's knowledge, awareness or understanding of their illness or issue for the purpose of monitoring, managing, maintaining or improving their health outcomes.

Counselling: Alleviating emotional, physiological, psychological, social and/or occupational consequences of a consumer's illness or issue, through the establishment of a supportive or therapeutic relationship. Counselling encompasses the provision of empathic acceptance, clarification, interpretation, problem solving and support.

Cognitive and/or behavioural therapy

MHIC codes 3011.xx (Individual) & 3012.xx (Group)

Definition

Includes features of both cognitive and behaviour treatments. *Cognitive and behavioural therapies* are psychotherapeutic interventions that aim to teach a mental health consumer(s) how to identify any unhealthy, negative and/or maladaptive patterns of thinking (cognitive) and behaviour (behavioural) in order to evaluate and then modify them with appropriate and adaptive alternatives. This type of intervention can be performed individually, with a group, or alone (through self-help instruction), and is characterised by homework assignments to identify, evaluate and modify maladaptive thoughts and behaviours as they arise in everyday situations. This intervention is predicated on the assumption that mental illness originates internally from distorted thought processes or manifests from learned patterns of maladaptive behaviour rather than from external social or situational influences. Techniques often used within cognitive and/or behavioural therapies include:

- Cognitive restructuring:
  - MHIC code 3011.01 (Individual)
  - MHIC code 3012.01 (Group)
- Desensitisation (graded exposure or exposure therapy):
  - MHIC code 3011.02 (Individual)
  - MHIC code 3012.02 (Group)
- Relapse-prevention:
  - MHIC code 3011.03 (Individual)
  - MHIC code 3012.03 (Group)
- Relaxation :
  - MHIC code 3011.04 (Individual)
  - MHIC code 3012.04 (Group)
- Response-prevention :
  - MHIC code 3011.05 (Individual)
  - MHIC code 3012.05 (Group)
- Rational emotive therapy:
  - MHIC code 3011.06 (Individual)
  - MHIC code 3012.06 (Group)
- Role play/rehearsal:
  - MHIC code 3011.07 (Individual)
  - MHIC code 3012.07 (Group)
- Structured problem solving:
  - MHIC code 3011.08 (Individual)
  - MHIC code 3012.08 (Group)
- Treatment adherence:
  - MHIC code 3011.09 (Individual)
  - MHIC code 3012.09 (Group).

Examples include but are not limited to cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT).

Insight-oriented therapy

MHIC codes 3021.00 (Individual) & 3022.00 (Group)

Definition

This is a group of psychotherapies whose theoretical models see symptoms as arising from unconscious psychological structures, process or conflicts. These models typically focus on stages or processes of early psychological development, and the way in which this development may be disrupted by factors in family or parental relationships, including trauma. Interventions used typically include a focus on the therapeutic relationship as an object of study and discussion, and identification of repeated patterns of thought, affect and behaviour within the therapeutic relationship and elsewhere in a person's life. These therapies may aim to produce change through greater conscious understanding of these patterns and processes, although conscious 'insight' is not seen as essential in all such therapies.

Examples include but are not limited to psychodynamic therapies, psychoanalysis, psycho-analytic psychotherapies, brief psychodynamic therapies, gestalt therapy, self-psychology, and therapies based on the Conversational Model.

Psychoeducation

MHIC codes 3031.00 (Individual) & 3032.00 (Group)

Definition

This involves a specific form of educative counselling tailored to consumers, carers, other treating professionals or their family members to help them understand the facts about mental illness and to access or learn strategies to deal with the illness and prevent relapse. Psychoeducation may be provided to individuals with a mental health condition.

Couple therapy

MHIC codes 3041.00(Individual) & 3042.00 (Group)

Definition

This is a systematic effort to produce change in a relationship by introducing changes into the patterns of partner interactions. The aim of *couple therapy* is to identify the presence of distress and dissatisfaction in the relationship, and to improve or alleviate the presenting symptoms and restore the relationship to a more effective and healthier level of functioning.

Examples of couple orientated treatments include psychoanalytic couple therapy, object relations couple therapy, ego analytical couple therapy and behavioural couple therapy.

Supportive psychotherapy

MHIC codes 3051.00 (Individual) & 3052.00 (Group)

Definition

A form of psychotherapy whose focus is on short-term improvement in distress or function through identifying a person's usual strengths and coping mechanisms and assisting the person to mobilise or strengthen those mechanisms in the face of, or following, significant stressors. Strengths and coping

mechanisms may be viewed in very different theoretical frameworks (e.g. ego-psychology, cognitive, social/systems). These therapies typically have an active stance, with a focus on more immediate issues.

Skills training

MHIC codes 3061.00 (Individual) & 3062.00 (Group)

Definition

This is characterised by a formal rehabilitative process that involves a schedule of instruction, active supervised practice by the consumer and evaluation of progress. It may be applied to a variety of functional areas ('skills') including physical and psychological skills. Examples include communication, socialisation and vocational skills, and self-care skills such as dressing and personal hygiene behaviours. The training may be aimed at improving the skills of the consumer, their carer and other treating health professionals.

Skills training attempts to build/refine functional skill deficits. In this way, skills training can be contrasted with Cognitive and/or behavioural therapy, which attempts to modify a mental health consumer's thoughts and/or behaviours that are perceived as negative or maladjusted, but are not necessarily related to a need to develop new or refine existing functional skills.

Play therapy

MHIC codes 3071.00 (Individual) & 3072.00 (Group)

Definition

A type of therapy which occurs with children and aims to decrease behavioural and emotional difficulties that interfere with a child's normal functioning. The treating health professional uses the consumer's fantasies and the symbolic meanings of the consumer's play as a medium for understanding and communicating with the consumer. Play therapy allows the consumer to express themselves through play and is aimed at improving:

- verbal expression
- improved impulse control
- more adaptive ways of coping with anxiety and frustration
- improved capacity to trust and to relate to others.

Interpersonal psychotherapy

MHIC codes 3081.00 (Individual) & 3082.00 (Group)

Definition

A brief, structured approach that addresses one or more problem area(s) in a consumer's interpersonal functioning. The underlying assumption is that mental health problems and interpersonal problems are interrelated. The therapy focuses on the consumer's current social context and social functioning, and does not attempt to see current situations as a function of internal conflict. The aim of interpersonal psychotherapy is to identify and resolve interpersonal difficulties, issues and problems, for example interpersonal deficits, grief, disputes and role transitions. Interpersonal psychotherapy explores a consumer's perceptions and expectations of relationships, and aims to improve interpersonal skills and communication.

Narrative therapy

MHIC codes 3091.00 (Individual) & 3092.00 (Group)

Definition

In narrative therapy, problems are described as stories. How a consumer thinks about important stories can restrict them from overcoming their present difficulties. The focus in narrative therapy is to understand the stories or themes that have shaped a consumer's life, and how these stories can be written and re-written. The change process involves assisting a consumer to identify unique outcomes and create more preferred stories about their problems. By reframing or re-telling a story, an altered relationship with the problem can be developed. To assist with reframing and re-telling a story, a major emphasis is on identifying a consumer's strengths, including the skills, beliefs and abilities they already possess. Key stages of narrative therapy can include:

- defining the problem
- mapping the influence of the problem
- evaluating and justifying the effects of the problem
- identifying unique outcomes
- re-storying.

Narrative therapy is of particular value to specific cultures (for example, Aboriginal and Torres Strait Islander people), where story-telling is a central part of their culture.

Family/carer-focussed therapy and interventions

MHIC codes 3101.00 (Individual) & 3102.00 (Group)

Definition

Family/carer-focussed therapy and interventions can be defined as therapeutic processes which promote, improve, and sustain the effective functioning of the family/carer, and/or work with the family/carer to achieve improvement in the mental health status of the consumer. The scope of interventions is limited to family/carers. It should be noted that in this context, 'family/carers' includes people who have a significant emotional connection to the consumer, such as friends and partners, and those who have a formal role as the consumer's carer.

Family/carer-focussed therapy and interventions can comprise a number of different processes which have in common a focus on changing the knowledge, skills, interactions or capacity of the family. These may include:

- Assisting family/carer to understand: the nature of the consumer's mental health problem; their roles and the role of others in the care plan; how the mental health problem may impact on the client's thinking, behaviour, relationships and educational/vocational functioning; factors which may assist or impair recovery; and warning signs of deterioration.
- Developing new skills and techniques to support positive family interactions and relationships.
- Promoting effective parenting/carer strategies relevant to the consumer's age, developmental needs and family circumstances.
- Enhancing the capacity of family/carers to anticipate and solve problems.
- Assisting the family/carer and client to see things from other's perspective and to develop shared understandings.
- Supporting the family/carer to navigate the mental health care system and to maintain their own health and well-being.

Family/carer-focussed therapy and interventions can include, but are not limited to, psychoeducation, problem solving/crisis management, counselling and skills training.

Interventions provided to family/carers, *with or without the consumer present*, should be recorded as 'Family/carer-focussed interventions'. Where interventions are focussed on improving the marital/couple relationship, these should be coded as Couple therapy (code 3041.00/3042.00).

Therapies using agents, not elsewhere classified

Electroconvulsive therapy (ECT)

MHIC codes 4011.xx (Unilateral) & 4012.xx (Bilateral)

Definition

This involves the use of electrical current to induce seizure-like electrical activity through the brain. It is conducted under general anaesthesia, and with the use of muscle relaxant medication.

Unilateral ECT typically involves the placement of one electrode above the temple on the non-dominant side of the brain with a second electrode placed further back on the scalp on the same side. An electrical current passes between the two electrodes.

Bilateral ECT typically involves the placement of an electrode on either side of the forehead. An electrical current passes through both hemispheres (sides) of the brain.

The intervention codes for ECT (both unilateral and bilateral) are split on the number of times the procedure is performed, with extensions for ≥ 99 ECT sessions. For example:

4011.01 – Unilateral ECT – 1 treatment

4012.20 – Bilateral ECT – 20 treatments.

See Attachment 3 for a full list of ECT codes.

Pharmacotherapy review

MHIC code 5011.xx

Definition

This incorporates a review of a consumer's current medication regime to determine appropriateness of the regime and an assessment of the consumer's ability to manage medication safely.

Pharmacotherapy review involves:

- Drug monitoring MHIC code 5011.01
- Medication management assessment MHIC code 5011.02
- Review of medication(s) MHIC code 5011.03.

Excludes: advice or education regarding medication or compliance assessment of illicit drug use.

Pharmacotherapy prescription

MHIC code ATC code for drug. Administration route and Prescription type

Definition

Pharmacotherapy prescription encompasses the clinical assessment and subsequent judgement that pharmacotherapy is appropriate and indicated for the consumer. It typically will also involve the prescribing of an appropriate pharmacological agent and may include the preparation and administration of oral or depot intramuscular injection (IMI).

As well as details of the medication prescribed, the administration route and whether the prescription is new or a repeat, is collected. The MHIC code for this intervention is designed to combine these components, that is:

- The list of Anatomical Therapeutic Chemical (ATC) codes for psychopharmacotherapeutic drugs can be found at Appendix 1
- The administration route will be coded as 1 = oral, 2 = depot IMI, and 3 = other
- The prescription type will be coded as 1 = new, 2 = repeat.

Therefore, the MHIC codes for pharmacotherapy prescription are a combination of the (ATC) code for the specific drug, the administration route, and whether the prescription is new or a repeat. For example, an oral dose of Alprazolam which is a new prescription would be coded as – N05BA12.11. The same prescription as a repeat would be N05BA12.12.

Emergency interventions

Emergency interventions include those that are aimed at avoiding or reducing, actual or potential harm.

Seclusion

MHIC code 7011.00

Definition

The act of confining a consumer in a room when it is not within their control to leave.

Restraint

MHIC code 7021.xx

Definition

A restrictive intervention that relies on external controls to limit the movement or response of a consumer.

Restraint can be viewed in three modalities:

1. Physical restraint refers to the use of physical force to prevent a consumer from placing themselves in a dangerous situation or harming themselves or others. MHIC code 7021.01
2. Direct mechanical restraint refers to the application of a device, materials or equipment (including belt, harness, manacle, sheet and strap) to directly prevent, restrict or subdue the voluntary movement of any part of the consumer's body without consent. It does not include the use of a 'Geri Chair'. MHIC code 7021.02
3. Indirect mechanical restraint refers to the application of a device for indirectly limiting the voluntary movement of a consumer (e.g.) Geri chair. MHIC code 7021.03

Rapid sedation

MHIC code 7022.00

Definition

Involves the use of medication to calm/lightly sedate the consumer, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression.

Service coordination interventions

For some consumers, the progression of an effective treatment plan includes interventions involving consultation with others, for example, case conferencing, liaison with other professionals, and secondary consultations.

It is planned that this category will also include those consultative processes involving the new 'care facilitator' role which was specified in the national mental health reform budget statement.

MHIC code 8011.xx

Definition

This involves consultation with others, for example, case conferencing, liaison with other professionals, and secondary consultations. This category will also include those consultative processes involving the new 'care facilitator' role which was specified in the national mental health reform budget statement.

The following components:

- Case conferencing (MHIC code 8011.01)
- Liaison with other professionals (MHIC code 8011.02)
- Secondary consultations (MHIC code 8011.03)
- Service coordination for consumers with severe, persistent mental illness and complex care needs involving care facilitator (MHIC code 8011.04)
- Other service coordination (MHIC code 8011.05).

Annex B: Psychopharmacotherapeutic drugs for the MHIC 1.0

Generic Drug Name	ATC Code	Group
Alprazolam	N05BA12	Anxiolytics, sedatives and hypnotics
Amisulpride	N05AL05	Antipsychotics
Amitriptyline	N06AA09	Antidepressants
Aripiprazole	N05AX12	Antipsychotics
Atomoxetine	N06BA09	Stimulant medication
Benztropine	N04AC01	Other psychoactive medication
Biperiden	N04AA02	Other psychoactive medication
Bromazepam	N05BA08	Anxiolytics, sedatives and hypnotics
Bromocriptine	G02CB01	Antiparkinsonian medication
Buspirone	N05BE01	Anxiolytics, sedatives and hypnotics
Carbamazepine	N03AF01	Mood stabilisers and anticonvulsants
Chlorpromazine	N05AA01	Antipsychotics
Citalopram	N06AB04	Antidepressants
Clobazam	N05BA09	Anxiolytics, sedatives and hypnotics
Clomipramine	N06AA04	Antidepressants
Clonazepam	N03AE01	Anxiolytics, sedatives and hypnotics
Clonidine	N02CX02	Antihypertensive medication
Clozapine	N05AH02	Antipsychotics
Dexamphetamine	N06BA02	Stimulant medication
Diazepam	N05BA01	Anxiolytics, sedatives and hypnotics
Diphenhydramine	D04AA32	Antiparkinsonian medication
Diphenhydramine	R06AA02	Other psychoactive medication
Donepezil	N06DA02	Other psychoactive medication
Dothiepin	N06AA16	Antidepressants
Doxepin	N06AA12	Antidepressants
Doxylamine	R06AA09	Anxiolytics, sedatives and hypnotics
Duloxetine	N06AX21	Antidepressants
Escitalopram	N06AB10	Antidepressants
Fluoxetine	N06AB03	Antidepressants
Flupenthixol	N05AF01	Antipsychotics
Fluphenazine	N05AB02	Antipsychotics
Fluvoxamine	N06AB08	Antidepressants
Galantamine	N06DA04	Other psychoactive medication
Haloperidol	N05AD01	Antipsychotics
Imipramine	N06AA02	Antidepressants
Lamotrigine	N03AX09	Mood stabilisers and anticonvulsants
Lithium	N05AN01	Mood stabilisers and anticonvulsants

Lorazepam	N05BA06	Anxiolytics, sedatives and hypnotics
Methylphenidate	N06BA04	Stimulant medication
Mianserin	N06AX03	Antidepressants
Midazolam	N05CD08	Anxiolytics, sedatives and hypnotics
Mirtazapine	N06AX11	Antidepressants
Moclobemide	N06AG02	Antidepressants
Nortriptyline	N06AA10	Antidepressants
Olanzapine	N05AH03	Antipsychotics
Oxazepam	N05BA04	Anxiolytics, sedatives and hypnotics
Paliperidone	N05AX13	Antipsychotics
Paroxetine	N06AB05	Antidepressants
Pericyazine	N05AC01	Antipsychotics
Phenelzine	N06AF03	Antidepressants
Propranolol	C07AA05	Other psychoactive medication
Quetiapine	N05AH04	Antipsychotics
Reboxetine	N06AX18	Antidepressants
Risperidone	N05AX08	Antipsychotics
Rivastigmine	N06DA03	Other psychoactive medication
Selegiline	N04BD01	Antidepressants
Selegiline	N04BD01	Antiparkinsonian medication
Sertraline	N06AB06	Antidepressants
Temazepam	N05CD07	Anxiolytics, sedatives and hypnotics
Thioridazine	N05AC02	Antipsychotics
Tranylcypromine	N06AF04	Antidepressants
Triazolam	N05CD05	Anxiolytics, sedatives and hypnotics
Trifluoperazine	N05AB06	Antipsychotics
Trihexyphenidyl	N04AA01	Antiparkinsonian medication
Trimipramine	N06AA06	Antidepressants
Valproic acid	N03AG01	Mood stabilisers and anticonvulsants
Venlafaxine	N06AX16	Antidepressants
Ziprasidone	N05AE04	Antipsychotics
Zolpidem	N05CF02	Anxiolytics, sedatives and hypnotics

Annex C: ICD-10-AM mental health-related codes

Code	Diagnosis
F00	Dementia in Alzheimer's disease
F01	Vascular dementia
F02	Dementia in other diseases classified elsewhere
F03	Unspecified dementia
F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances
F05	Delirium, not induced by alcohol and other psychoactive substances
F06	Other mental disorders due to brain damage and dysfunction and to physical disease
F07	Personality and behavioural disorders due to brain disease, damage and dysfunction
F09	Unspecified organic or symptomatic mental disorder
F10	Mental and behavioural disorders due to use of alcohol
F11	Mental and behavioural disorders due to use of opioids
F12	Mental and behavioural disorders due to use of cannabinoids
F13	Mental and behavioural disorders due to use of sedatives or hypnotics
F14	Mental and behavioural disorders due to use of cocaine
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine
F16	Mental and behavioural disorders due to use of hallucinogens
F17	Mental and behavioural disorders due to use of tobacco
F18	Mental and behavioural disorders due to use of volatile solvents
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances
F20	Schizophrenia
F21	Schizotypal disorder
F22	Persistent delusional disorders
F23	Acute and transient psychotic disorders
F24	Induced delusional disorder
F25	Schizoaffective disorders
F28	Other non-organic psychotic disorders
F29	Unspecified non-organic psychosis
F30	Manic episode
F31	Bipolar affective disorder
F32	Depressive episode
F33	Recurrent depressive disorder
F34	Persistent mood (affective) disorders
F38	Other mood (affective) disorders
F39	Unspecified mood (affective) disorder
F40	Phobic anxiety disorders
F41	Other anxiety disorders
F42	Obsessive–compulsive disorder
F43	Reaction to severe stress, and adjustment disorders
F44	Dissociative (conversion) disorders

F45	Somatoform disorders
F48	Other neurotic disorders
F50	Eating disorders
F51	Non-organic sleep disorders
F52	Sexual dysfunction, not caused by organic disorder or disease
F53	Mental and behavioural disorders associated with the puerperium, not elsewhere classified
F54	Psychological and behavioural factors associated with disorders or diseases classified elsewhere
F55	Harmful use of non-dependence-producing substances
F59	Unspecified behavioural syndromes associated with physiological disturbances and physical factors
F60	Specific personality disorders
F61	Mixed and other personality disorders
F62	Enduring personality changes, not attributable to brain damage and disease
F63	Habit and impulse disorders
F64	Gender identity disorders
F65	Disorders of sexual preference
F66	Psychological and behavioural disorders associated with sexual development and orientation
F68	Other disorders of adult personality and behaviour
F69	Unspecified disorder of adult personality and behaviour
F70	Mild mental retardation
F71	Moderate mental retardation
F72	Severe mental retardation
F73	Profound mental retardation
F78	Other mental retardation
F79	Unspecified mental retardation
F80	Specific developmental disorders of speech and language
F81	Specific developmental disorders of scholastic skills
F82	Specific developmental disorder of motor function
F83	Mixed specific developmental disorders
F84	Pervasive developmental disorders
F88	Other disorders of psychological development
F89	Unspecified disorder of psychological development
F90	Hyperkinetic disorders
F91	Conduct disorders
F92	Mixed disorders of conduct and emotions
F93	Emotional disorders with onset specific to childhood
F94	Disorders of social functioning with onset specific to childhood and adolescence
F95	Tic disorders
F98	Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99	Mental disorder, not otherwise specified
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G47.0	Disorders initiating and maintaining sleep

G47.1	Disorders excessive somnolence
G47.2	Disorders of the sleep–wake schedule
G47.8	Other sleep disorders
G47.9	Sleep disorder, unspecified
O99.3	Mental disorder nervous system pregnancy and birth
R44.0	Auditory hallucinations
R44.1	Visual hallucinations
R44.2	Other hallucination
R44.3	Hallucinations, unspecified
R44.8	Other/not otherwise specified symptom involving general sensation perception
R45.0	Nervousness
R45.1	Restlessness and agitation
R45.4	Irritability and anger
R48.0	Dyslexia and alexia
R48.1	Agnosia
R48.2	Apraxia
R48.8	Other and unspecified symbolic dysfunctions
Z00.4	General psychiatric examination, not elsewhere classified
Z03.2	Observation for suspected mental and behavioural disorder
Z04.6	General psychiatric examination, requested by authority
Z09.3	Follow-up examination after psychotherapy
Z13.3	Special screening examination for mental and behavioural disorders
Z50.2	Alcohol rehabilitation
Z50.3	Drug rehabilitation
Z54.3	Convalescence following psychotherapy
Z61.9	Negative life event in childhood, unspecified
Z63.1	Problems relationship w parents & in-laws
Z63.8	Other spec problems related to prim support group
Z63.9	Problem related to primary support group, unspecified
Z65.8	Other specified problems related to psychosocial circumstances
Z65.9	Problem related to unspecified psychosocial circumstances
Z71.4	Counselling and surveillance for alcohol use disorder
Z71.5	Counselling and surveillance for drug use disorder
Z76.0	Issue of repeat prescription

Annex D: Electroconvulsive therapy MHIC codes

No. treatments	Unilateral ECT	Bilateral ECT
1	4011.01	4012.01
2	4011.02	4012.02
3	4011.03	4012.03
4	4011.04	4012.04
5	4011.05	4012.05
6	4011.06	4012.06
7	4011.07	4012.07
8	4011.08	4012.08
9	4011.09	4012.09
10	4011.10	4012.10
11	4011.11	4012.11
12	4011.12	4012.12
13	4011.13	4012.13
14	4011.14	4012.14
15	4011.15	4012.15
16	4011.16	4012.16
17	4011.17	4012.17
18	4011.18	4012.18
19	4011.19	4012.19
20	4011.20	4012.20
21	4011.21	4012.21
22	4011.22	4012.22
23	4011.23	4012.23
24	4011.24	4012.24
25	4011.25	4012.25
26	4011.26	4012.26
27	4011.27	4012.27
28	4011.28	4012.28
29	4011.29	4012.29
30	4011.30	4012.30
31	4011.31	4012.31
32	4011.32	4012.32
33	4011.33	4012.33
34	4011.34	4012.34
35	4011.35	4012.35
36	4011.36	4012.36
37	4011.37	4012.37
38	4011.38	4012.38
39	4011.39	4012.39

40	4011.40	4012.40
41	4011.41	4012.41
42	4011.42	4012.42
43	4011.43	4012.43
44	4011.44	4012.44
45	4011.45	4012.45
46	4011.46	4012.46
47	4011.47	4012.47
48	4011.48	4012.48
49	4011.49	4012.49
50	4011.50	4012.50
51	4011.51	4012.51
52	4011.52	4012.52
53	4011.53	4012.53
54	4011.54	4012.54
55	4011.55	4012.55
56	4011.56	4012.56
57	4011.57	4012.57
58	4011.58	4012.58
59	4011.59	4012.59
60	4011.60	4012.60
61	4011.61	4012.61
62	4011.62	4012.62
63	4011.63	4012.63
64	4011.64	4012.64
65	4011.65	4012.65
66	4011.66	4012.66
67	4011.67	4012.67
68	4011.68	4012.68
69	4011.69	4012.69
70	4011.70	4012.70
71	4011.71	4012.71
72	4011.72	4012.72
73	4011.73	4012.73
74	4011.74	4012.74
75	4011.75	4012.75
76	4011.76	4012.76
77	4011.77	4012.77
78	4011.78	4012.78
79	4011.79	4012.79
80	4011.80	4012.80
81	4011.81	4012.81
82	4011.82	4012.82
83	4011.83	4012.83

84	4011.84	4012.84
85	4011.85	4012.85
86	4011.86	4012.86
87	4011.87	4012.87
88	4011.88	4012.88
89	4011.89	4012.89
90	4011.90	4012.90
91	4011.91	4012.91
92	4011.92	4012.92
93	4011.93	4012.93
94	4011.94	4012.94
95	4011.95	4012.95
96	4011.96	4012.96
97	4011.97	4012.97
98	4011.98	4012.98
≥ 99	4011.99	4012.99

Annex E: MHIC 09 Pilot Study Report

Methodology

Survey design and logistics

MHIC pilot study survey instruments

The MHIC 09 pilot study survey instruments, capturing client level data on mental health interventions, were developed for clinicians and clinical coders, each on a single-sided A4 page.

Clinician survey

The clinician survey instrument (Attachment A) was developed for use by clinicians regardless of the mental health service setting in which the intervention was provided. Clinicians were requested to provide a survey response for each service contact (community setting) or patient interaction (admitted/residential setting) that would warrant a dated entry in the clinical record/file of the client/patient/resident.

Clinicians were informed that the scope of the pilot study was aimed at direct service contacts; meaning the client was present during the contact (client participation), with the exception of 'Family/carer-focussed therapy and interventions'. For group sessions, the MHIC 09 survey was to be completed for each client (as a function of the service contact).

Effectiveness ratings for the MHIC 09 protocol were requested for each clinician survey, with a scale ranging from very effective to very ineffective, excluding a neutral response option. The clinician survey was considered complete if no 'significant' intervention was deemed by the participant to have been provided to the client (Question 5). Therefore, the effectiveness rating of the MHIC 09 protocol could not be assessed for these non-significant survey responses.

Due to privacy concerns, the clinician survey instrument did not separately identify individual clinicians, limiting the ability to remove bias resulting from multiple responses from the same clinician(s), for some outcomes.

Coder survey

The clinical coder survey instrument (Attachment B) was developed for coders working in the public or private admitted patient service setting. Clinical coders were requested to use the survey to code each mental health-related separation that occurred during the pilot study time frame. A mental health-related separation was defined as an episode of care for an admitted patient, who was placed under the care of a psychiatric physician and/or team and had a mental health-related principal diagnosis.

Coders were advised that the scope of the pilot study was direct service contacts; meaning the client was present during the contact. For the purpose of the pilot study, coder surveys for same-day patients were requested for every admission.

Coder surveys did not include duration of contact or the client status. Coder surveys also did not have the option to suggest significant interventions not considered covered by the MHIC 09 protocol, however, specific mental health-related ACHI procedure codes were requested.

Feedback survey

Clinician and coder feedback surveys were developed. Participants were encouraged to complete the feedback survey at the end of the trial period, which focused on the experience of the participant with the MHIC 09 protocol. The survey was designed to explore in more detail the specific objectives of the pilot study.

Survey logistics

MHISS members were requested to identify mental health services to participate in the MHIC 09 pilot study. Nominated participating mental health service sites were then contacted by the AIHW to ascertain the number of clinician/coder participants. Once participant figures were confirmed, each site was allocated an individual site number for administrative purposes only. Further attributes of the site were not captured (for example, service target population).

A training and support package for each participant was sent to sites, tailored to the type of participants (coders/clinicians). Each package contained an information brief, MHIC 09 guidelines, MHIC 09 training compact disc data response booklet (included the survey instrument and feedback questionnaire) and an online survey address.

Paper survey booklet distribution

A total of 537 clinician and 10 coder paper survey response booklets were sent to nominated mental health service sites. Paper surveys were sent to for the total number of estimated participating clinicians or coders, regardless if the site had nominated to conduct the survey online.

Online survey option

AIHW staff used a commercial online survey provider (Survey Gizmo) to develop an online version of the survey. Individual online survey addresses were supplied to each participating service site. Apple iPads, with pre-loaded individual links to the online survey, were made available for use by some clinicians at a subset of participating sites.

Jurisdictional source data supply

The option for jurisdictions to supply data direct from their current data collection systems was also made available to jurisdictions. The ACT was the only jurisdiction to agree to this form of data supply, with data provided from its mental health information system. The ACT only supplied data for individual clinicians agreeing to participate in the pilot study.

Ethics approval

Ethics committee approval was sought and granted from the AIHW Ethics Committee that assessed the merits of the application on aspects of the survey design, logistics and information privacy principles. The AIHW is obliged to provide annual updates to the Ethics Committee until the project is considered complete.

Pilot study time frames

To increase the diversity of pilot participants, flexible pilot study time frames were negotiated with participants. Clinical coders were limited to the month of May 2011. Clinician participation was staggered over three periods: 16 May to 27 May 2011, 23 May to
3 June 2011, and 20 June to 1 July 2011.

Pilot study support

MHIC 09 guidelines, including clinician and coder versions, were published and provided to all participants, specifying the variables of the MHIC 09 protocol. An additional training compact disc, including an introduction from the MHISS Chair, was developed to provide further detail to the guidelines and survey booklets. Throughout the trial period a dedicated 1800 support helpline and email address was made available to trial participants by the AIHW.

Results

Pilot study participants

Mental health service sites

A total of 34 mental health service sites participated in the pilot study, with representation from all jurisdictions except the Northern Territory. Participant sites included public and private sector mental health services, in the admitted and community mental health service settings (Figure 2b). Despite considerable effort, the AIHW was unable to secure participation from a residential mental health service. Further feasibility testing of the classification scheme in the residential mental health service setting may therefore be considered warranted before any national implementation of the MHIC 09 protocol.

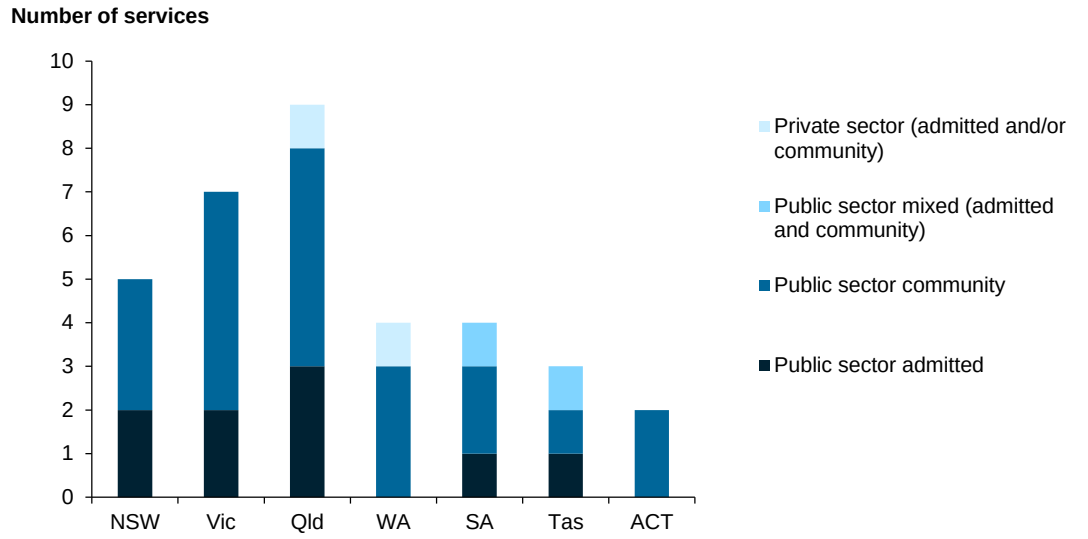


Figure 2b: Number of mental health service pilot study sites, by setting, states and territories

Total surveys collected

A total of 6,084 surveys (Table 2) were completed for the MHIC 09 pilot study, comprising 5,272 clinician and 812 coder survey responses. This exceeded the collection aims of the pilot study (2,660 surveys; see Table 1).

Multiple collection methodologies allowed participants to choose the method that would most suit their individual work arrangements. The online/iPad survey methods provided the added benefit of usable data within a week of the start of trial period, enabling an initial assessment of the feasibility of the MHIC 09 protocol. This method also reduced the data entry burden for the trial coordinators.

Despite the availability of iPads and the online survey methodologies, paper responses (4,716 or 77.5%) were by far the most used survey response mechanism (Table 2). A total of 5,272 clinician surveys were collected, comprising 747 online responses (iPads and online), 3,967 paper responses and an additional 558 responses direct from the Australian Capital Territory jurisdictional information system. For coders, 749 surveys were provided as paper responses with an additional 63 provided via the online survey.

Table 2: Number of surveys, by survey mode, participant type

	Clinicians	Coders	Total	Per cent
Paper	3,967	749	4,716	77.5
Online	202	63	265	4.4
iPad	545	. .	545	9.0
MHAGIC	558	. .	558	9.2
Total	**5,272**	**812**	**6,084**	**100.0**

. . Not applicable.

Clinician surveys

The majority of clinician surveys were from participants working in the public community setting (73.8%, Table 3). The pilot study survey design did not enable the identification of individual participants; therefore, the total number of individual clinicians participating in the study cannot be ascertained.

Table 3: Number of clinician surveys, by setting, states and territories

	NSW	Vic	Qld	WA	SA	Tas	ACT	Missing	Total	Per cent
Admitted	3	160	37	. .	321	52	. .	. .	573	10.9
Community	388	1,213	376	359	930	66	558	. .	3,890	73.8
Residential	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .
Mixed (public sector)	. .	. .	. .	. .	169	5	. .	. .	174	3.3
Private (admitted and/or community)	. .	. .	231	356	. .	. .	. .	. .	587	11.1
Missing	. .	. .	. .	. .	. .	. .	. .	48	48	0.9
Total	**391**	**1,373**	**644**	**715**	**1,420**	**123**	**558**	**48**	**5,272**	**100.0**

. . Not applicable.

Surveys were completed by clinicians representing a wide range of professions. Nurses completed the most surveys (2,089 or 39.6%) (Table 4). Social workers (892 or 16.9%) completed the largest number of surveys among all allied health professional categories. A total of 423 responses (8.0%) did not include the profession of the clinician.

Table 4: Number of clinician surveys, by clinician profession, states and territories

	NSW	Vic	Qld	WA	SA	Tas	ACT	Missing	Total	Per cent
Psychiatrist[(a)]	10	139	58	83	46	15	55	0	406	7.7
Medical officer	0	11	16	1	40	0	24	0	92	1.8
Nurse	142	406	371	471	381	52	266	0	2,089	39.6
Psychologist[(b)]	97	300	62	44	180	20	76	0	779	14.8
Social worker	1	233	68	66	426	0	98	0	892	16.9
Other allied health[(c)]	133	155	57	34	156	0	38	18	591	11.2
Missing	8	129	12	16	191	36	1	30	423	8.0
Total	**391**	**1,373**	**644**	**715**	**1,420**	**123**	**558**	**48**	**5,272**	**100.0**

(a) Includes psychiatrists and psychiatry registrars.

(b) Includes psychologists and neuropsychologists.

(c) Includes mostly occupational therapists.

The duration of the service contact provided by a clinician to a client was reported for 5,205 (98.8%) of all clinician surveys (Table 5). The service contact duration recorded ranged from 1 minute to 12 hours. Contact duration recorded was most commonly between 15 minutes and 3 hours (4,334 or 83.3%). The reported average contact duration was highest for other allied health professionals (76 minutes) and lowest for psychiatrists (44 minutes).

Table 5: Number of clinician surveys, by clinician profession, duration of service contact

	<5 minutes	5–15 minutes	>15–30 minutes	>30–60 minutes	>1 hour–3 hours	>3 hours	Missing	Total	Average contact duration[a]
Psychiatrist[b]	0	81	104	163	52	1	5	406	44
Medical officer	0	2	39	34	9	8	0	92	64
Nurse	29	458	577	573	418	9	25	2,089	47
Psychologist[c]	0	59	132	392	179	5	12	779	60
Social worker	0	81	161	416	217	8	9	892	58
Other allied health[d]	0	42	108	230	175	29	7	591	76
Missing	4	47	72	202	81	8	9	423	56
Total	**33**	**770**	**1,193**	**2,010**	**1,131**	**68**	**67**	**5,272**	**55**

(a) Average contact duration is derived using actual responses from the clinician surveys and therefore cannot be derived from the grouped figures presented in this table.

(b) Includes psychiatrists and psychiatry registrars.

(c) Includes psychologists and neuropsychologists.

(d) Includes mostly occupational therapists.

Coder surveys

A total of 812 survey responses were completed by clinical coders working in the admitted setting (Table 6). The relatively small proportion of surveys for the public sector (26.4%) was mainly due to the limited number of site nominations received for the sector. In addition, one of the participating private hospitals in Western Australia has a substantial same-day separation program, and was therefore able to complete surveys for a large number of mental health-related separations over the trial period. The coder data is therefore not considered a reflective sample of the entire Australian admitted mental health service setting, however, does provide valuable insights into the coder experience with the MHIC 09. Broader feasibility testing may therefore be considered warranted before any national implementation is proposed for the admitted service setting.

Table 6: Number of coder surveys, by sector, states and territories

	Vic	Qld	WA	Total	Per cent
Public sector	36	178	. .	214	26.4
Private sector	. .	. .	598	598	73.6
Total	**36**	**178**	**598**	**812**	**100.0**

. . Not applicable.

Client statistics overview

The majority of surveys (1,705 or 28.0%) were completed for interventions provided to clients less than 15 years old (Table 7). While this is not considered a representative sample of the proportion of interventions

provided to the various age groups nationally, a substantial number of surveys were completed for all client age groups.

Medical staff (186 surveys) most commonly completed surveys for the less than 15 years age group (Table 7). Nurses (563 surveys) completed the most surveys for the 15–24 years client age group and also completed the greatest proportion of surveys for clients aged 15–64. Social workers (23.3%) completed the largest proportion of surveys for the less than 15 years client age group. Psychologists, social workers and other allied health professionals (mostly occupational therapists) provided an increased proportion of surveys for the 65 years and over age group. Coders completed the most number of surveys (184) for the 35–44 years age group and provided the greatest proportion of responses for the 65 years and over age group (27.4%).

Table 7: Number of surveys, by participant type and profession, client age group

	<15 years	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65+ years	Missing	Total
Clinician surveys									
Medical[a]	186	106	47	43	41	16	23	36	498
Nursing	336	563	313	306	295	109	84	83	2,089
Psychologist[b]	362	182	72	64	45	9	22	23	779
Social worker	395	259	43	48	22	6	67	52	892
Other allied health[c]	170	169	56	53	39	9	69	26	591
Missing	244	109	24	14	14	9	3	6	423
Subtotal	*1,693*	*1,388*	*555*	*528*	*456*	*158*	*268*	226	*5,272*
Coder surveys	12	123	121	184	161	108	101	2	812
Total	**1,705**	**1,511**	**676**	**712**	**617**	**266**	**369**	**228**	**6,084**
				Per cent					
Clinician surveys									
Medical[a]	10.9	7.0	7.0	6.0	6.6	6.0	6.2	15.8	8.2
Nursing	19.7	37.3	46.3	43.0	47.8	41.0	22.8	36.4	34.3
Psychologist[b]	21.2	12.0	10.7	9.0	7.3	3.4	6.0	10.1	12.8
Social worker	23.2	17.1	6.4	6.7	3.6	2.3	18.2	22.8	14.7
Other allied health[c]	10.0	11.2	8.3	7.4	6.3	3.4	18.7	11.4	9.7
Missing	14.3	7.2	3.6	2.0	2.3	3.4	0.8	2.6	7.0
Subtotal	*99.3*	*91.9*	*82.1*	*74.2*	*73.9*	*59.4*	*72.6*	*99.1*	*86.7*
Coder surveys	0.7	8.1	17.9	25.8	26.1	40.6	27.4	0.9	13.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Includes psychiatrists, psychiatry registrars and other medical officers.

(b) Includes psychologists and neuropsychologists.

(c) Includes mostly occupational therapists.

Principal diagnosis

A total of 4,671 survey responses (76.8%) included at least one valid mental health-related ICD-10-AM code, as specified by the MHIC 09 guidelines, for the client's principal diagnosis (Table 8). The clinician surveys had a spread of principal diagnosis codes, while coder survey responses were mainly for the ICD-10-AM codes F30–F39 and F40–F49.

The majority of principal diagnosis codes reported by clinicians were for codes F20–F29 (25.1%), F30–F39 (26.9%) and F40–F49 (23.6%). Mood (affective) disorders were the most commonly reported principal diagnosis code reported by both clinicians (26.9%) and coders (61.7%).

Table 8: Number of surveys[a], by principal diagnosis

		Clinicians		Coders		Total	
ICD-10-AM code	Principal diagnosis	Number	Per cent	Number	Per cent	Number	Per cent
F00–F09	Organic, including symptomatic, mental disorders	88	1.9	24	3.0	112	2.4
F10–F19	Mental and behavioural disorders due to psychoactive substance use	349	7.7	225	27.7	574	12.3
F20–F29	Schizophrenia, schizotypal and delusional disorders	1,139	25.1	109	13.4	1,248	26.7
F30–F39	Mood (affective) disorders	1,217	26.9	500	61.7	1,717	36.8
F40–F48	Neurotic, stress-related and somatoform disorders	1,068	23.6	345	42.5	1,413	30.3
F50–F59	Behavioural syndromes associated with physiological disturbances and physical factors	127	2.8	12	1.5	139	3.0
F60–F69	Disorders of adult personality and behaviour	192	4.2	77	9.5	269	5.8
F70–F79	Mental retardation	36	0.8	3	0.4	39	0.8
F80–F89	Disorders of psychological development	171	3.8	1	0.1	172	3.7
F90–F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	519	11.5	21	2.6	540	11.6
F99	Unspecified mental disorder	19	0.4	0	0.0	19	0.4
G codes	Diseases of the nervous system[b]	1	0.0	3	0.4	4	0.1
R codes	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified[c]	17	0.4	5	0.6	22	0.5
Z codes	Factors influencing health status and contact with health services [d]	207	4.6	19	2.3	226	4.8
	Total number of survey responses[a]	**4,530**	**100.0**	**811**	**100.0**	**4,671**	**100.0**

(a) The number and per cent of diagnoses will not sum to the total since a client may have more than one principal diagnosis recorded. Data limited to those survey responses with a principal diagnosis code recorded considered in-scope as defined in footnotes b, c and d, plus all F codes.

(b) Includes codes G30.0, G30.1, G30.8, G30.9, G47.0, G47.1, G47.2 and G47.8 only.

(c) Includes code R44.0, R44.1, R44.2, R44.3, R44.8, R45.0, R45.1, R45.4, R48.0, R48.1, R48.2 and R48.8 only.

(d) Includes codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z50.2, Z50.3, Z54.3, Z61.9, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0 only.

There were a further 158 principal diagnoses codes that were either potentially out of scope as a mental health-related code (108 responses) or were invalid text responses (50 responses) (Table 9). The most commonly reported out-of-scope principal diagnosis codes were Z61.7 (*Personal frightening experience in childhood*) and Z63.7 (*Stressful life events affecting family and household*), each with 10 responses. Importantly, these coded were reported by more than one participant from a number of different pilot sites. The full list of ICD-10-AM codes specified on survey responses considered potentially out of scope as mental health-related codes is in the accompanying Microsoft Excel workbook.

Table 9: ICD-10-AM codes specified as principal diagnosis, not considered in-scope[(a)] for the MHIC 09 pilot study

ICD-10-AM code[(a)]	Principal diagnosis	Number
Z61.7	Personal frightening experience in childhood	10
Z63.7	Stressful life events affecting family and household	10
Z61.0	Loss of love relationship in childhood	9
Z61.6	Problems related to alleged physical abuse of child	9
Z64.3	Seeking and accepting behavioural and psychological interventions known to be hazardous and harmful	8
Z81.8	Family history of other mental and behavioural disorders	8
R45.8	Other symptoms and signs involving emotional state [suicidal ideation]	6
Z62.4	Emotional neglect of child	5
	Other ICD-10-AM codes	43
	Text (non-ICD-10-AM codes)	50
Total		**158**

(a) All reported codes other than all F codes and codes G30.0, G30.1, G30.8, G30.9, G47.0, G47.1, G47.2, G47.8, R44.0, R44.1, R44.2, R44.3, R44.8, R45.0, R45.1, R45.4, R48.0, R48.1, R48.2, R48.8, Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z50.2, Z50.3, Z54.3, Z61.9, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

MHIC 09 code usage

Clinician and coder surveys were able to include one or more significant intervention per client contact/patient separation. Clinicians also had the option to provide text responses for significant interventions not considered covered by the MHIC 09 protocol.

Clinician survey responses

The majority of all clinician surveys (4,925 or 93.4%) recorded one or more significant intervention (Table 10). Of these, the majority (4,419 or 89.7%) were able to describe the intervention using at least one MHIC 09 code, with most (3,901 surveys or 88.3%) exclusively using MHIC 09 codes.

A significant intervention was recorded as not being provided to the client for 6.6% of all clinician survey responses received. However, this is considered an under-representation of the proportion of clinician activity not involving a significant intervention, as some sites indicated that they considered that coding of all activity as per the pilot protocol would be too burdensome for participants. Therefore, this data should not be considered as an accurate estimate of the proportion of non-significant interventions, as defined by the MHIC 09.

Table 10: Number of clinician surveys and interventions, by significant intervention recorded

Significant intervention recorded	Number of surveys	Per cent	Number of significant interventions recorded	Per cent
Yes	*4,925*	*93.4*	*9,401*	*100.0*
MHIC codes only	3,901	74.0	7,291	77.6
Not elsewhere classified only	506	9.6	534	5.7
MHIC codes and not elsewhere classified	518	9.8	1,576	16.8
No	*347*	*6.6*	. .	. .
Total	**5,272**	**100.0**	**9,401**	**100.0**

. . Not applicable

The pilot study data demonstrated that the majority of significant mental health interventions (87.8%) could be described using a MHIC 09 code (Table 11). The proportion of interventions described using a MHIC 09 code varied when the mental health service setting, clinician profession and client age group are considered.

Clinicians providing interventions in the private mental health service setting recorded on average the most number of significant interventions per client contact (2.3) and described the intervention using a MHIC 09 code most often (97.5%) (Table 11). The reasons for this are unclear; however, the MHIC 09 code usage rates may be influenced by the type of work being performed by the individual participants and/or the particular service in which the sample was taken. Note also that the private mental health service setting data includes participants working in both the admitted and community mental health service settings.

Significant interventions not described using a MHIC 09 code were most commonly recorded by clinicians providing interventions in the public community mental health service setting (85.7%). This finding will be explored in greater detail in the 'Significant interventions not classified by MHIC 09' section of this report.

Table 11: Number of clinician surveys with significant intervention recorded, by setting

	Admitted	Community	Mixed[(a)]	Private[(b)]	Missing	Total
Total number of surveys	**556**	**3,593**	**173**	**557**	**46**	**4,925**
Total significant interventions	**1,193**	**6,556**	**281**	**1,306**	**65**	**9,401**
Average interventions per client separation or contact	2.1	1.8	1.6	2.3	1.4	1.9
Significant interventions						
MHIC 09 coded intervention	1,063	5,618	249	1,273	55	8,258
Significant interventions not elsewhere classified	130	938	32	33	10	1,143
Per cent						
MHIC 09 coded intervention	89.1	85.7	88.6	97.5	84.6	87.8
Significant interventions not elsewhere classified	10.9	14.3	11.4	2.5	15.4	12.2

(a) Public sector admitted and community.

(b) Admitted and/or community.

Medical staff and nurses (2.0) recorded the most number of significant interventions per client contact (Table 12). When the occupation of the participant was identified, nurses (89.8%) described interventions using a MHIC 09 code most often, while other allied health professionals (83.0%) (mostly occupational therapists) coded interventions least often.

Table 12: Number of clinician surveys with significant intervention recorded, by clinician profession

	Medical[a]	Nurse	Psychologist[b]	Social worker	Other allied health[c]	Missing	Total
Total number of surveys	**471**	**1,929**	**733**	**843**	**559**	**390**	**4,925**
Total significant interventions	**959**	**3,834**	**1,213**	**1,581**	**1,050**	**764**	**9,401**
Average interventions per client separation or contact	2.0	2.0	1.7	1.9	1.9	2.0	1.9
Significant interventions							
MHIC 09 coded intervention	849	3,444	1,064	1,380	871	650	8,258
Significant intervention not elsewhere classified	110	390	149	201	179	114	1,143
Per cent							
MHIC 09 coded intervention	88.5	89.8	87.7	87.3	83.0	85.1	87.8
Significant intervention not elsewhere classified	11.5	10.2	12.3	12.7	17.0	14.9	12.2

(a) Includes psychiatrists, psychiatry registrars and other medical officers.

(b) Includes psychologists and neuropsychologists.

(c) Includes mostly occupational therapists.

The highest number of significant interventions per client contact was recorded for the age group 55–64 years (2.2 interventions per contact), and these were most likely to be described using a MHIC 09 code (94.4%, Table 13). Interventions provided to the 65+ age group were described using MHIC 09 codes the least (83.1%, Table 13). Interestingly, social workers and other allied health clinicians provided an increased proportion of surveys for this age group (Table 7), and these professional categories were least likely to code interventions using a MHIC 09 code (Table 12). It is unclear whether the work performed by these professional categories, or the types of interventions provided to the 65 years and over client age group, are behind the reduced MHIC 09 code usage.

Table 13: Number of clinician surveys with significant intervention recorded, by client age group

	<15 years	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65+ years	Missing	Total
Total number of surveys	**1,628**	**1,302**	**483**	**483**	**419**	**152**	**252**	**206**	**4,925**
Total significant interventions	**2,930**	**2,685**	**920**	**957**	**774**	**341**	**539**	**255**	**9,401**
Average interventions per client contact	1.8	2.1	1.9	2.0	1.8	2.2	2.1	1.2	1.9
Significant interventions									
MHIC 09 coded intervention	2,565	2,314	822	875	711	322	448	201	8,258
Significant intervention not elsewhere classified	365	371	98	82	63	19	91	54	1,143
Per cent									
MHIC 09 coded intervention	87.5	86.2	89.3	91.4	91.9	94.4	83.1	78.8	87.8
Significant intervention not elsewhere classified	12.5	13.8	10.7	8.6	8.1	5.6	16.9	21.2	12.2

MHIC 09 intervention group

Of the 8,258 interventions described by clinicians with a MHIC 09 code, *Structured psychological therapies* (55.9%) was the most commonly coded intervention group, followed by *Assessment and review* (21.0%) (Table 14).

Table 14: Number of clinician surveys and significant intervention recorded, by MHIC 09 intervention group

	Surveys[(a)]		Interventions	
	Number	Per cent	Number	Per cent
MHIC 09 intervention group				
Assessment and review	1,847	35.0	1,970	21.0
Detoxification from alcohol and other drugs	29	0.6	29	0.3
Structured psychological therapies	3,119	59.2	5,253	55.9
Therapies using agents, not elsewhere classified	21	0.4	21	0.2
Pharmacotherapy review	355	6.7	355	3.8
Pharmacotherapy prescription	620	11.8	620	6.6
Emergency interventions	9	0.2	10	0.1
Significant interventions not elsewhere recorded	1,024	19.4	1,143	12.2
No significant intervention provided	347	6.6	. .	. .
Total	**5,272**	**100.0**	**9,401**	**100.0**

. . Not applicable.

(a) The number and per cent will not sum to the total since each survey may report more than one significant intervention.

The mental health service setting had an impact on the profile of intervention groups reported in the pilot study sample data (Figure 3). Variations were also observed when the MHIC 09 intervention groups are presented by profession (Figure 4) and client age group (Figure 5)

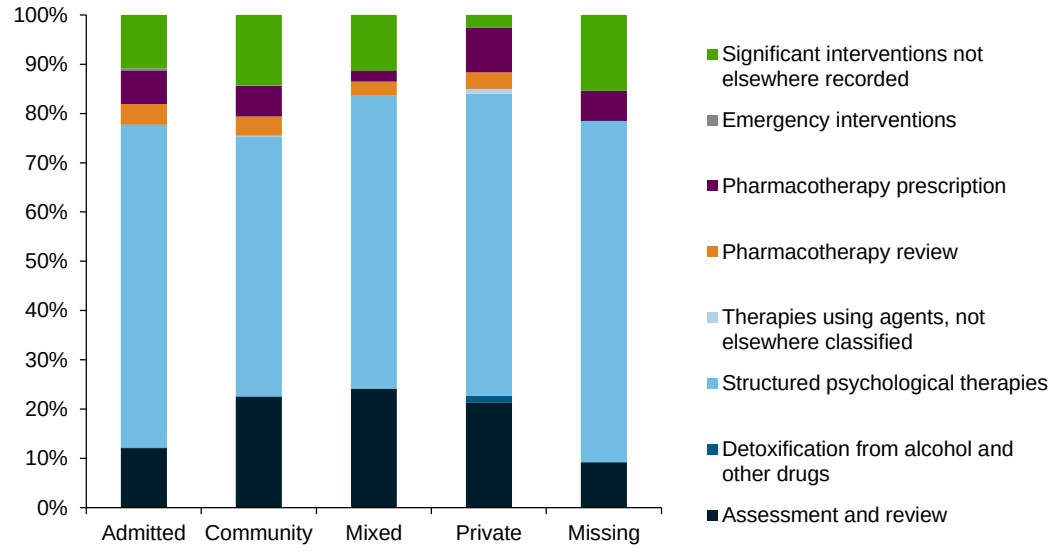


Figure 3: Number of clinician significant interventions, by MHIC 09 intervention group, setting

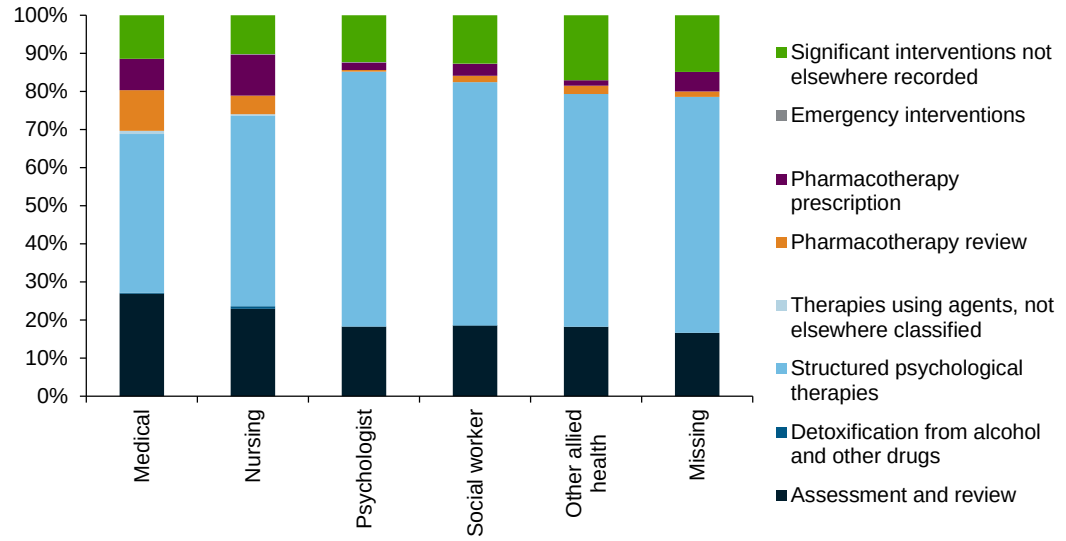


Figure 4: Number of clinician significant interventions, by MHIC 09 intervention group, clinician profession

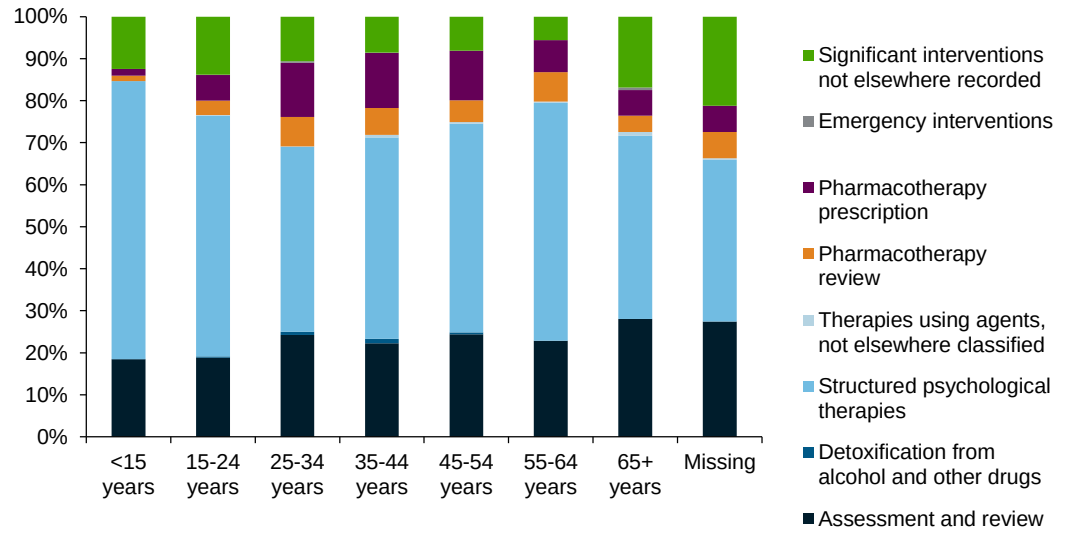


Figure 5: Number of clinician significant interventions, by MHIC 09 intervention group, client age group

Coder survey responses

There were a total of 812 surveys completed by coders, describing 1,207 significant interventions using a MHIC 09 code (Table 15). *Assessment and review* (39.4%) was the most commonly coded intervention group in the coder sample, followed by *Pharmacotherapy prescription* (20.6%). The MHIC intervention group profile for the coder sample was different to the clinician data (Table 14); however, this is not unexpected given the coders only had access to information in a patient file.

For coder data it is important to note that the volume of some interventions is not captured by the MHIC 09. For example, it is unclear if multiple sessions of CBT were reported individually for each separation. This contrasts with data reported by clinicians where each client contact would have been reported separately. The coder data sample therefore potentially underestimates the number of interventions provided in the admitted setting, given uncertainty with the volume component of interventions provided.

A total of 306 coder surveys (37.7%) reported that no significant intervention was recorded or identified in the medical file; that is, the details of any interventions during the episode of care could not be readily identified by the coder. This is considered an over-estimation of the number of mental health-related separations that did not involve a significant intervention, as coders expressed anecdotally their frustration at being unable to locate matching terminology between MHIC 09 codes and the information recorded in the patient file by attending clinicians.

Table 15: Number of coder surveys and significant interventions recorded, by MHIC 09 intervention group

	Surveys		Interventions	
	Total[(a)]	Per cent[(a)]	Total	Per cent
MHIC 09 significant intervention group				
Assessment and review	277	34.1	475	39.4
Detoxification from alcohol and other drugs	24	3.0	25	2.1
Structured psychological therapies	214	26.4	223	18.5
Therapies using agents, not elsewhere classified	78	9.6	78	6.5
Pharmacotherapy review	137	16.9	137	11.4
Pharmacotherapy prescription	249	30.7	249	20.6
Emergency interventions	18	2.2	20	1.7
No significant intervention recorded	306	37.7	. .	. .
Total	**812**	**100.0**	**1,207**	**100.0**

. . Not applicable.

(a) The number and per cent will not sum to the total since each survey may report more than one significant intervention.

Separations coded in the public hospital setting recorded the most number of significant interventions per separation using MHIC 09 codes (3.0 interventions per separation) in contrast with the private setting (0.9 interventions per separation) (Table 16). The difference may be due to the types of separations provided, with much of the private hospital data coming from a single service with a substantial same-day separation program, which may have involved a single intervention type, for example, ECT.

Table 16: Number of coder surveys and significant interventions recorded, by sector

	Public	Private	Total
Total number of surveys	**214**	**598**	**812**
MHIC 09 coded interventions	**645**	**562**	**1,207**
Average intervention per client separation	3.0	0.9	1.5

The proportion of MHIC intervention groups reported by coders differed between the public and private sector (Figure 6), which may be a reflection of the type of interventions being provided by the public acute hospital involved in the pilot trial compared with private hospitals. Comparing the coder data (Figure 6) with the clinician data (Figure 3), coders in the public sector appear to have had particular difficulty identifying terminology associated with *Structured psychological therapies*. However, it is unclear whether

this is a genuine reflection of the intervention group profile within the public hospital admitted mental health service setting. A similar issue was identified in the private hospital data, however, to a lesser extent.

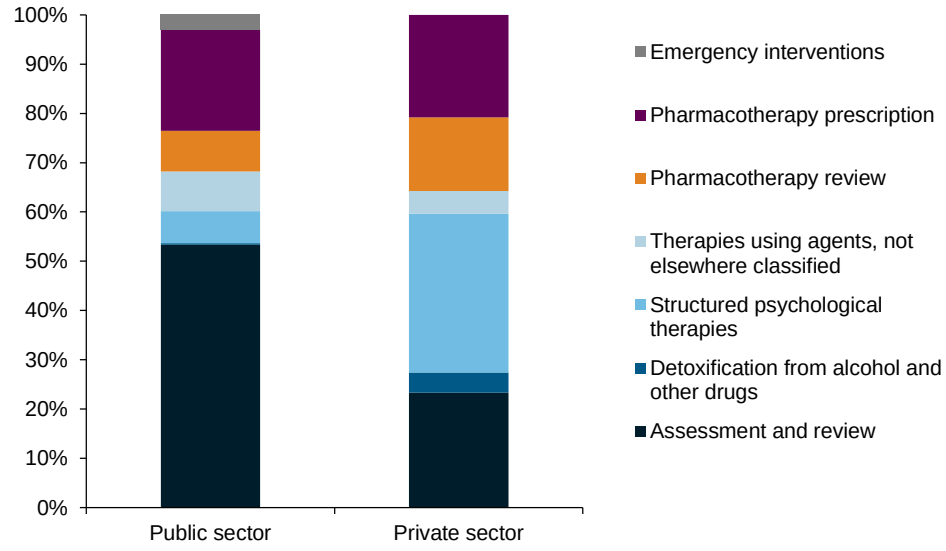


Figure 6: Number of coder significant interventions, by MHIC 09 intervention group, sector

Significant interventions not classified by MHIC 09

Clinician responses

The clinician survey gave the clinicians the option to identify via a free text response any significant interventions they considered were not covered by a MHIC 09 code. A total of 1,143 (12.2%) significant interventions were not considered by clinicians to be adequately described by a MHIC 09 code, with 1,119 further specified on the survey responses. Some of these additional interventions may have been described by a MHIC 09 code as specified in the guidelines (for example, 'risk assessment'). The reason why a clinician did not apply an apparently relevant MHIC 09 code could not be ascertained from the pilot trial data.

The most commonly reported significant interventions not elsewhere classified was *Hospital liaison* (41 interventions) (Table 17), although it should be noted that this response was provided by participants from a single site in the community setting. The full list of responses is in the accompanying Microsoft Excel workbook. The large proportion of 'other' responses (974 interventions) was due to non-matching text responses. Grouping of these responses was beyond the scope of this report; however, if future refinement of the MHIC codes is considered warranted, these responses are likely to be valuable.

Data presented previously shows that other allied health professionals (mostly occupational therapists) were mostly likely to list significant interventions not specified by the MHIC 09 protocol (17.0%, Figure 4). Nurses (10.2%) were the least likely to record additional interventions.

Table 17: Most frequent significant interventions not elsewhere classified

Significant interventions not elsewhere classified	Number	Per cent
Hospital liaison	41	3.7
Mother infant therapy	18	1.6
Motivational Interviewing	17	1.5
Limit setting	14	1.3
Risk assessment	12	1.1
Exercise group/Gym	12	1.1
Supportive psychotherapy	11	1.0
Case conference	10	0.9
Group program	10	0.9
Other	974	87.0
Total[(a)]	**1,119**	**100.0**

(a) Excludes 24 surveys with a significant intervention indicated, however, no further specification was made.

Coder responses

The ability for coders to specify significant interventions not described by a MHIC 09 code was intentionally not part of the coder survey design. However, coders were asked to provide an ACHI code for procedures considered to be mental health-related. The coder guidelines contained a list of ACHI codes considered in-scope, however, some survey responses included ACHI codes considered out-of-scope as defined by the MHIC 09 guidelines. This provides the opportunity to examine ACHI codes deemed by coders to be a valid mental health-related response that could not be described with a MHIC 09 code.

A total of 440 procedures were described using an ACHI code that was considered out of scope for the MHIC 09 pilot study (Table 18). About three-quarters of these did not include any associated MHIC 09 code. The most common out-of-scope ACHI code was *Allied health intervention, other* (248 procedures). Discussions with coders indicate that this is a valid code for mental health-related interventions with insufficient additional information. Procedures described as *Allied health intervention, occupational therapy* (150 responses) were the next most common response. This is consistent with the experience of occupational therapists who responded as clinicians (Figure 4).

Table 18: ACHI codes considered out of scope for the MHIC 09 pilot study

ACHI code	Description	Number
95550-11	Allied health intervention, other	248
95550-02	Allied health intervention, occupational therapy	150
95550-10	Allied health intervention, psychology	20
92514-99	General anaesthesia, ASA 99	7
95550-01	Allied health intervention, social work	5
96027-00	Prescribed/self-selected medication assessment	2
92001-00	Other physiological assessment	1
92515-99	Sedation, ASA 99	1
95550-00	Allied health intervention, dietetics	1
96022-00	Health maintenance or recovery assessment	1
96023-00	Ageing assessment	1
96028-00	Home management assessment	1
96029-00	Financial management assessment	1
96199-04	Intravenous administration of pharmacological agent, antidote	1
Total		**440**

Workload implications

Clinician survey responses

The majority of clinician surveys with a valid response for time taken to complete the survey were completed in 2 minutes or less (2,489 or 75.3%), with an estimated average survey completion time of 7.3 minutes (Table 19). This includes responses from participants using the online/iPad survey methodologies where the time taken to complete the survey was generated automatically by the survey software. Data for the online/iPad surveys may include instances where a survey was started at the beginning of a client contact and not completed until the end of the contact. This is reflected in the higher estimated average response time for iPad surveys (60.1 minutes). This is in contrast to the paper responses (1.1 minutes), where respondents specified the time taken to complete the survey on each individual form. Therefore, the time taken for the online/iPad surveys has been excluded from further analysis of workforce implications.

Table 19: Number of clinician survey responses, by time taken to complete survey, survey mode

	Paper	Online[(a)]	iPad[(a)]	Total
1 minute or less	1,224	136	239	1,599
2 minutes	719	35	136	890
3 minutes	204	7	65	276
4 minutes	54	5	24	83
5 minutes	283	3	15	301
6–10 minutes	63	10	24	97
11–20 minutes	10	1	12	23
Greater than 20 minutes	0	5	30	35
Missing[(b)]	1,410	0	0	1,968
Total	**3,967**	**202**	**545**	**5,272**
Average time per response[(c)] (minutes)	1.1	10.0	60.1	7.3

(a) Time taken to complete these surveys was automatically generated by the software survey.

(b) Includes all responses provided by the ACT's MHAGIC system.

(c) Average survey response time is derived using actual responses from the clinician surveys and therefore cannot be derived from the grouped figures presented in this table.

The time taken to complete a MHIC 09 paper survey was longest for nurses (1.5 minutes) and shortest for other allied health clinicians (0.4 minutes) (Table 20). This average survey response time can be reported as a proportion of the average intervention duration for each clinical profession (data source Table 5). Nurses (3.1%) have the highest proportion of the client intervention spent completing the survey in contrast to other allied health professionals with the least (0.5%).

Table 20: Number of paper clinician surveys, by time taken to complete survey, clinician profession

	Medical[(a)]	Nursing	Psychologist[(b)]	Social worker	Other allied health[(c)]	Missing	Total
1 minute or less	81	405	213	252	125	148	1224
2 minutes	96	234	128	153	68	40	719
3 minutes	16	67	34	46	20	21	204
4 minutes	3	33	3	6	9	0	54
5 minutes	15	137	49	46	8	28	283
6–10 minutes	0	41	11	11	0	0	63
11–20 minutes	0	8	2	0	0	0	10
Missing	157	395	239	221	213	185	1410
Total	**368**	**1320**	**679**	**735**	**443**	**422**	**3967**
Average survey response time[(d)] (minutes)	0.7	1.5	1.1	1.1	0.4	0.6	1.1
Average survey response time as a proportion of contact duration (per cent)	1.4	3.1	1.8	1.9	0.5	1.0	1.9

(a) Includes psychiatrists, psychiatry registrars and other medical officers.

(b) Includes psychologists and neuropsychologists.

(c) Includes mostly occupational therapists.

(d) Average survey time is derived using actual responses from the clinician surveys and therefore cannot be derived from the grouped figures presented in this table.

The average time taken to complete the MHIC 09 survey can be extrapolated across the currently available national mental health activity data to derive an approximate time cost for implementing the collection. In the public community service setting, a response time of 1.1 minutes would roughly equate to about 65 FTE working years for the approximate
6.5 million service contacts reported to the National Community Mental Health Care Database for 2008–09. This figure takes into account the proportion of interventions not considered significant in the sample data (6.6%; Table 14), and assumes a 38-hour 44-week FTE working year.

Coder survey responses

The majority of coder surveys with a valid response for time taken to complete the survey were completed in 2 minutes or less (552 or 73.9%), with an estimated average survey completion time of 2.5 minutes (Table 21). Unlike the clinician response, there was limited difference for the time taken to complete the survey between the paper (2.5 minutes) and online (3.0 minutes) methodologies. This is considered a reflection of the work flow of coders compared with clinicians.

Table 21: Number of coder surveys, by time taken to complete survey, survey mode

	Paper	Online[(a)]	Total
1 minute or less	465	32	497
2 minutes	41	14	55
3 minutes	20	5	25
4 minutes	76	2	78
5 minutes	36	1	37
6–10 minutes	12	5	17
11–20 minutes	24	3	27
Greater than 20 minutes	10	1	11
Missing	65	0	65
Total	**749**	**63**	**812**
Estimated average time per response (minutes)	2.5	3.0	2.5

(a) Time taken to complete these surveys was automatically generated by the software survey.

The average time taken to complete the MHIC 09 survey by coders can be extrapolated across the currently available national mental health separations data to derive an approximate time cost for national implementation of the collection. In the public and private specialised mental health hospital service setting, a response time of 2.5 minutes would roughly equate to about 8.5 FTE working years for the approximate 348,000 mental health-related separations reported to the National Hospital Morbidity Database for 2008–09, assuming a 38-hour 44-week FTE working year. This figure includes ambulatory equivalent separations in the total number of mental health-related separations.

MHIC 09 pilot survey effectiveness ratings

Clinician responses

There were 4,925 clinician survey responses with a significant intervention recorded, of which 4,634 (94%) provided a valid effectiveness rating. The majority of surveys with a valid effectiveness rating (3,219 or 69.5%) rated the MHIC 09 protocol as either effective or very effective (Figure 7). There was variability

among the settings, with the private sector (87.8%) most likely to rate the MHIC 09 protocol as effective or very effective, compared with participants in the public sector (66.7%).

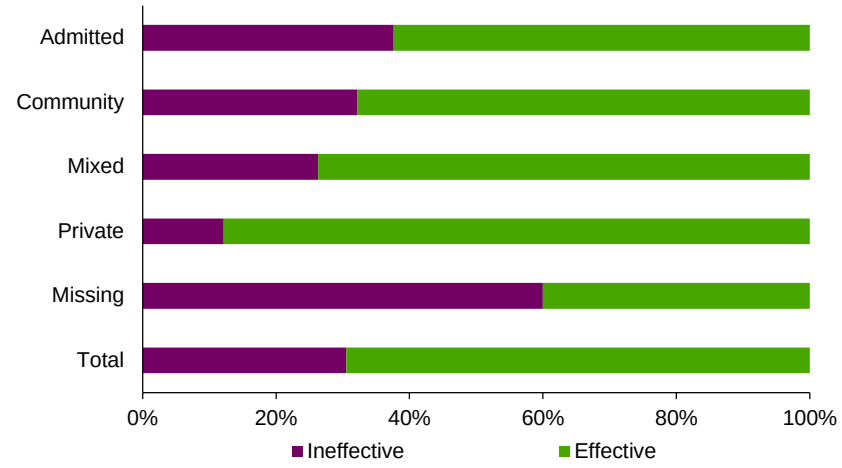


Figure 7: Number of clinician surveys with a significant intervention recorded, by effectiveness rating, setting

Social workers (79.7%) rated the MHIC 09 protocol as effective or very effective most often, while other diagnostic health professionals (59.6%), mostly comprising occupational therapists, rated the protocol as effective or very effective the least often (Figure 8).

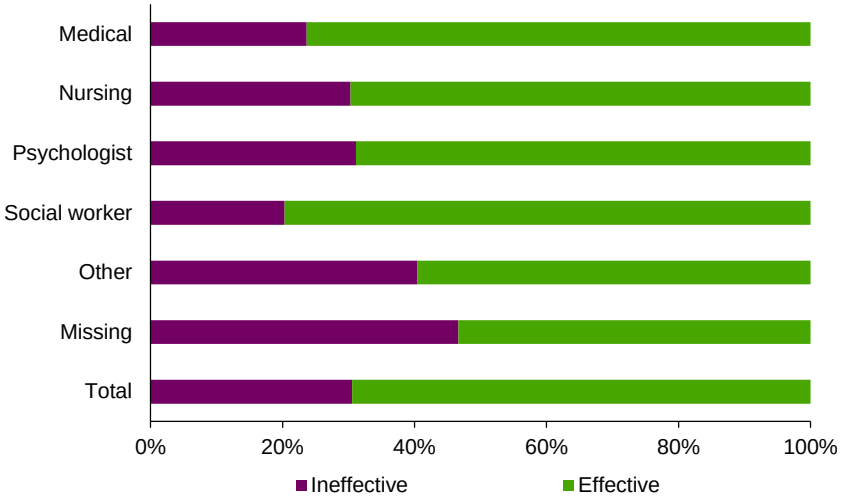


Figure 8: Number of clinician surveys with a significant intervention recorded, by effectiveness rating, clinician profession

Effectiveness ratings were variable when the age group of the client was considered (Figure 9). Effective or very effective response ratings were highest for surveys completed for the 55–64 years age group (83.0%) and lowest for the 65 years and over age group (55.8%).

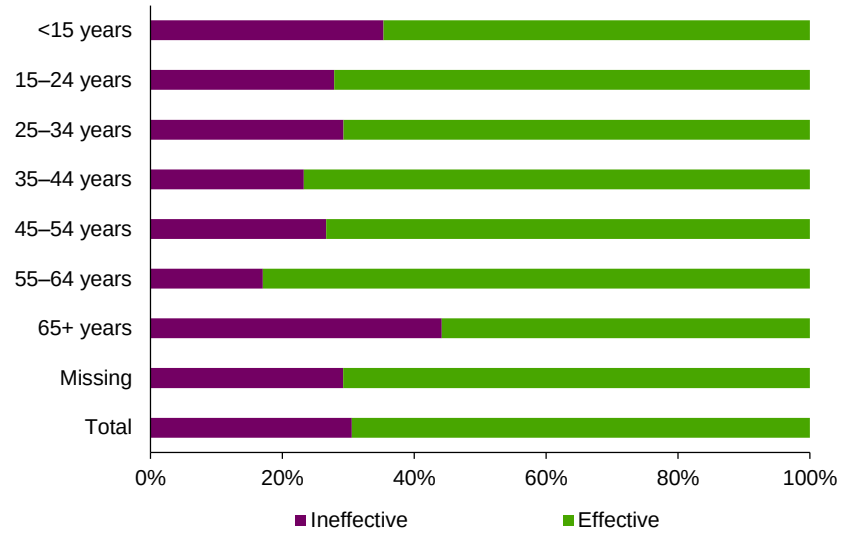


Figure 9: Number of clinician surveys with a significant intervention recorded, by effectiveness rating, client age group

The clinician survey form permitted the survey to be considered complete if the clinician deemed that no significant intervention was provided, thereby excluding the effectiveness rating from being required. Therefore, the pilot study data could not measure the effectiveness of the MHIC 09 protocol to identify only significant interventions.

Coder responses

Coders working in the admitted setting appear to have had a different experience with the MHIC 09 protocol. Many indicated to the AIHW via phone or email that they were having trouble identifying key words in the clinical notes of patients that matched the terminology used in the MHIC 09 documentation. This may have influenced the rates of usage of the MHIC 09 codes during the trial period and the reported effectiveness rating for the protocol. Unlike the clinician survey, effectiveness ratings were captured for the majority of responses when no significant intervention was provided or identified in the patient file. The coder experience with the MHIC 09 protocol appears to be influenced by the ability to identify key words in the patient file that matched MHIC 09 codes, with 80.0% of surveys rated as effective or very effective ratings when a MHIC 09 significant intervention could be assigned (Figure 10).

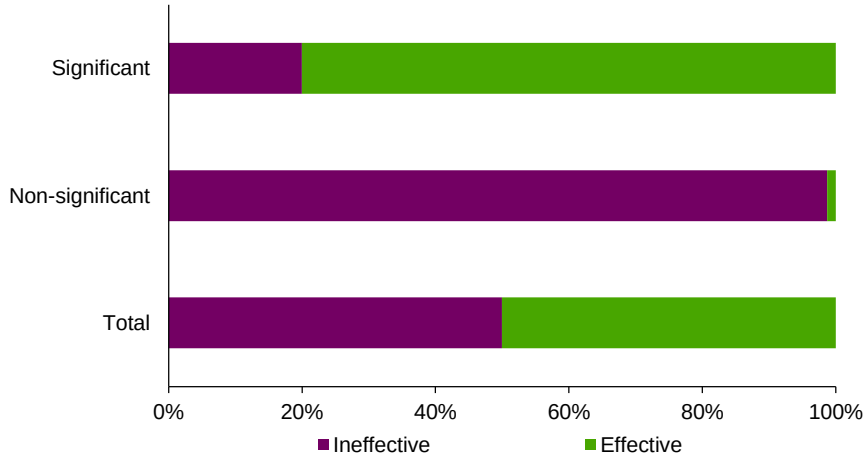


Figure 10: Number of coder surveys, by effectiveness rating, intervention type

To permit comparison with the clinician experience, the following effectiveness ratings are provided using only those coder responses with a significant intervention recorded. The overall effectiveness ratings provided by coders were slightly more positive than the clinician experience, with 80.0% of coder surveys rated as effective or very effective (Figure 11).

Effectiveness ratings were variable when the age group of the client was considered (Figure 11). Effective or very effective response ratings were highest for surveys completed for the less than 15 years age group (100.0%) and lowest for the 55–64 years age group (70.9%). Note, however, that there were only 11 responses for the less than 15 years age group.

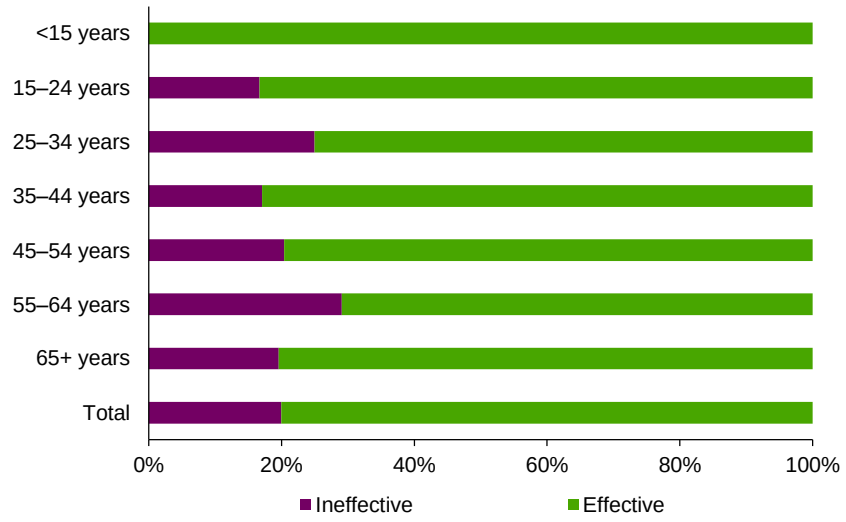


Figure 11: Number of coder surveys with a significant intervention recorded, by effectiveness rating, client age group

Participant feedback survey

As part of the pilot study, all participants were requested to complete a feedback survey at the end of the pilot period. The number of feedback surveys provided by coders (6) was considered too small for in-depth analyses; however, the coder sentiment provided has been incorporated into the discussion section of this report. The following feedback survey results are therefore limited to clinician responses.

Clinician participants

A total of 191 feedback surveys were completed by clinician participants, as summarised in Table 22. Allied health professionals, including psychologists, social workers and other allied health professionals, provided the most number of feedback responses (108 surveys or 56.5%). Due to the relatively small number of clinicians providing feedback surveys, data has been collapsed into a smaller number of professional groups. Note also that the majority of responses were provided by clinicians working in the community service setting (77.0%). Feedback survey analysis by setting is therefore limited to the community setting.

Table 22: Number of clinician feedback surveys, by clinician profession, setting

	Admitted	Community	Mixed[(a)]	Private[(b)]	Missing	Total	Per cent
Psychiatrist[(c)]	2	11	2	1	0	16	8.4
Medical officer	0	4	0	0	0	4	2.1
Nurse	11	33	2	9	1	56	29.3
Psychologist[(d)]	3	37	1	0	0	41	21.5
Social worker	6	39	1	0	0	46	24.1
Other allied health[(e)]	1	20	0	0	0	21	11.0
Missing	0	3	1	0	3	7	3.7
Total	**23**	**147**	**7**	**10**	**4**	**191**	**100.0**
Per cent	12.0	77.0	3.7	5.2	2.1	100.0	. .

. . Not applicable.

(a) Public sector.

(b) Admitted and/or community.

(c) Includes psychiatrists and psychiatry registrars.

(d) Includes psychologists and neuropsychologists.

(e) Includes mostly occupational therapists.

The responses provided for feedback questions described here may have been influenced by the MHIC 09 pilot study survey instrument design and the survey methodology. For example, it is unclear if the pilot study requirement to supply a response for every client contact influenced the assessment provided through the feedback survey. In addition, the profile of respondents may bias the results as it is unclear what proportion of participants provided feedback and if a more negative response to the protocol generated a higher response rate. Therefore, results described should be approached with caution.

Question 1a: The MHIC 09 covers the significant mental health interventions I provide to consumers.

Medical staff (60.0%) were most likely to agree or strongly agree that the MHIC 09 covered the interventions they provided to clients (Figure 12), although, the relatively small number of surveys in this group is noted (20 surveys). Nurses and allied health professionals were roughly equally divided in their opinion. When the service setting of the clinician was considered, there was also a roughly even split between those who agreed or strongly agreed with the proposition and those who did not in the community setting (data not shown).

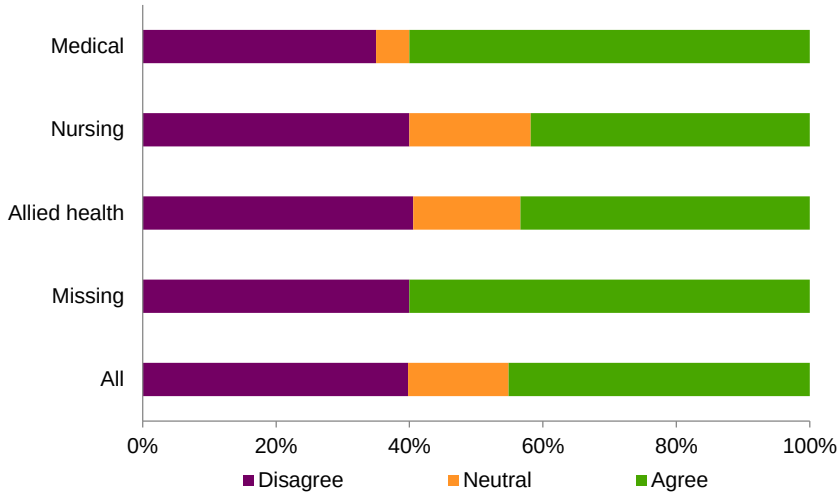


Figure 12: Clinician feedback responses to feedback question 1a, by rating, clinician profession

Question 1b: The descriptions of the significant interventions in the MHIC 09 were clear.

About three-quarters (72.0%) of participants agreed that the descriptions of the significant interventions in the MHIC 09 were clear (Figure 13), with a further 17.6% neutral in their response. Medical staff were most likely to agree that the descriptions were clear (72.0%).

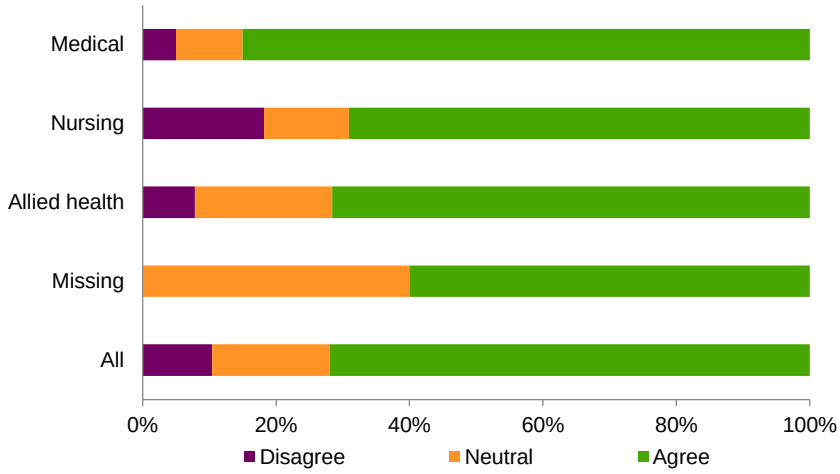


Figure 13: Clinician feedback responses to feedback question 1b, by rating, clinician profession

Question 1c: As a practitioner, I found the MHIC 09 easy to use.

Almost three-quarters (73.5%) of participants agreed or strongly agreed that the MHIC 09 was easy to use, with an additional 18.4% neutral in their response (Figure 14). There was limited variability recorded among the professional groups. A slightly higher proportion of clinicians in the community setting agreed or strongly agreed that the MHIC 09 was easy to use (79.1%) (data not shown).

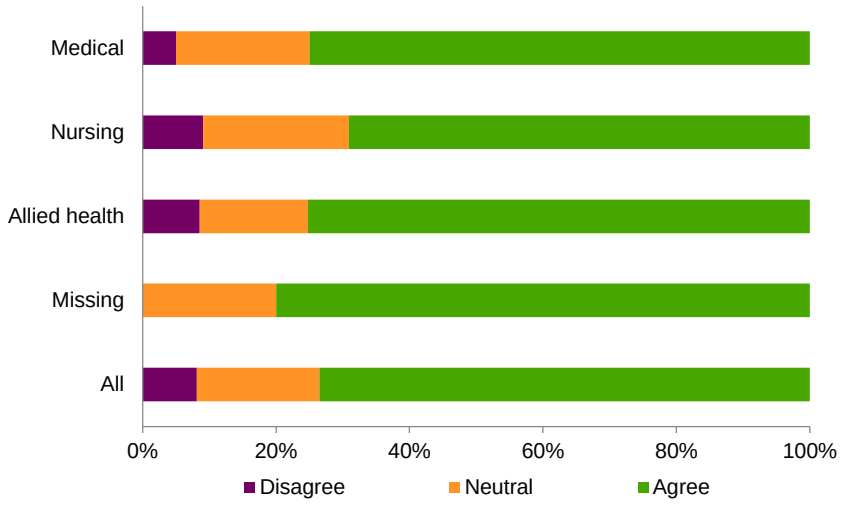


Figure 14: Clinician feedback responses to feedback question 1c, by rating, clinician profession

Question 1d: The data collection required by the MHIC 09 places minimal burden on staff.

Less than half (48.1%) of the respondents agreed or strongly agreed that the MHIC 09 placed minimal burden on staff (Figure 15), with a relatively high neutral response rate (23.2%) across all clinician professional categories. Nurses (45.5%) and allied health professionals (45.7%) were least likely to agree or strongly agree, compared with medical staff (65.0%).

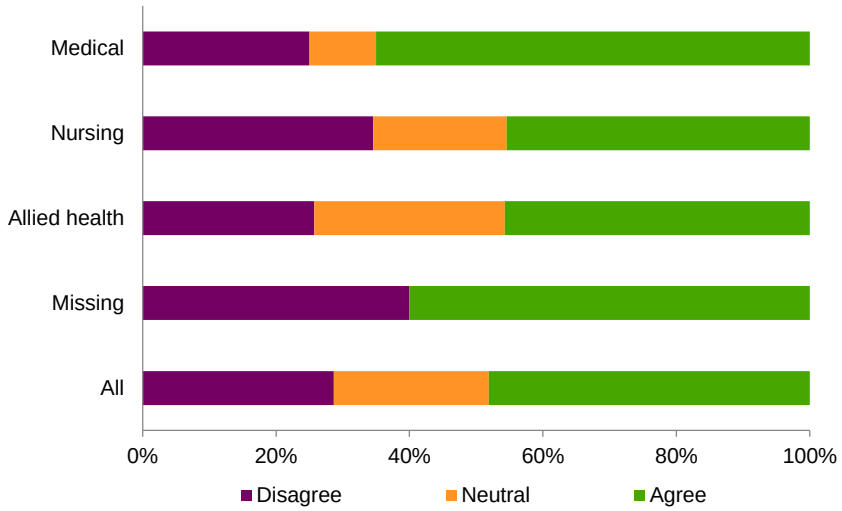


Figure 15: Clinician feedback responses to feedback question 1d, by rating, clinician profession

Question 1e: The MHIC 09 is feasible for use on a routine basis.

Less than half (42.9%) of the respondents agreed or strongly agreed that the MHIC 09 was feasible for use on a routine basis, with a further 19.0% neutral in their response (Figure 16). Nurses (43.6%) disagreed with the proposition the most often.

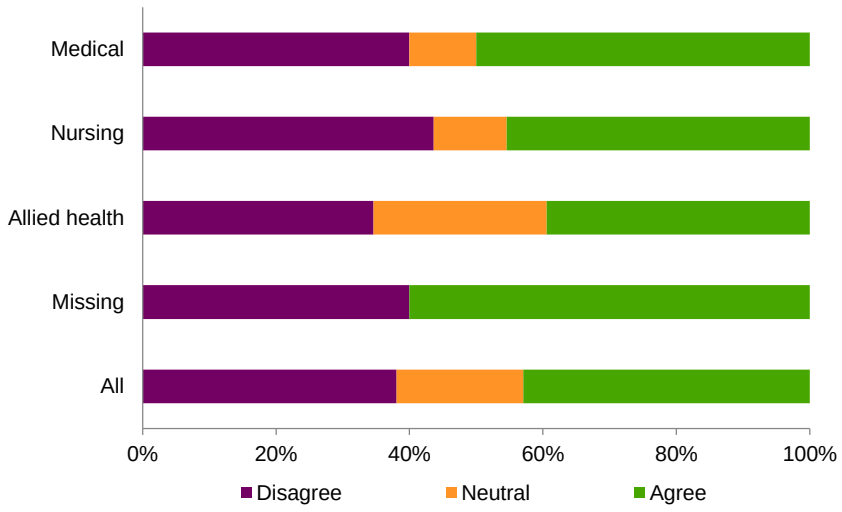


Figure 16: Clinician feedback responses to feedback question 1e, by rating, clinician profession

Question 1f: The MHIC 09 could be used by health providers from different health professions.

Interestingly, when respondents were asked to rate the MHIC 09 from the perspective of other health professions, the majority (58.2%) agreed or strongly agreed the MHIC 09 could be used by others to describe interventions (Figure 17). A further one-quarter (26.1%) were neutral in their response.

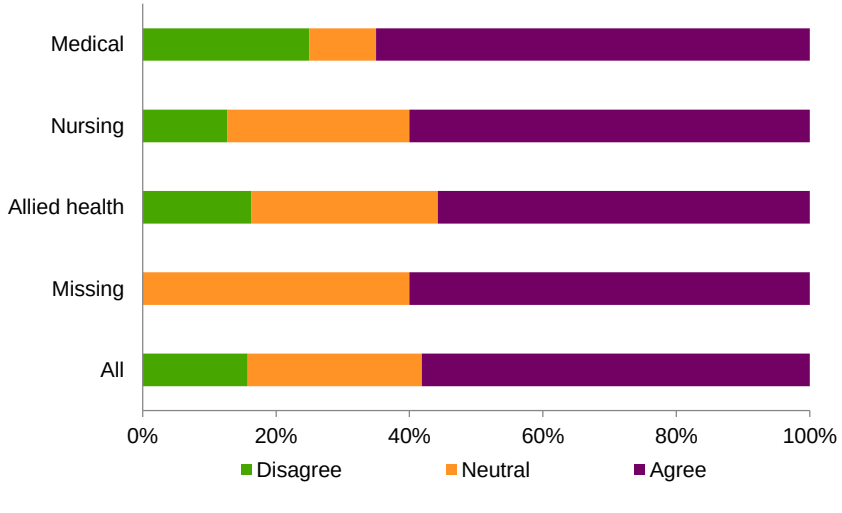


Figure 17: Clinician feedback responses to feedback question 1f, by rating, clinician profession

Question 1g: The MHIC 09 provides a way of consistently describing the significant mental health interventions provided to consumers.

Despite the high rate of coded interventions presented previously (Table 10), clinicians rated the MHIC 09 poorly as a method to describe the significant mental health interventions provided to consumers. Less than half (41.4%) agreed or strongly agreed with the proposition (Figure 18). Nurses (43.4%) disagreed or strongly disagreed most often, which appears inconsistent with the low proportion of significant interventions not considered by nurses to be described by a MHIC 09 code (10.2%) (Table 12).

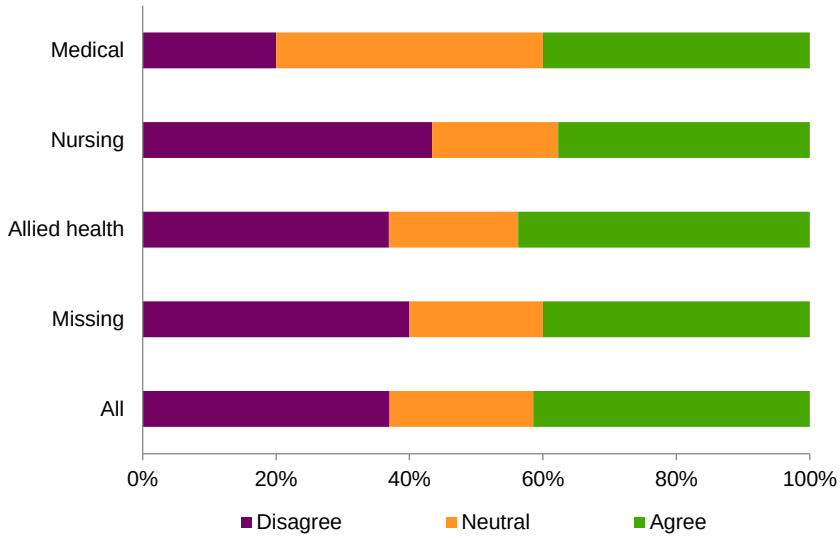


Figure 18: Clinician feedback responses to feedback question 1g, by rating, clinician profession

Question 1h: Overall, the MHIC 09 is suitable in its current form for implementation for national data collection.

Only about one-quarter of all respondents (26.1%) agreed or strongly agreed that the MHIC 09 was ready for national implementation, with an additional one-quarter (23.9%) neutral in their response (Figure 19). Disagreement proportions were similar for nurses (48.1%) and allied health professionals (52.4%). This also appears inconsistent with the ability of all professional groups to code a high proportion of interventions using the MHIC 09 (Table 12).

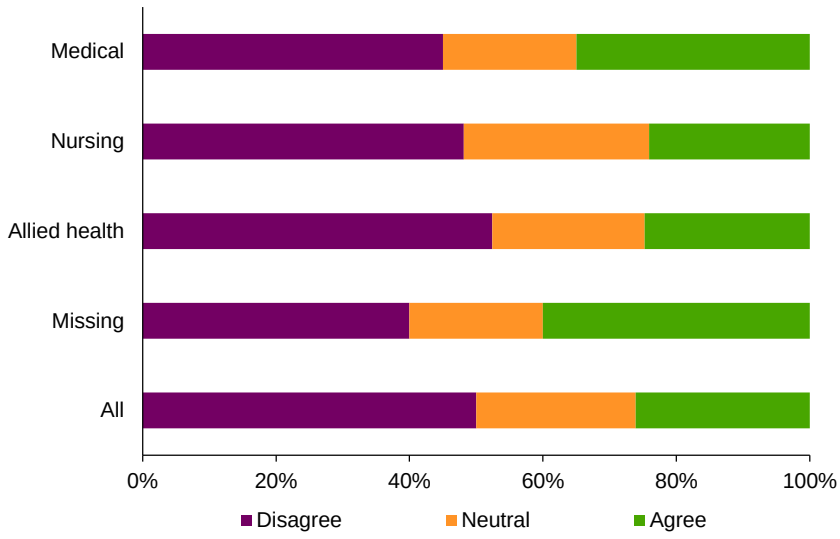


Figure 19: Clinician feedback responses to feedback question 1h, by rating, clinician profession

Question 2a: When locating a code to record interventions, how often did you refer to the MHIC 09 guidelines?

Most participants (79.3%) referred to the MHIC 09 guidelines at least sometimes (Figure 20). Nurses (58.2%) were most likely to report that they often or always referred to the guidelines. This may explain the high proportion of interventions provided by nurses (89.8%) described with a MHIC 09 code (Table 13).

This may also explain that nurses on average required the longest time to complete a survey (1.5 minutes, Table 20).

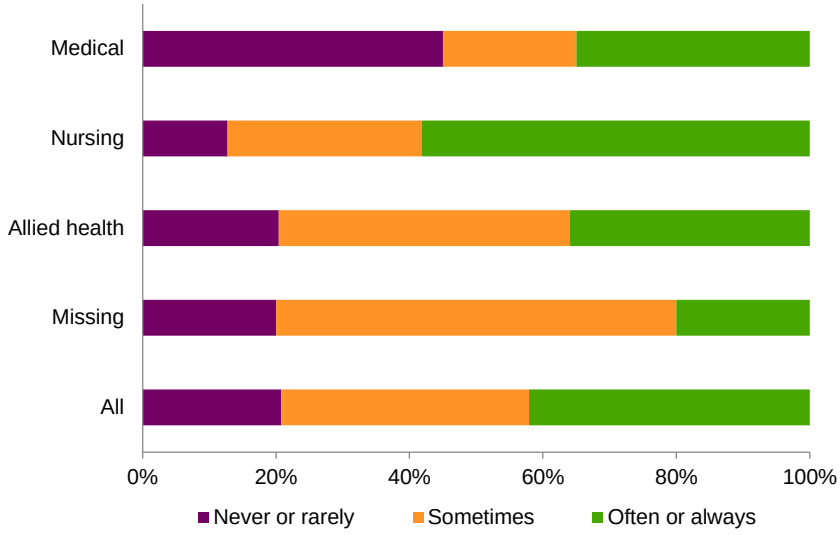


Figure 20: Clinician feedback responses to feedback question 2a, by rating, clinician profession

Question 2b When locating a code to record interventions, how often did you read the intervention descriptions within the MHIC 09 guidelines?

The responses to this question were similar to question 2a, with nurses (47.3%) again most likely to respond that they often or always read the intervention descriptions (Figure 21).

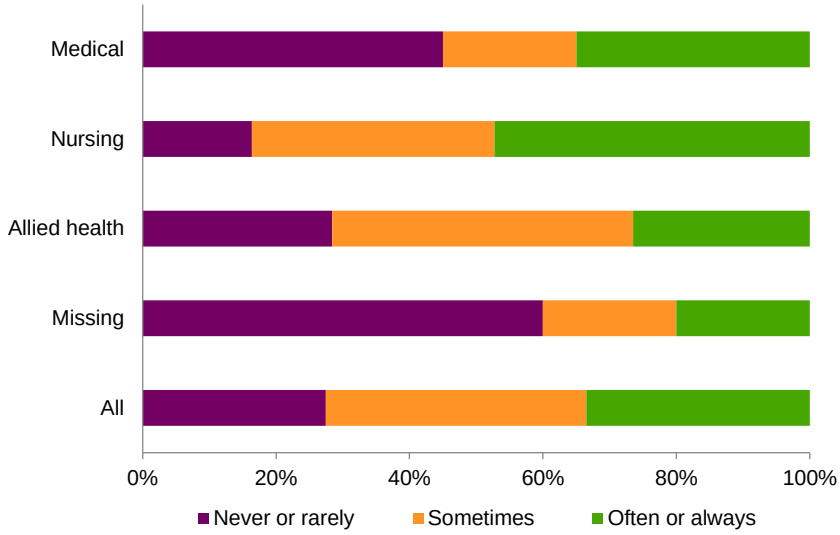


Figure 21: Clinician feedback responses to feedback question 2b, by rating, clinician profession

Question 3: Are there any significant mental health interventions missing from the MHIC 09? Yes, please list.

A diverse range of interventions were listed by clinicians as 'missing' from the MHIC 09 codes, with 253 suggestions. Similar to the client level survey responses, it would appear that some interventions listed could have been described using a MHIC 09 code, which may indicate limited experience with the survey instrument and the guidelines, or that participants may have felt the guidelines descriptions did not describe the actual intervention provided.

The bias towards interventions provided to clients less than 25 years old (52.9%, Table 6), may influence the types of interventions considered by responding clinicians to be missing from the MHIC 09 protocol.

Case conferencing/management/review and so forth was listed by seven participants from various sites and settings. This may be a similar intervention category to *Hospital liaison* (3 responses), *Interagency meetings/planning* (5) *Liaison with other professionals/agencies/services* (10) and *Secondary consultations* (9). In addition, *School visits/meeting* was specified by at least eight participants from different sites and professions. Development of classification codes for this segment of apparently highly valued work may be considered if refinement of
MHIC 09 is deemed warranted.

Most responses for *Attachment theory/therapy*, of which there were eight, were provided by participants from a single service site, however, they were listed by a number of clinicians.

The full list of responses to this question is in the accompanying Microsoft Excel workbook associated with this report. These responses will be a valuable resource if major refinements to the MHIC 09 are considered necessary.

Q4: Were there any positive features in using the MHIC 09 to code significant interventions? Yes, please comment.

There were 76 comments provided regarding use of the MHIC 09. There were about 10 responses that the MHIC 09 was easy to use/understand. The comments provided are considered to be of limited assistance to answer the objectives of the pilot study. However, the comments have been included in the accompanying Microsoft Excel workbook published with this report.

Q5: How could the MHIC 09 be improved?

Participants provided 98 comments suggesting improvements that could be made to the MHIC 09 classifications, with suggestions ranging from generic statements to specific refinements. For example:

- Filling it out for every contact is a lot of work—just to keep it in mind—perhaps summarising the main interventions used per episode of care would capture data but be a lot less annoying.
- Combine this with contact stats so that we don't have to do two sets of paperwork for each client.
- If rolled out to be used full time, training sessions to 'standardise' practitioners' interpretation of the codes would be useful. There is lots of scope to code things in different ways which would make comparing data from different sites difficult.
- Include 'systems intervention', for example, case management and inter-team, intra-team, and inter-agency collaboration and consultation, care planning.
- Capture the extensive consultation and liaison required when providing a service for children and adolescents and their family.
- Develop child and adolescent specific data collection. The adult mental health focus is not appropriate for the child/adolescent setting/way of working.

- Include professions such as 'psychology intervention', 'occupational therapy intervention' and 'social work intervention' as this would eliminate the need for these professionals to find the specific approach they were using which is not comprehensive enough to cover what they offer.
- The 'Group' versus 'Individual' boxes are unclear. Does the group include or exclude the client?
- There is a core, routine function/intervention consistently used by all mental health workers which is not listed/coded, but could usefully be added. It is a supportive contact, but includes MSE, psychoeducation, monitoring sleep, appetite, activities, Mx compliance, EPSE etc. There is no coding for this although elements of it are coded separately, say as psychoeducation. Given its centrality and significance, surely it deserves a separate coding.

If further refinements to the MHIC 09 classification are considered necessary, then these comments will be a valuable starting point. For the purpose of this report, the responses play a limited role in answering the specific objectives of the pilot study, however, the detailed responses are in the accompanying Microsoft Excel workbook.

Q6: Do you have any additional comments about the MHIC 09?

The 69 responses provided by participants varied from survey design comments through to comments about individual MHIC 09 codes. Again, the impact of these responses on measuring the objectives of the pilot study are limited and will therefore not be discussed in detail, however, the responses are in the accompanying Microsoft Excel workbook.

MHISS Expert advisory panel feedback

Additional feedback from the expert advisory panels was presented to MHISS in June 2011 (Agenda Item 24, 2–3 June 2011) and is worth noting in the context of the MHIC 09 pilot feedback.

There were some concerns expressed by the CAMHIDEAP Chair and the Deputy Chair that some of their previously provided recommendations about the MHIC were not reflected in the current version being used in the pilot phase. This particularly related to the intervention work undertaken by CAMHS when the consumer was not actually present, for example, work with schools, education departments, community service department, general practitioners and other. The CAMHS representatives noted that this was significant work and needed to be captured. The pilot study data identified this issue, as detailed in objective 3 above. Additional development work to capture this activity may be considered warranted.

The FMHIDEAP also made a number of comments about the MHIC 09, as it might apply to the forensic mental health service setting. In seclusion and restraint situations, there is substantial 'background' activity that occurs which may not be captured in this classification. Work with inpatients on community re-integration may not be adequately captured, for example, escorting to activities. There was some feeling that the categories and language used was more suited to some disciplines (psychology and medicine) than others (social work, nursing, occupational therapy).

The FMHIDEAP provided two specific recommendations for MHISS:

1. With the implementation of activity-based funding, there will be greater use of the data gathered from initiatives such as the MHIC 09. It is therefore important that the classification is relevant and applicable across all types of mental health services and service settings, including forensic mental health.
2. Recognising that the current classification has been reviewed and condensed from a previously 'granular' approach, there is still a need to capture more details of the different interventions taking place in services.

While a single forensic community mental health service was included in the pilot study, providing about 80 survey responses, the data did not identify an unusually low proportion of interventions coded with a MHIC 09, with 83.6% of interventions coded using MHIC 09. Analysis of the feedback survey responses

supports the position of the FMHIDEAP, with identification of violence/stalking/sexual violence risk assessment as missing interventions. Separate codes were suggested for forensic risk assessment, forensic second opinion, transition management, and offence specific intervention.

Discussion

The results of this comprehensive pilot study of the MHIC 09 classification will be explored in relation to the specific objectives of the pilot study, as specified in the project plan.

Are the MHIC 09 codes broad and transferable (objective 1)?

Are the MHIC 09 codes sufficiently broad and transferable for use in different jurisdictions and mental health settings?

Clinician experiences

The pilot study established that the MHIC 09 protocol could be used to describe the majority (87.8%) of significant interventions provided by clinicians in the public and private sectors, in admitted and community mental health services, by a variety of clinical professions and across the broad spectrum of client demographics.

The proportion of interventions coded using MHIC 09 provided by clinicians in the public admitted and community settings were similar. The relatively high proportion of interventions coded using MHIC 09 by the private sector (97.5%) may be partially explained by the participant profession, with more than 85% of responses in the private sector sample provided by nurses, who describe the highest proportion of interventions using MHIC 09 (89.8%; Table 12). Feasibility testing in the residential mental health service setting may be considered warranted before national implementation.

Interventions provided by other allied health professionals (mostly occupational therapists) were least likely to be coded with a MHIC 09 (83.0%; Table 12), which may indicate that the MHIC 09 has become a more generalist protocol, excluding highly specialised interventions provided by specific segments of the mental health workforce.

The proportion of interventions assigned a MHIC 09 code was related to the effectiveness rating provided by participants. For example, medical officers with a high proportion of MHIC 09 coded interventions (88.5%; Table 12) rated the MHIC 09 survey as effective or very effective most often (71.3%; Figure 7). In contrast, other allied health professionals (mostly occupational therapists) described 83.0% of significant interventions using a MHIC 09 code, and rated the MHIC 09 as effect or very effective least often (58.3%).

Interestingly, nurses described the highest proportion interventions using a MHIC 09 code (89.8%), and referred to the guidelines most often (58.2%; Figure 20). This may indicate that either the interventions provided by nurses are well captured by the MHIC 09 or that experience with the protocol may increase the proportion of coded interventions.

Clinician effectiveness ratings were variable when the age group of the client was considered (Table 13 and Figure 9). Effective or very effective response ratings were highest for surveys completed for the 55–64 years age group (83.0%) and lowest for the 65 years and over age group (55.8%). This could be a reflection of the clinician profile providing interventions to the various age groups. For example, a higher proportion of interventions in the sample data for the 65 years and over age group were provided by social workers and other allied health professionals. These professional categories were less likely to describe the intervention provided using a MHIC 09 code. It is unclear whether the ability to code the intervention, and the impact on the effectiveness rating recorded, was age- or profession-specific.

Coder experiences

Survey data completed by coders demonstrated that MHIC 09 codes could be used to describe interventions provided to admitted patients, with 1,207 MHIC 09 coded interventions identified from 812 separations. The limited amount of public hospital data in the pilot trial suggests that additional feasibility testing may be warranted before any national implementation strategy.

Despite the limited education of the coder workforce before the trial, the coding of interventions in the admitted setting from patient files suggests that the MHIC 09 uses a level of established terminology. However, coders indicated anecdotally throughout the trial period that they had difficulty with the identification of key words in the clinical notes of patients that matched the terminology used in the MHIC 09 documentation. Coders rated the MHIC 09 protocol as effective or very effective most often when a significant intervention could be identified (Figure 10). Implementation planning would need to consider targeted workforce education to facilitate the effective coding of interventions in the admitted hospital service setting.

Summary

The pilot study results suggest that the MHIC 09 codes could be used to describe the majority of significant interventions provided by clinicians from a broad range of professions, to clients/patients of public and private admitted hospital mental health services and community mental health-care services, across a broad range of client demographics. Additional pilot testing of the protocol in the residential service setting may be required if it is intended to extend the intervention classification to that service setting.

Refinements to the MHIC 09 in its current form may be required to capture interventions provided by 'Other diagnostic and health professionals' (mostly occupational therapists), as these were least likely to be described using a MHIC 09 code.

The pilot study also established that the MHIC 09 codes could be assigned by coders in the admitted patient setting using the clinical files of patients with a mental health-related separation. However, anecdotal evidence from coders provided throughout the trial, supports the need for targeted workforce education as part of any national implementation strategy, to improve the identification of mental health interventions by coders.

Does the MHIC 09 adequately describe 'significant' mental health interventions (objective 2)?

Does the MHIC 09 allow for the effective coding and description of the 'significant' mental health interventions being provided to mental health consumers?

Clinician experiences

A total of 4,925 (93.4%) of all clinician survey responses reported one or more significant interventions (Table 10). Of these, 4,419 surveys or 89.7% were able to use at least one MHIC 09 code to describe a significant intervention, with the majority (3,901 surveys or 79.2%) exclusively using MHIC 09 codes. More importantly, MHIC 09 codes were used to describe 87.8% of all significant interventions in the sample data.

Interventions described using MHIC 09 can be reported by intervention groups. Variation in the proportion of interventions in each intervention group was identified in the clinician data, between service settings (Figure 3), clinician profession (Figure 4) and client age group (Figure 5). This data suggests that the MHIC 09 has enough specificity to capture variation in the interventions provided across the mental health sector.

The experience of clinicians, reported via the feedback survey, appear to contradict the apparent high proportion of interventions coded with MHIC 09. About half of the respondents agreed or strongly agreed that the MHIC 09 covered the significant interventions they provided to consumers (Figure 12). This may indicate that the guidelines were not specific enough for clinicians to feel confident that a particular MHIC

09 code was applicable, however, that a 'best-fit' option was chosen for the client level survey response. This is further supported by the relatively poor positive response (41.4%) by clinicians that the MHIC 09 provided a way of consistently describing the significant interventions they provided to consumers (Figure 18). Interestingly, when asked to consider if the MHIC 09 could be used by other health professionals, the responses were more positive (Figure 17).

Throughout the trial, participants engaged with the AIHW via phone and email to clarify the term 'significant intervention'. The use of the word 'significant' may have been viewed by participants as placing a value judgment on the work performed by the clinician, despite the clarification of the term 'significant' in the guidelines. This may be evidenced by the large variety of different interventions deemed by clinicians as significant but not covered by a MHIC 09 code. This may have also influenced the effectiveness ratings reported for the client level surveys and the feedback surveys. Further development of the MHIC may consider changing the term 'significant' a less emotive term, for example 'selected', to maintain the definitional intent and also reduce some of the reported negativity.

Coder experiences

The proportion of MHIC intervention groups in the coder data did not follow a similar proportional profile to the data reported by clinicians in the admitted service setting (figures 6 and 3 respectively). This was particularly evident in the public sector data with coders unable to identify key words associated with the *Structured psychological therapies* interventions. It is unclear whether this is a genuine reflection of the actual separations in the sample data, or that key terms required to identify interventions in this group were not readily used by clinicians in their write-ups and available in the patient files.

The average number of interventions recorded by coders per mental health-related separation was higher for the public sector than the private sector (3.0 and 0.9 respectively; Table 16). Comparing the public coder and public admitted clinician data, the number of coder reported interventions per separation (3.0) was similar to the clinician data (2.1 interventions per contact). This potentially highlights that for coders, the volume aspect of interventions provided in the admitted setting may not have been captured by the MHIC 09 protocol. For example, multiple interventions involving CBT may or may not have been coded individually for the entire admitted separation. A similar issue has been resolved for the ACHI code for ECT, with multiple codes for the volume aspect of ECT. A volume component for interventions occurring in the admitted setting may require additional development before national implementation.

Summary

The MHIC 09 protocol was successfully used by clinicians to describe the majority of all significant mental health interventions and the MHIC 09 intervention codes distinguished differences between interventions provided by clinicians of varying professions working in different mental health service settings. Refinement of the supporting guidelines may be necessary to further specify the intervention descriptions for individual codes.

However, trial participant feedback suggests that the use of the term 'significant' may have been a barrier to the perceived effectiveness of the MHIC 09 to describe mental health interventions. Clinicians appear to have perceived the use of the term as a value judgment on their work, potentially causing undue negative reaction to the classification scheme. It is suggested that consideration be given to substituting the term 'significant' with 'selected' or 'designated' to address the negativity expressed by some participants. In addition, further specification of the terminology used to describe each of the codes in the MHIC 09 guidelines may improve the proportion of interventions classified using MHIC 09.

The pilot study data confirmed that the MHIC 09 protocol in its current form could be used by coders to describe interventions provided in the admitted setting, including the identification of differences in the proportions of intervention groups between service settings. However, the volume of interventions may not have been effectively recorded. For example, a course of CBT within the admitted setting may have only been recorded as a single intervention for the entire separation. This potentially contrasts with the

clinician data where interventions are recorded for each patient contact. The coding of interventions in the admitted setting may require additional conceptual work to address this issue.

Are there 'significant' mental health interventions not classified using MHIC 09 (objective 3)?

Are there 'significant' mental health interventions which cannot be classified using MHIC 09?

Clinician experiences

There were 1,119 interventions specified by clinicians as 'not elsewhere classified' in the survey sample, with a wide range of interventions suggested for potential inclusion in the MHIC. In addition, a further 253 interventions were listed by clinicians in the feedback surveys as interventions 'missing' from the MHIC 09 protocol.

However, the bias of the pilot study clinician data towards the younger client age group, with over half of the surveys completed for clients less than 25 years, may have influenced the perceived missing interventions. The most common recurring theme expressed by clinicians, via the client level survey data and feedback surveys, was regarding secondary consultations/liaison/case conferencing with others. This may be a deliberate design of the protocol, given the consumer focused intent; however, it does support the position of the CAMHIDEAP that provision for this group of highly valued interventions should be considered for inclusion in any refinement of MHIC 09.

The highly specific work of some clinicians may have influenced the interventions deemed not specified by the MHIC 09 protocol. For example, other allied health professionals (mostly occupational therapists) listed interventions not currently covered by the MHIC 09 protocol most often (17.0%; Table 12). This may indicate that the MHIC 09 protocol has become a more generic classification system. This is likely intentional given the long history of the protocol, with the MHIC 09 excluding some highly specific mental health-related interventions in favour of a simpler classification system compared with the more detailed MHIC 06. The development of a non-specific intervention option, for example 'Other intervention not elsewhere specified', may be considered warranted to ensure highly specialised intervention activity is captured. Alternatively, analysis of the missing interventions could inform refinement of the MHIC 09 codes.

Coder experiences

Coders were not required to attempt to describe interventions considered not describe by a MHIC code, however, some surveys were completed with ACHI codes considered out of scope as mental health-related for the MHIC 09 pilot study. Interestingly, coders listed a large number of non-specific ACHI codes for non-specific allied health interventions and interventions provided by occupational therapists. This supports the clinician experience that the development of a non-specific intervention code, may be required.

Summary

Clinicians most commonly reported that interventions involving consultation with others, for example, case conferencing, liaison with other professionals, secondary consultations and so forth, were significant interventions not covered by the MHIC 09 protocol. This may have been influenced by the demographic of the sample data, however, the pilot study data supports the position of CAMHIDEAP that provision for this type of intervention should be included as part of any refinement of MHIC 09.

In addition, the development of a non-specific intervention option, for example 'Other intervention not elsewhere specified', may be considered warranted to capture highly specialised interventions that are

omitted from the MHIC 09 codes. Alternatively, the pilot study data provide the opportunity to examine suggested missing interventions to assist with identifying and defining additional codes for inclusion.

What proportion of clinical activity cannot be allocated a MHIC 09 code (objective 4)?

What proportion of contacts/interventions/separations reviewed were not allocated a MHIC 09 code?

There are two aspects to this objective. Firstly, what proportion of activity was not allocated a MHIC 09 code as it was not significant? Secondly, what proportion of activity was not allocated a code as a MHIC 09 code could not be applied? These two aspects are mixed in the data collected for both clinicians and coders, as discussed below.

Clinician survey responses

A total of 347 surveys (6.6%) responded that no significant intervention was provided (tables 10 and 14). For clinicians, this is considered an under-estimation of the proportion of activity involving a non-significant intervention, as some sites indicated during the trial period that coding all activity would be too burdensome for participants. This is not considered a limitation of the pilot study, however, this data cannot necessarily be used to estimate the amount of activity performed by clinicians that would not be described using the significant intervention approached specified by the MHIC 09.

In addition, the significant interventions listed by clinicians as 'not elsewhere classified' are a mix of three possible scenarios: genuine missing significant interventions, those that could have been described using a MHIC 09 code but for some reason were not, and those that would not be considered significant based on the definition.

Coder surveys

A total of 306 surveys (37.7%) completed by coders responded that no significant intervention was recorded or identified in the medical file. This is considered an over-estimation of the proportion of separations that did not include a significant intervention, given the self-reported inability of coders to identify matching terminology in the patient file for mental health-related separations. Targeted workforce education is likely to reduce the proportion of mental health-related separations without an intervention recorded.

Summary

Almost 7% of clinician activity and 38% of coded mental health-related separations were not considered to include a significant intervention. As described above, there are issues with these estimates that prevent accurate analysis of this objective.

Workload implications for mental health practitioners (objective 5).

What are the time/workload implications for mental health practitioners using MHIC 09?

The average paper survey response time of 1.1 minutes for clinicians was about 2.0% of the average intervention duration. Variation in the average survey completion time was observed between professions, and was directly related to how often the clinician referred to the guidelines when considering the appropriate MHIC 09 code. On average, coders completed a MHIC 09 survey for a mental health-related separation in 2.5 minutes.

As a crude estimate, these results can be used to calculate the number of FTE working years required for an annual national collection of the MHIC 09, for the admitted hospital mental health-related separations and community mental health client contacts, estimated using 2008–09 activity data. The estimated total for

national implementation of the MHIC 09 would be about 73.5 FTE working years, comprising about 65 FTE working years for the community mental health setting and about 8.5 FTE working years for the admitted service setting.

About half of all responding clinicians agreed that the MHIC 09 placed minimal burden on staff (48.1%), with a further one-quarter neutral in their opinion (Figure 15). The reported perceived burden of the collection may have been influenced by the design of the pilot study, rather than a genuine assessment of the MHIC 09 codes themselves. That is, the request to provide a survey for all client contacts may have influenced the reported workload burden. In addition, the proportion of clinician feedback responses indicating the MHIC 09 guidelines were often or always accessed during client survey reporting influenced the perceived workload burden of the collection. Some clinicians also indicated that intervention data was already collected by jurisdictional systems, in effect duplicating workload, which also may have influenced the outcome for this objective.

As with any new classification system, experience with the protocol over time should reduce the need to access the supporting documentation, reducing the workload implications for clinicians and coders.

Summary

Analysis of the balance between the workload costs of implementation compared to the need for the data is beyond the scope of this report; however, the results from the pilot study could be used for more detailed modelling of the national cost of MHIC.

Is MHIC 09 ready for national implementation (objective 6)?

Is MHIC 09 appropriate for national implementation, either in its current form or with minor refinements?

The pilot study sample data indicate a high proportion of significant interventions can be described using the MHIC 09 protocol. Despite this, less than half of the clinician participants who provided feedback survey responses agreed or strongly agreed that the MHIC 09 codes covered the significant mental health interventions they provided to consumers (Figure 12). Further, about one-quarter of clinician participants agreed that the MHIC 09 was ready for national implementation (Figure 19).

Refinements to the MHIC 09 were suggested by participants, ranging from improvement to the guidelines through to addition of codes to capture liaison activities highly valued by CAMHS workers. Additional suggested refinements to the MHIC 09 presented previously, appear to imply a more detailed classification scheme is required. This would imply that the MHIC 09 may not yet achieve the right balance between a more generic classification protocol versus the highly specific nature of the MHIC 06. However, it is unclear whether the participating clinicians were aware of the history of MHIC 06 when suggesting modifications to the MHIC 09 protocol.

The lack of agreement from participants that the protocol is ready for implementation relates to a number of recurring themes.

Firstly, as previously discussed, clinicians disagreed with the term ‘significant’. This appears to be a major obstacle for many clinicians. The suggestion to replace the term ‘significant’ with ‘selected’ may solve much of the opposition to the MHIC 09.

Secondly, respondents indicated that much of the data collected by the MHIC 09 protocol was already collected and suggested that the data be taken directly from existing information systems. Implementation plans would need to consider jurisdictional systems that have been independently developed during the long history of the MHIC project, including mapping between jurisdictional codes and any nationally defined intervention classification scheme. This further emphasises the need for the development of, and jurisdictional agreement to, a nationally consistent intervention classification system.

Finally, comments were made during the trial period that the MHIC 09 protocol in its current form, appeared to have been designed for the vast majority of interactions between a client and clinician that involve one visiting the other, at a particular place and time, for a conventional intervention. Refinement of explicit collection guidelines for direct and indirect client contacts may be considered warranted. For example, data collection rules for direct contacts with multiple clinicians providing an intervention to one or more clients may need consideration. In addition, collection guidelines for indirect service contacts; for example, case conferencing, as identified previously, may also be considered warranted in any refinement of MHIC 09. Improved data collection rules would ensure that innovative models of mental health care are not excluded from the intervention data.

Summary

Notwithstanding respondents' ratings captured in the feedback survey and concerns that the classification in its current form may not be sufficiently refined for national implementation; the merit in taking the MHIC 09 forward is supported by the high proportion of interventions in the pilot study sample data that could be described using a MHIC 09 code. However, the pilot study has identified that refinements of the MHIC 09 could be made to the codes, business rules and guidelines, to improve the usability of the classification scheme.

To summarise, the following suggested refinements have been identified by the MHIC 09 pilot study:

- Improvements to the guidelines through more detailed descriptions of the individual interventions.
- Add codes and/or new group for case conferencing/liaison interventions, to meet the needs of the CAMHS.
- Replace the term 'significant' with an alternate, less emotive, term such as 'selected' or 'designated' to describe the intervention classification.
- Add a generic 'Other intervention not elsewhere specified' code for highly specialised interventions, or, consider new codes to capture the apparently highly specialised work of some allied health professionals, for example, occupational therapists.
- Create strong business rules for data reporting when more than one client and/or clinician is present during the intervention.
- Create a 'volume' aspect to the MHIC codes for interventions provided to admitted patients, due to the possibility of one or more of the same intervention being provided during a single separation. Note that this type of coding concept currently exists for the ACHI coding of ECT.

If major refinements are considered warranted, then additional analysis of the pilot study data could be undertaken to determine additional codes considered by trial participants to be missing from the MHIC 09 classification.

Conclusions

The MHIC 09 pilot study conducted in May 2011 has indicated that a series of refinements could be undertaken to the MHIC 09 improve the usability of its classification scheme. In addition to the identified refinements, implementation challenges, such as clarification of the point of collection, the publication vehicle for the MHIC, jurisdictional collection systems and workforce preparation, would all need to be considered in any implementation plan.

The pilot study has established though that the MHIC 09 can be used to describe the majority of significant mental health interventions provided to clients/patients. The MHIC 09 can also be used to describe the interventions provided by clinicians of different professions, in different mental health service settings, to clients of varying demographics. The pilot study has also identified a number of implementation challenges that would need to be further explored before any nationally mandated collection of mental health interventions using the MHIC 09.

Attachment A: MHIC 09 Clinician survey instrument

Mental Health Intervention Classification (MHIC) 09 - Mental Health Clinicians

1. Age group (Please tick box)

- ☐ <15 years
- ☐ 15–24 years
- ☐ 25–34 years
- ☐ 35–44 years
- ☐ 45–54 years
- ☐ 55–64 years
- ☐ 65+ years

2. Client status (Please tick box)

- ☐ New client
- ☐ Continuing client
- ☐ Final service contact (no appointment made)

3. Principal diagnosis (ICD-10-AM code if known)

(Only report codes listed in Table 3 of the MHIC 09 Guidelines)

_____

4. Duration of contact

_____ mins

5. Was a 'significant' intervention provided? (Please tick box)

☐ Yes continue to question 6 ☐ No (form is complete)

6. MHIC 09 code (Please tick relevant box/es) Group refers to more than one consumer

Code	Significant Intervention			Individual	Group
Assessment and review					
1011	Triage/initial assessment	☐			
1021	Comprehensive mental health assessment	☐			
1031	Rehabilitation assessment	☐			
1041	Physical assessment	☐			
Detoxification from alcohol and other drugs					
2011/2012	Detoxification	☐ Non-medicated	☐ Medicated		
Structured psychological therapies					
3011/3012	Cognitive and/or behavioural therapies			☐	☐
3021/3022	Insight-oriented therapies			☐	☐
3031/3032	Psychoeducation			☐	☐
3041/3042	Couple therapy			☐	☐
3051/3052	Supportive psychotherapy			☐	☐
3061/3062	Skills training			☐	☐
3071/3072	Play therapy			☐	☐
3081/3082	Interpersonal psychotherapy			☐	☐
3091/3092	Narrative therapy			☐	☐
3101/3102	Family/carer-focussed therapy and interventions			☐	☐
Therapies using agents, not elsewhere classified					
4011/4012	Electroconvulsive therapy			☐ Uni.	☐ Bi.
Pharmacotherapy review					
5011	Pharmacotherapy review	☐			
Emergency interventions					
7011	Seclusion	☐			
7021	Physical restraint	☐			
7022/7023	Mechanical restraint	☐ Direct	☐ Indirect		
7031	Rapid sedation	☐			

7. Pharmacotherapy prescription Please include Route (Oral=01, Depot IMI=02, Other=03). For example, oral Alprazolam is N05BA12-01. Please refer to MHIC 09 guidelines for list of ATC names and codes

ATC code(s) (Please write name of medication if code is not listed in MHIC 09)

1. _____ 2. _____ 3. _____

8. Significant interventions not elsewhere classified (not listed in MHIC 09)

1. _____

2. _____

9. How effective was the MHIC 09 in capturing the intervention(s) for this contact (Circle rating)

1	2	3	4
Very ineffective	Ineffective	Effective	Very effective

Approximate time to complete form _____ min(s)

Attachment B: MHIC 09 Clinical coder survey instrument

Mental Health Intervention Classification (MHIC) 09 - Clinical Coders (Admitted)

1. Age group (Please tick box)

☐ <15 years ☐ 25–34 years ☐ 45–54 years ☐ 65+ years

☐ 15–24 years ☐ 35–44 years ☐ 55–64 years

2. ICD-10-AM code(s) if known. (Only report codes listed in Table 3 of the MHIC 09 Guidelines)

1. _____ 2. _____ 3. _____

3. Procedure codes (ACHI code/s) (Only include mental health codes from Chapter 19)

1. _____ 2. _____ 3. _____

4. MHIC 09 code (Please tick box/es) Group refers to more than one consumer

Code	Significant intervention			
Assessment and review				
1011	Triage/initial assessment	☐		
1021	Comprehensive mental health assessment	☐		
1031	Rehabiliation assessment	☐		
1041	Physical assessment	☐		
Detoxification from alcohol and other drugs				
2011/2012	Detoxification	☐ Non-medicated	☐ Medicated	
Structured psychological therapies			Individual	Group
3011/3012	Cognitive and/or behavioural therapies		☐	☐
3021/3022	Insight-oriented therapies		☐	☐
3031/3032	Psychoeducation		☐	☐
3041/3042	Couple therapy		☐	☐
3051/3052	Supportive psychotherapy		☐	☐
3061/3062	Skills training		☐	☐
3071/3072	Play therapy		☐	☐
3081/3082	Interpersonal psychotherapy		☐	☐
3091/3092	Narrative therapy		☐	☐
3101/3102	Family/carer-focussed therapy and interventions		☐	☐
Therapies using agents, not elsewhere classified				
4011/4012	Electroconvulsive therapy		☐ Uni.	☐ Bi.
Pharmacotherapy review				
5011	Pharmacotherapy review	☐		
Emergency interventions				
7011	Seclusion	☐		
7021	Physical restraint	☐		
7022/7023	Mechanical restraint	☐ Direct	☐ Indirect	
7031	Rapid sedation	☐		

5. Pharmacotherapy prescription Please include Route (oral=01, Depot IMI=02, Other=03). For example, oral Alprazolam is N05BA12-01. Please refer to MHIC 09 guidelines for list of ATC names and codes

ATC code(s) (Please only include medications listed in the MHIC 09 guidelines)

1. _____ 2. _____ 3. _____

6. No significant intervention reported or available in medical file ☐

7. How effective was the MHIC 09 in capturing the interventions recorded in this medical file? (Circle rating)

1	2	3	4
Very ineffective	Ineffective	Effective	Very effective

Approximate time to complete form _____ min/s

List of tables

List of figures

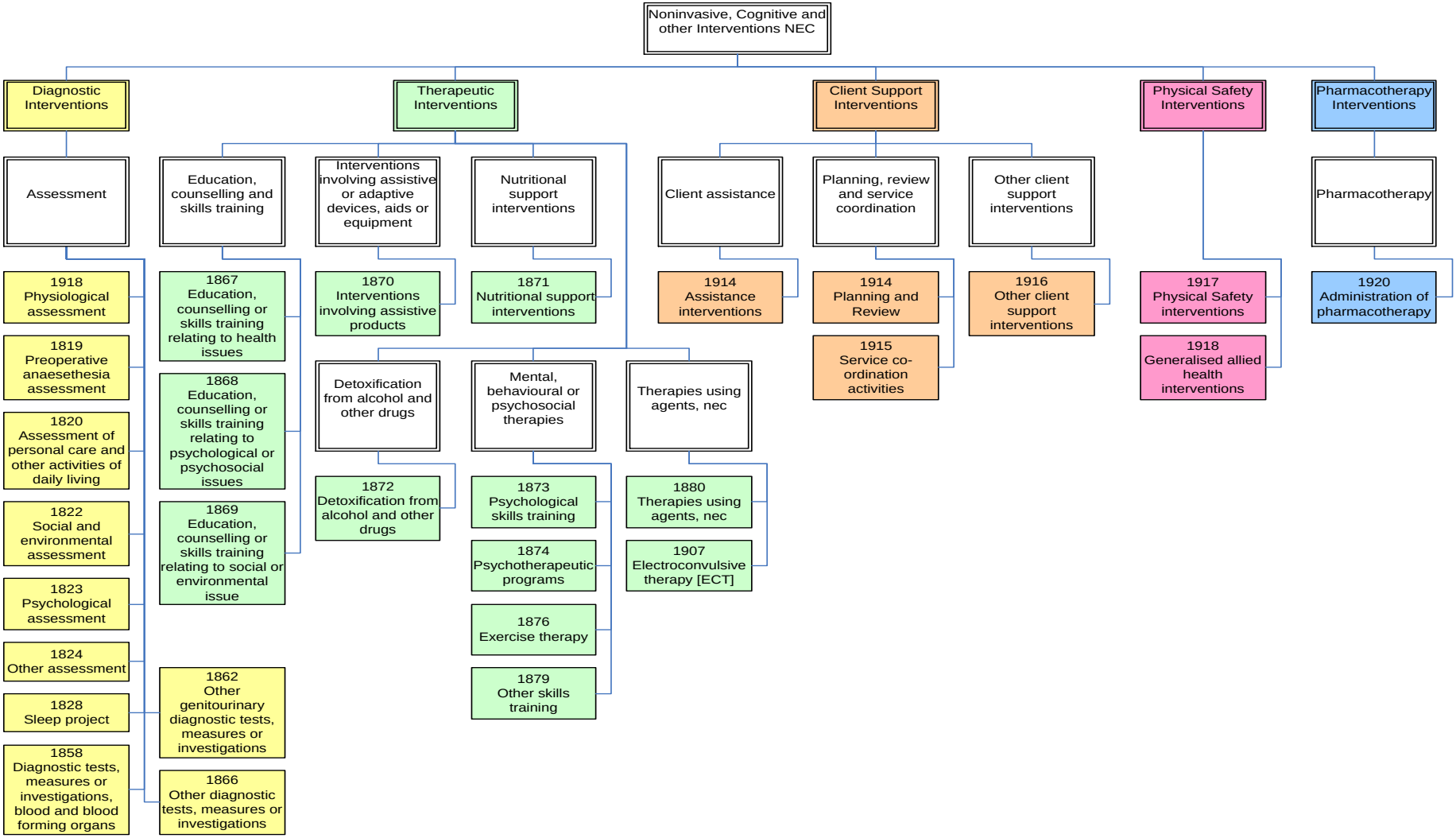
Appendix 1: Mental Health Intervention Classification (MHIC 06)

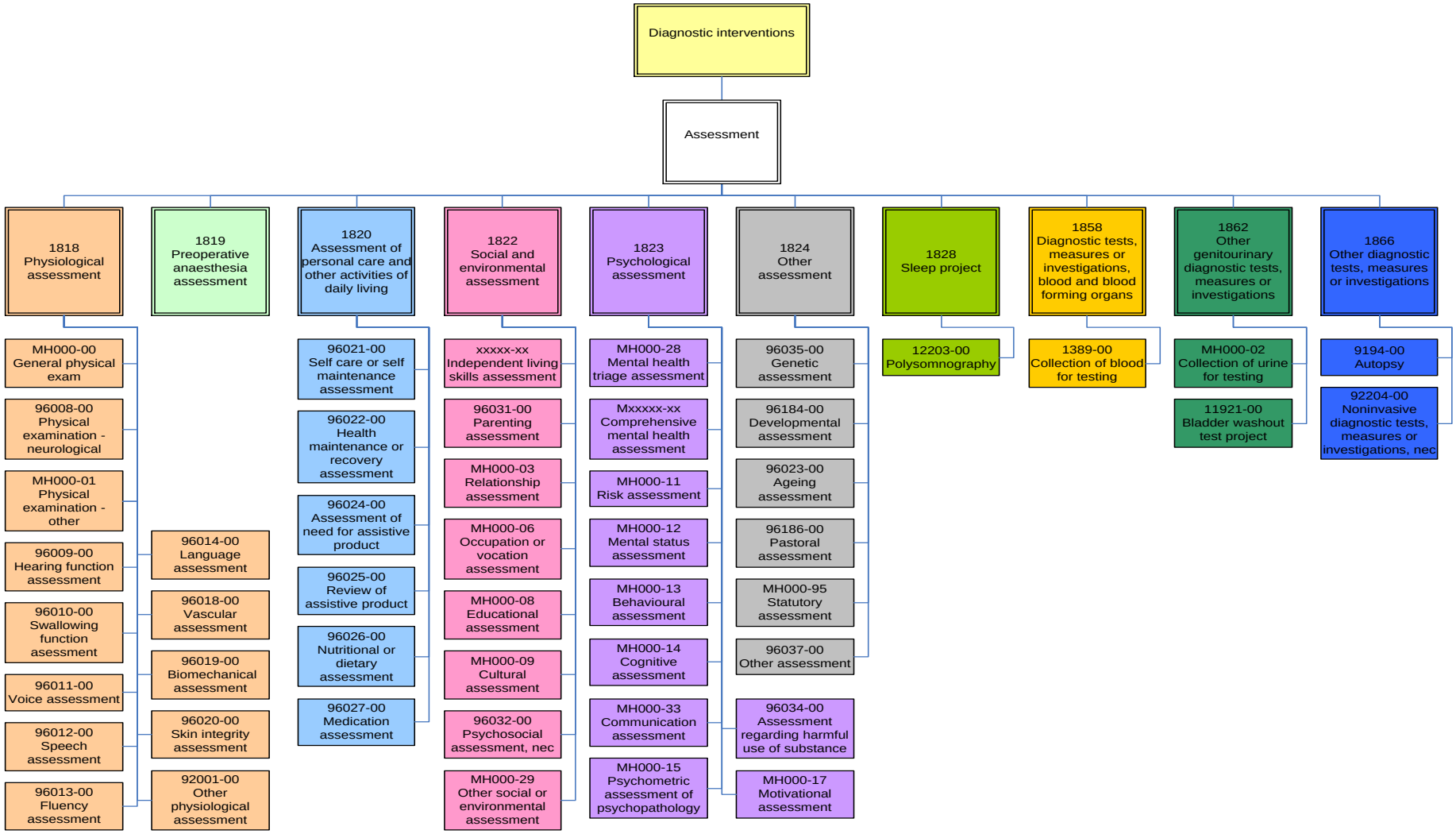
INTRODUCTION

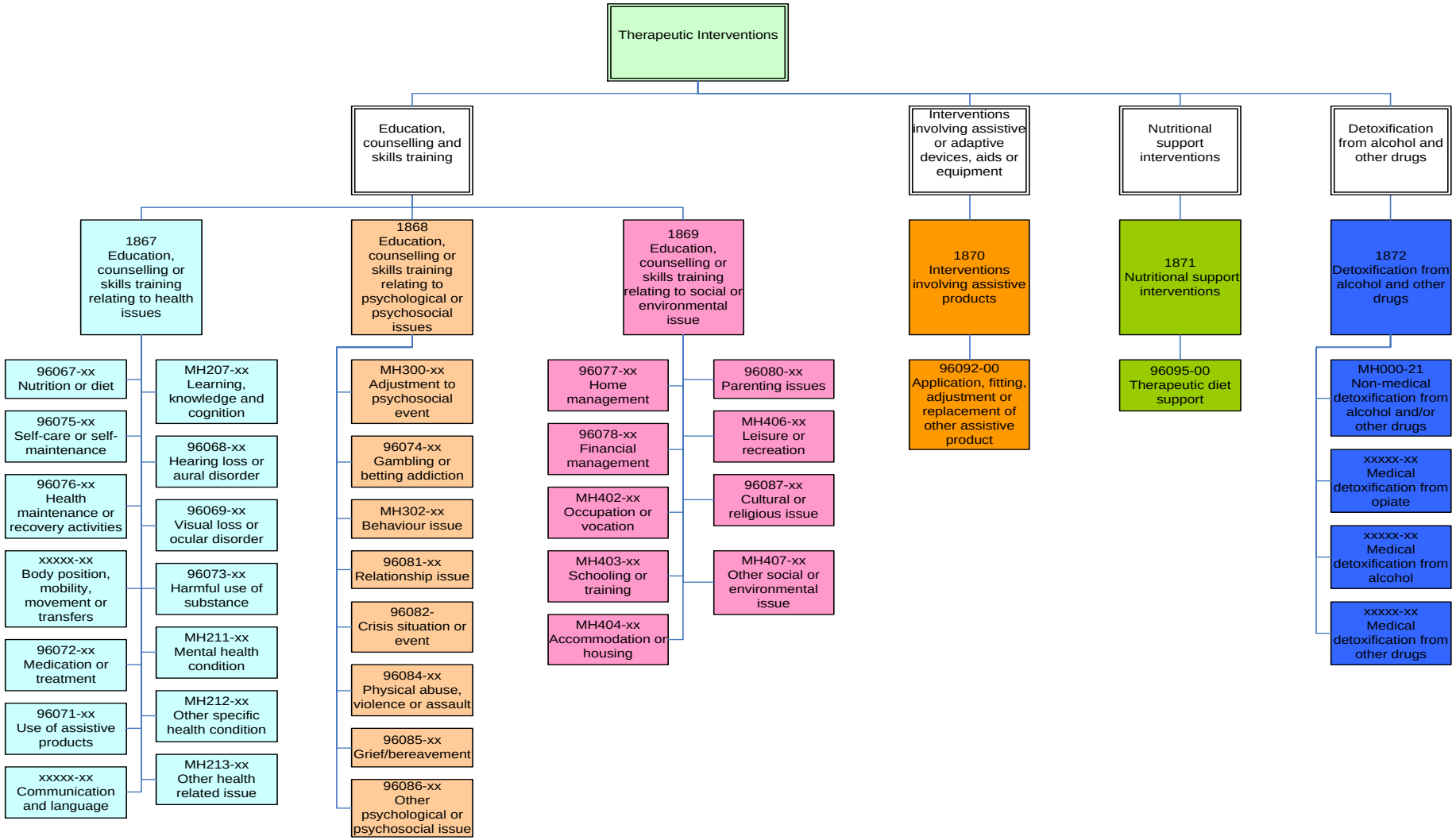
Chapter Four (of the Mental Health Manual) contains selected codes from the Australian Classification of Health Interventions (ACHI) Sixth Edition (July 2008) that describe the majority of interventions provided to consumers of mental health services.

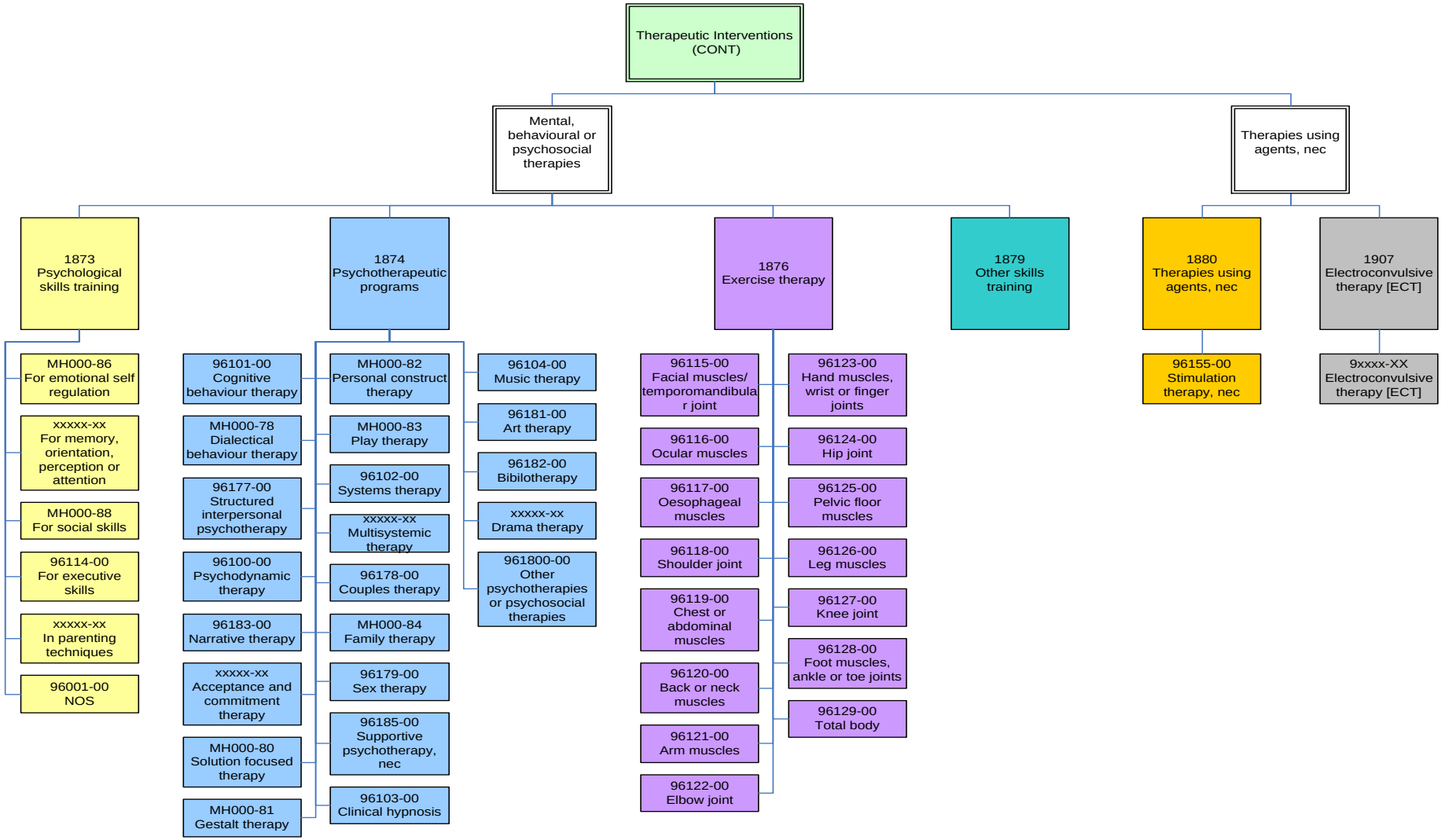
The classification aims to provide codes for a broad range of health care professionals working within the mental health field. Thus the interventions listed are not solely used to treat 'mental health' conditions, but include general interventions that patients within mental health facilities may undergo. This list of codes is not exhaustive and service providers may use interventions that are not contained in this classification. Should this occur, it is suggested that the user refer instead to the parent classification, ACHI, for an appropriate code.

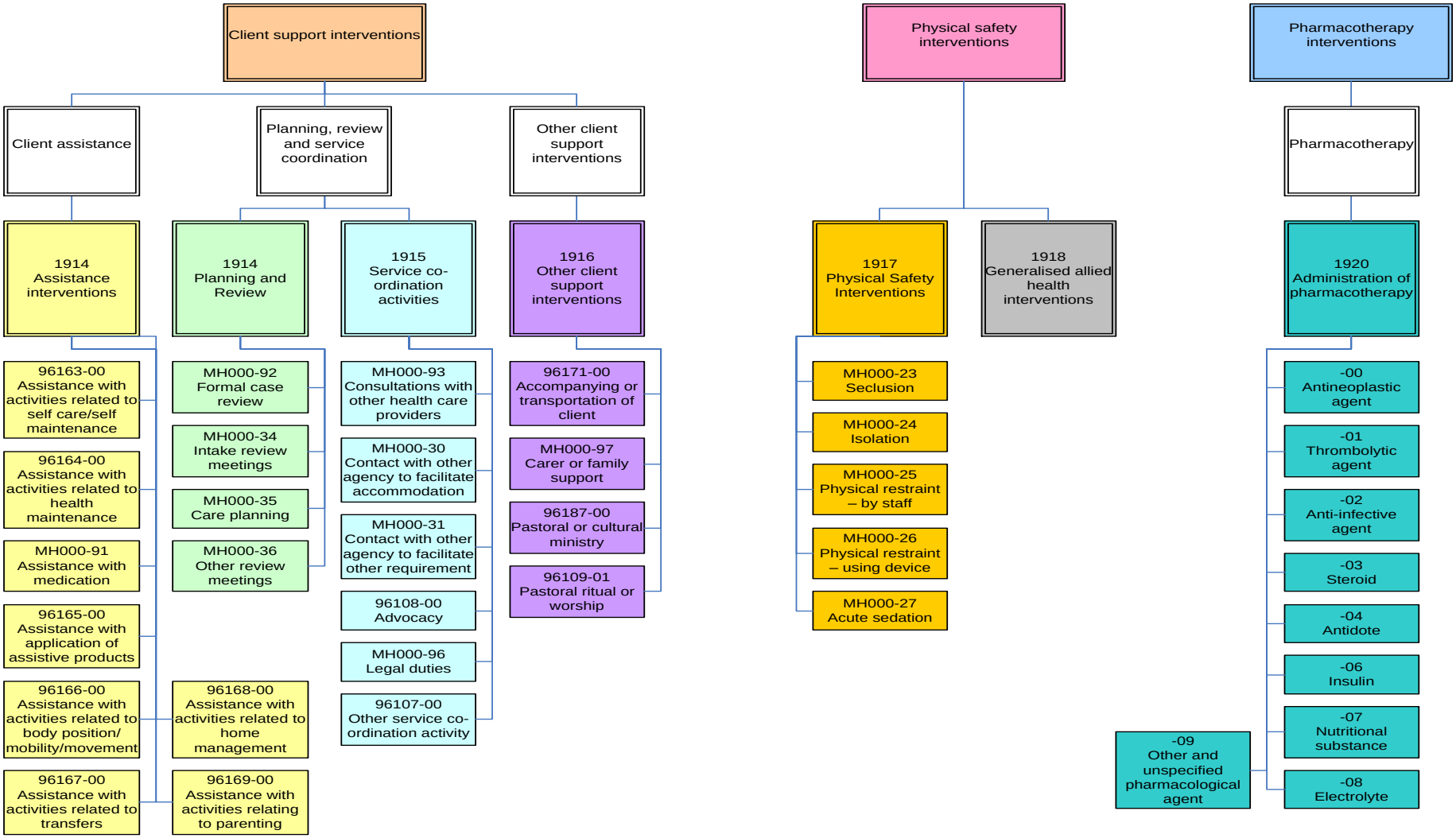
A key principle of procedure classification development is that interventions should be 'provider neutral', that is, the same code should be assigned for a specific intervention regardless of which health professional performs the intervention.


Noninvasive, Cognitive and other Interventions NEC
Diagnostic Interventions
Therapeutic Interventions
Client Support Interventions
Physical Safety Interventions
Pharmacotherapy Interventions
Assessment
Education, counselling and skills training
Interventions involving assistive or adaptive devices, aids or equipment
Nutritional support interventions
Client assistance
Planning, review and service coordination
Other client support interventions
Pharmacotherapy
1918 Physiological assessment
1819 Preoperative anaesthesia assessment
1820 Assessment of personal care and other activities of daily living
1822 Social and environmental assessment
1823 Psychological assessment
1824 Other assessment
1828 Sleep project
1858 Diagnostic tests, measures or investigations, blood and blood forming organs
1867 Education, counselling or skills training relating to health issues
1868 Education, counselling or skills training relating to psychological or psychosocial issues
1869 Education, counselling or skills training relating to social or environmental issue
1862 Other genitourinary diagnostic tests, measures or investigations
1866 Other diagnostic tests, measures or investigations
1870 Interventions involving assistive products
1871 Nutritional support interventions
Detoxification from alcohol and other drugs
Mental, behavioural or psychosocial therapies
Therapies using agents, nec
1872 Detoxification from alcohol and other drugs
1873 Psychological skills training
1874 Psychotherapeutic programs
1876 Exercise therapy
1879 Other skills training
1880 Therapies using agents, nec
1907 Electroconvulsive therapy [ECT]
1914 Assistance interventions
1914 Planning and Review
1915 Service co-ordination activities
1916 Other client support interventions
1917 Physical Safety interventions
1918 Generalised allied health interventions
1920 Administration of pharmacotherapy


Diagnostic interventions
Assessment
1818 Physiological assessment
MH000-00 General physical exam
96008-00 Physical examination - neurological
MH000-01 Physical examination - other
96009-00 Hearing function assessment
96010-00 Swallowing function asessment
96011-00 Voice assessment
96012-00 Speech assessment
96013-00 Fluency assessment
1819 Preoperative anaesthesia assessment
96014-00 Language assessment
96018-00 Vascular assessment
96019-00 Biomechanical assessment
96020-00 Skin integrity assessment
92001-00 Other physiological assessment
1820 Assessment of personal care and other activities of daily living
96021-00 Self care or self maintenance assessment
96022-00 Health maintenance or recovery assessment
96024-00 Assessment of need for assistive product
96025-00 Review of assistive product
96026-00 Nutritional or dietary assessment
96027-00 Medication assessment
1822 Social and environmental assessment
xxxxx-xx Independent living skills assessment
96031-00 Parenting assessment
MH000-03 Relationship assessment
MH000-06 Occupation or vocation assessment
MH000-08 Educational assessment
MH000-09 Cultural assessment
96032-00 Psychosocial assessment, nec
MH000-29 Other social or environmental assessment
1823 Psychological assessment
MH000-28 Mental health triage assessment
Mxxxxx-xx Comprehensive mental health assessment
MH000-11 Risk assessment
MH000-12 Mental status assessment
MH000-13 Behavioural assessment
MH000-14 Cognitive assessment
MH000-33 Communication assessment
MH000-15 Psychometric assessment of psychopathology
1824 Other assessment
96035-00 Genetic assessment
96184-00 Developmental assessment
96023-00 Ageing assessment
96186-00 Pastoral assessment
MH000-95 Statutory assessment
96037-00 Other assessment
96034-00 Assessment regarding harmful use of substance
MH000-17 Motivational assessment
1828 Sleep project
12203-00 Polysomnography
1858 Diagnostic tests, measures or investigations, blood and blood forming organs
1389-00 Collection of blood for testing
1862 Other genitourinary diagnostic tests, measures or investigations
MH000-02 Collection of urine for testing
11921-00 Bladder washout test project
1866 Other diagnostic tests, measures or investigations
9194-00 Autopsy
92204-00 Noninvasive diagnostic tests, measures or investigations, nec


Therapeutic Interventions
Education, counselling and skills training
Interventions involving assistive or adaptive devices, aids or equipment
Nutritional support interventions
Detoxification from alcohol and other drugs
1867 Education, counselling or skills training relating to health issues
1868 Education, counselling or skills training relating to psychological or psychosocial issues
1869 Education, counselling or skills training relating to social or environmental issue
1870 Interventions involving assistive products
1871 Nutritional support interventions
1872 Detoxification from alcohol and other drugs
96067-xx Nutrition or diet
96075-xx Self-care or self-maintenance
96076-xx Health maintenance or recovery activities
xxxxx-xx Body position, mobility, movement or transfers
96072-xx Medication or treatment
96071-xx Use of assistive products
xxxxx-xx Communication and language
MH207-xx Learning, knowledge and cognition
96068-xx Hearing loss or aural disorder
96069-xx Visual loss or ocular disorder
96073-xx Harmful use of substance
MH211-xx Mental health condition
MH212-xx Other specific health condition
MH213-xx Other health related issue
MH300-xx Adjustment to psychosocial event
96074-xx Gambling or betting addiction
MH302-xx Behaviour issue
96081-xx Relationship issue
96082- Crisis situation or event
96084-xx Physical abuse, violence or assault
96085-xx Grief/bereavement
96086-xx Other psychological or psychosocial issue
96077-xx Home management
96078-xx Financial management
MH402-xx Occupation or vocation
MH403-xx Schooling or training
MH404-xx Accommodation or housing
96080-xx Parenting issues
MH406-xx Leisure or recreation
96087-xx Cultural or religious issue
MH407-xx Other social or environmental issue
96092-00 Application, fitting, adjustment or replacement of other assistive product
96095-00 Therapeutic diet support
MH000-21 Non-medical detoxification from alcohol and/or other drugs
xxxxx-xx Medical detoxification from opiate
xxxxx-xx Medical detoxification from alcohol
xxxxx-xx Medical detoxification from other drugs


Therapeutic Interventions (CONT)
Mental, behavioural or psychosocial therapies
Therapies using agents, nec
1873 Psychological skills training
1874 Psychotherapeutic programs
1876 Exercise therapy
1879 Other skills training
1880 Therapies using agents, nec
1907 Electroconvulsive therapy [ECT]
MH000-86 For emotional self regulation
xxxxx-xx For memory, orientation, perception or attention
MH000-88 For social skills
96114-00 For executive skills
xxxxx-xx In parenting techniques
96001-00 NOS
96101-00 Cognitive behaviour therapy
MH000-78 Dialectical behaviour therapy
96177-00 Structured interpersonal psychotherapy
96100-00 Psychodynamic therapy
96183-00 Narrative therapy
xxxxx-xx Acceptance and commitment therapy
MH000-80 Solution focused therapy
MH000-81 Gestalt therapy
MH000-82 Personal construct therapy
MH000-83 Play therapy
96102-00 Systems therapy
xxxxx-xx Multisystemic therapy
96178-00 Couples therapy
MH000-84 Family therapy
96179-00 Sex therapy
96185-00 Supportive psychotherapy, nec
96103-00 Clinical hypnosis
96104-00 Music therapy
96181-00 Art therapy
96182-00 Bibilotherapy
xxxxx-xx Drama therapy
961800-00 Other psychotherapies or psychosocial therapies
96115-00 Facial muscles/ temporomandibular joint
96116-00 Ocular muscles
96117-00 Oesophageal muscles
96118-00 Shoulder joint
96119-00 Chest or abdominal muscles
96120-00 Back or neck muscles
96121-00 Arm muscles
96122-00 Elbow joint
96123-00 Hand muscles, wrist or finger joints
96124-00 Hip joint
96125-00 Pelvic floor muscles
96126-00 Leg muscles
96127-00 Knee joint
96128-00 Foot muscles, ankle or toe joints
96129-00 Total body
96155-00 Stimulation therapy, nec
9xxxx-XX Electroconvulsive therapy [ECT]


Client support interventions
Client assistance
Planning, review and service coordination
Other client support interventions
1914 Assistance interventions
1914 Planning and Review
1915 Service co-ordination activities
1916 Other client support interventions
96163-00 Assistance with activities related to self care/self maintenance
96164-00 Assistance with activities related to health maintenance
MH000-91 Assistance with medication
96165-00 Assistance with application of assistive products
96166-00 Assistance with activities related to body position/ mobility/movement
96167-00 Assistance with activities related to transfers
MH000-92 Formal case review
MH000-34 Intake review meetings
MH000-35 Care planning
MH000-36 Other review meetings
96168-00 Assistance with activities related to home management
96169-00 Assistance with activities relating to parenting
MH000-93 Consultations with other health care providers
MH000-30 Contact with other agency to facilitate accommodation
MH000-31 Contact with other agency to facilitate other requirement
96108-00 Advocacy
MH000-96 Legal duties
96107-00 Other service co-ordination activity
96171-00 Accompanying or transportation of client
MH000-97 Carer or family support
96187-00 Pastoral or cultural ministry
96109-01 Pastoral ritual or worship
Physical safety interventions
1917 Physical Safety Interventions
1918 Generalised allied health interventions
MH000-23 Seclusion
MH000-24 Isolation
MH000-25 Physical restraint – by staff
MH000-26 Physical restraint – using device
MH000-27 Acute sedation
Pharmacotherapy interventions
Pharmacotherapy
1920 Administration of pharmacotherapy
-00 Antineoplastic agent
-01 Thrombolytic agent
-02 Anti-infective agent
-03 Steroid
-04 Antidote
-06 Insulin
-07 Nutritional substance
-08 Electrolyte
-09 Other and unspecified pharmacological agent

Appendix 1: Contents

CHAPTER FOUR

ASSESSMENT

Note: *Assessment* – the gathering, evaluation and recording of information relative to the client's problem, functional status or situation through the use of cognitive skills and simple measurements (eg observation, history taking, anthropometry). Assessment is performed for the purpose of diagnosis, screening, monitoring, follow-up, review, case management or discharge planning.

Excludes: assessments performed as a routine part of other interventions (omit code)

Physical assessment

Physiological assessments

Note: A physiological investigation to assess function using techniques such as history taking, observation, inspection, palpation, percussion, auscultation and other such physical tests.

Excludes: that as part of:

- ageing assessment (96023-00, p.12)
- developmental assessment (96184-00, p.11)
- genetic assessment (96035-00, p.11)

MH000-00 General physical examination

Physical examination NOS

96008-00 Physical examination - neurological

MH000-01 Physical examination – other

96009-00 Hearing function assessment

Excludes: that to determine need for assistive hearing device (96024-00, p.6)

96010-00 Swallowing function assessment

96011-00 Voice assessment

96012-00 Speech assessment

96013-00 Fluency assessment

96014-00 Language assessment

Note: Assessment of communication skills (comprehension, expression, recognition) for spoken / nonspoken and written / nonwritten language

Excludes: communication assessment (MH000-33, p.11)

96019-00 Biomechanical assessment

Balance assessment (with sensory organisation testing)

Mobility/gait analysis

Musculoskeletal evaluation

Posture assessment

Range of movement/muscle testing (without devices or equipment)

96020-00 Skin integrity assessment

Evaluation of:

- general skin integrity
- scar
- skin lesion
- ulcer
- wound

92001-00 Other physiological assessment

Excludes: developmental testing (96184-00, p.11)

Assessment of personal care and other activities of daily living

96021-00 Self-care or self-maintenance assessment

Activities of daily living skills assessment

Assessment of client's ability to care for themselves, including activities such as:

- caring for body parts (teeth, hair, nails etc)
- dressing [clothing]
- eating and drinking
- sleeping
- toileting
- washing oneself

Excludes: assessment of:

- ageing (96023-00, p.12)
- food intake (dietary) (nutritional) (96026-00, p.6)
- health maintenance or recovery (96022-00, p.6)
- home management (xxxxx-xx, p.x)
- leisure or recreaction (xxxxx-xx, *Independent living skills assessment,* p.x)

96022-00 Health maintenance or recovery assessment

Assessment of:

- ability to perform diagnostic testing/monitoring (for conditions such as asthma or diabetes)
- adequacy of access to health services and required treatment
- adjustment to a disease or condition and its clinical and functional implications
- health maintenance activities (eg applying bandages or dressings, foot/leg care, stoma care)
- personal health behaviours (eg regular exercise)
- preventative measures (eg self examination)
- self injection

Excludes: assessment of:

- medication regime or management, including compliance issues (96027-00, p.6)
- personal hygiene related to ability to perform activities of daily living (96021-00, p.6)

96024-00 Assessment of need for assistive product

Measurement for assistive product

Prescription for assistive product

***Note: For explanation of** 'Assistive product' see p.*

96025-00 Review of assistive product

Evaluation of assistive product

***Note:For explanation of** 'Assistive product' see p.*

Excludes: that with fitting, adjustment or repair (96092-00, p.13)

96026-00 Nutritional or dietary assessment

Note: An evaluation of the client's nutritional status to determine if intake meets the metabolic needs of the client or to determine nutritional qualities, composition and effects on health.

Excludes: assessment of client's understanding or ability to undertake own dietary requirements (96021-00, p.x)

96027-00 Medication assessment

Drug monitoring

Medication management assessment

Review of medication(s)

Includes: taking history of medication(s) (all prescribed, over-the-counter, self-selected or complimentary medicines)

provision of medication summary and plan

Note: Medication assessment incorporates a review of a client's current medication regime to determine appropriateness of regime and an assessment of the client's ability to manage medications safely, including compliance issues.

Drug monitoring includes recording/reviewing and interpreting results, detection and management of adverse drug reactions. It does not include advice, education or recommendations on prevention and other aspects of adverse drug reaction management or recommendations about medication regimes.

Excludes: advice or education regarding medication or compliance (MH055-xx, p.xx)

assessment of illicit drug use (96034-00, p.11)

assistance with management of oral medication aids (eg dosette) (MH000-91 pX)

that as part of a comprehensive mental health assessment, (xxxxx-xx, p.x)

Imaging & other tests

Electroencephalography [EEG]

11000-00 Electroencephalography

Central nervous system evoked responses

Includes: that by computerised averaging techniques

Note: *One study* - 1 stimulus at 1 point

Second or subsequent studies - a different stimulus at the same point or another point of stimulation.

11024-00 Investigation of central nervous system evoked responses, 1 or 2 studies

11027-00 Investigation of central nervous system evoked responses, ≥ 3 studies

Sleep study

12203-00 Polysomnography

Polysomnography for investigation of sleep apnoea

Sleep study

Note: Sleep apnoea investigation – involves continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph (polysomnogram), and recordings of EEG, EOG, submental EMG, anterior tibial respiratory movement, airflow, oxygen saturation and ECG

92012-00 Other sleep disorder function tests

Multiple sleep latency test [MSLT]

Pathology tests

13839-00 Collection of blood for testing

Collection of blood for (drug) screening

Blood tests

Monitoring of pharmaceutical levels in blood

MH000-02 Collection of urine for testing

Collection of urine for (drug) screening

Urine tests

Single photon emission CT [SPECT] and Positron emission tomography [PET]

Includes: administration of:

- radioactive tracer
- radioisotope
- radionuclides
- planar imaging

61405-00 Brain study with blood brain barrier agent

Cerebral single photon emission CT [SPECT] with blood brain barrier agent

61402-00 Cerebral perfusion study with single photon emission computerised tomography [SPECT]

Cerebral single photon emission computerised tomography [SPECT]

Excludes: cerebral positron emission tomography [PET] (90905-00, p.8)

- with blood barrier agent (61405-00, p.8)

90905-00 Cerebral positron emission tomography [PET]

Excludes: cerebral single photon emission CT [SPECT] (61402-00, p.8)

- with blood barrier agent (61405-00, p.8)

Computerised tomography [CT] - brain

Computerised tomography of head NOS

56001-00 Computerised tomography of brain

56007-00 Computerised tomography of brain with intravenous contrast medium

Computerised tomography of brain without, then with, intravenous contrast medium

Magnetic resonance imaging [MRI] - brain

90901-00 Magnetic resonance imaging of brain

Excludes: functional magnetic resonance imaging of brain (90901-09, p.8)

90901-09 Functional magnetic resonance imaging of brain

Trans-cranial doppler (TCD)

11614-00 Examination and recording of wave forms of intracranial arterial circulation using transcranial Doppler

Examination and recording of wave forms of carotid or vertebral vessels

Other non-invasive tests or imaging

92204-00 Noninvasive diagnostic tests, measures or investigations, not elsewhere classified

Near infra-red spectroscopy (NIRS)

Social and environmental assessment

xxxxx-xx Independent living skills assessment

Assessment of coping/skills in:

- home management (housekeeping, shopping, etc)
- financial management (budgeting, use of financial services etc)
- physical living circumstances (housing, transport, driving ability etc)
- recreation or leisure activities

96031-00 Parenting assessment

Note: The assessment of parental understanding of their child/ren's developmental stage and associated physical, emotional, cognitive, educational and relationship needs and the capacity to meet these needs. It includes assessment of risk and protective factors and support requirements.

MH00003 Relationship assessment

Assessment of:

- children's peer relationships
- couples
- family
- social network
- social support

Attachment assessment

Note: evaluates the pattern of social, emotional and verbal communication between the parties in the relationship. This may involve an assessment of (1) the number and range of different types of relationships or the extent to which these cover the range of different life domains that are known to benefit from social connections, and (2) regularity of social contact and ease of contact.

MH000-06 Occupation or vocation assessment

Suitability for employment

Employment goals

Access issues

MH000-08 Educational assessment

Assessment of:

- school environment
- scholastic skills
- access issues

MH000-09 Cultural assessment

Assessment of need for cultural services (other than routine)

Identification of cultural issues affecting need for care or services

96032-00 Psychosocial assessment, not elsewhere classified

Note: Psychosocial assessment, evaluation of a client's issue(s) or functioning within the context of their social situation. Includes exploration of psychosocial needs, ability to cope with adversity, strengths, adjustment and personal/situational resources.

Excludes: specific assessments classified elsewhere – see Index: Assessment, by type

MH000-29 Other social or environmental assessment

Psychological assessment

MH000-28 Mental health triage assessment

Intake assessment for mental health

Note: An intervention that involves determining the relative priority and appropriateness of new referrals or re-referrals to a mental health service. It is a usually a brief initial process of evaluation that occurs when contact about a consumer (not currently receiving care from the mental health service) is first made to the service. Intake (mental health triage) enables consumers to be directed appropriately within or outside the mental health service.

Excludes: subsequent detailed assessments performed (see Assessment, by type)

case review or service planning that may follow (see ….)

xxxxx-xx Comprehensive mental health assessment

Note: A multi-component assessment usually conducted when a consumer first enters or is reviewed by the mental health service.

The *ComprehensiveMental Health Aassessment* involves the gathering, evaluation and recording of information relative to the client's problem/s, strengths, functional status or situation and must include (but is not limited to) ALL of the following assessment components:

- mental status assessment (MH000-12, p.x)
- risk assessment (MH000-11, p.x)
- medication assessment (96027-00, px)
- social and environment assessment (p.x – p.x)
- assessment summary and clinical formulation
- development of a further action plan (even if that plan is that no further services are to be provided).

Code also when performed:

- mental health triage assessment (MH000-28, p.x)
- any consequent specialist assessments (see Index: Assessment, by type)
- any one component that occupies the majority of the comprehensive assessment (eg a specific aspect of social assessment) (see Index: Assessment, by type)

MH000-11 Risk assessment

Assessment of risk :

- from others (such as domestic violence, sexual abuse, child protection, HIV exposure, financial exploitation)
- of absconding
- to others (due to violence, aggression)
- to self

Forensic risk assessment

Excludes: that as part of a comprehensive mental health assessment (xxxxx-xx, p.x)

MH000-12 Mental status assessment

Mental state examination (MSE)

Note: Examines a person's mental functions, perceptions, thought, mood and behaviour. This may involve a formal process and testing.

Excludes: that as part of:

- other specific assessment (see Assessment, by type)
- a comprehensive mental health assessment (xxxxx-xx, p.x)

MH000-13 Behavioural assessment

Note: A behavioural assessment may involve a general assessment interview, observation and psychometric testing.

Functional assessment of psychological distress including; behaviours, cognitions, physiological correlates, triggers and moderators.

MH000-14 Cognitive assessment

May include:

- neuropsychological assessment
- psychological/psychometric tests
- specific skill assessment (executive, spatial, etc)
- capacity assessment (testamentary capacity)

Excludes: assessment of cognitive function as part of developmental testing (96184-00, p.11)

MH000-33 Communication assessment

May include assessment of:

- core language skills
- high level language skills
- functional language skills (discourse, narrative and problem solving)
- pragmatic language

Note: *Formal and informal* investigation to assess communication function using techniques such as history taking, checklists, observation and standardised testing

Excludes: assessment of:

- swallowing (96010-00, p.4)
- fluency (96013-00, p.4)
- voice (96011-00, p.4)
- language: phonics, literacy (96014-00, p.5)

developmental assessment (96184-00, p.11)

that as part of other specific assessment (see Assessment, by type)

MH000-15 Psychometric assessment of psychopathology

Note: formal assessment of psychopathology using psychological instruments such as:

- Minnesota Multiphasic Personality Inventory (MMPI)
- Clinical Analysis Questionnaire (CAQ)
- Rorschach inkblot test

Excludes: that as a part of:

- behaviour assessment (MH000-13, p.x)
- cognitive assessment (MH000-14, p.x)

96034-00 Assessment regarding harmful use of substance

Note: Assessment of a client's alcohol and other drug use with a focus on developing a treatment plan to reduce the harm resulting from alcohol or other drug use disorders.

Excludes: medication assessment (96027-00, p.6)

motivational assessment (MH000-17, p.11)

MH000-17 Motivational assessment

Note {to be inserted}

MHxxx-xx Crisis situation/event assessment

Assessment of effect of psychological trauma

Note: A crisis may result from an event such as sudden death, physical assault, violence or abuse, separation or divorce, financial problems, housing problems, a response to major surgery or medical illness, retrenchment from employment or natural disasters such as storm or flood, a new job or promotion, marriage or retirement.

Excludes: that with counselling (96082-xx, p.x)

MHxxx-xx Other psychological assessment

Mental health assessment, not elsewhere classified

Other assessment

96035-00 Genetic assessment

Genetic tracing

Includes: general physical examination

Note: Assessment of a client's genetic history by construction of a genogram.

96184-00 Developmental assessment

Assessments for autism spectrum disorders

Assessment of infant self-regulation

Growth and development examination

Note: Assessment of motor, language, social, adaptive and/or cognitive functioning by standardised developmental instruments.

Excludes: educational assessment MH000-08 (p.x)

96023-00 Ageing assessment

Includes: physiological and psychosocial assessment

Note: An evaluation of a client's ability to cope with the characteristics of the ageing process performed particularly to distinguish the effects of ageing from the effects of pathology in order to determine the most suitable care or treatment for the client.

MH000-95 Statutory assessment

Assessment conducted as it is required under legislation, such as:

- ACAT assessment
- criminal law (forensic assessment)
- Mental Health Act assessment
- Workers Compensation

96037-00 Other assessment

Assessment NOS

Consultation NOS

Evaluation NOS

Interview NOS

PHYSICAL INTERVENTIONS

Electroconvulsive therapy [ECT]

ECT

Includes: consultation

electroencephalographic monitoring

stimulus dosing techniques

injection of muscle relaxant

Note: The following list of extensions is provided for use with code 9xxxx-XX Electroconvulsive therapy [ECT] to denote the number of ECT treatments performed in the episode of care:

-00 Unspecified number of treatments

-01 1 treatment

-02 2 treatments

-03 3 treatments

-04 4 treatments

-05 5 treatments

-06 6 treatments

-07 7 treatments

-08 8 treatments

-09 9 treatments

-10 10 treatments

-11 11 treatments

-12 12 treatments

-13 13 treatments

-14 14 treatments

-15 15 treatments

-16 16 treatments

-17 17 treatments

-18 18 treatments

-19 19 treatments

-20 20 treatments

-21 > 20 treatments

9xxxx-XX Electroconvulsive therapy [ECT]

GA

92514-99 General anaesthesia, ASA 99

General anaesthesia:

- gaseous
- inhalational
- intravenous

Includes: use of artificial airway

Other psychotherapeutic procedures

Light therapy

14050-02 Narrow band ultraviolet B therapy

Narrow band ultraviolet B therapy:

- of whole body

Note: Includes light therapy as a treatment for Seasonal Affective Disorder.

Detoxification

Includes: administration of medications used to control withdrawal symptoms

observation

supportive care

Note: *Medical detoxification* – aims to lessen the severity of withdrawal symptoms (such as shaking, nausea and vomiting, cramping, seizures, anxiety etc) by weaning the body from the addictive substance and simultaneously providing relief from the symptoms. In cases of severe withdrawal, other drugs similar to the addictive substance are also administered in tapering amounts to slowly wean the body from the addictive substance over time.

Non-medical detoxification – process which involves going "cold turkey" to rid the body of the addictive substance.

Code also when performed:

- counselling for harmful use of substance (MH000-01)
- therapy (see Index: Therapy, by type)

MH000-21 Non-medical detoxification from alcohol and/or other drugs

Withdrawal from alcohol or drug NOS

xxxxx-xx Medical detoxification from opiate

Withdrawal from drugs such as:

- codeine
- heroin
- methadone
- morphine
- oxycontin

xxxxx-xx Medical detoxification from alcohol

xxxxx-xx Medical detoxification from other drugs

Withdrawal from drugs such as: {to be inserted}

Administration of medication

Excludes: Medication given for acute sedation for patient safety (see *Physical safety interventions*, p.17)

Administration of antidepressant

96203-10 Oral…….antidepressant

96206-10 Unspecified route.....antidepressant

Administration of antipsychotic

96203-11 Oral…….antipsychotic

96197-11 Intramuscular…….antipsychotic

96199-11 Intravenous……antipsychotic

96206-11 Unspecified route…..antipsychotic

Administration of anti-anxiety/sedative

96203-12 Oral…….anti-anxiety / sedative

96197-12 Intramuscular…….anti-anxiety/sedative

96199-12 Intravenous……anti-anxiety/sedative

96206-12 Unspecified route…..anti-anxiety / sedative

Administration of mood stabiliser

Includes: Lithium

Anticonvulsants

96203-13 Oral…….mood stabiliser

96206-13 Unspecified route..mood stabiliser

Administration of stimulant

96203-14 Oral……..stimulant

96205-14 Transdermal……..……stimulant

96206-14 Unspecified route……...stimulant

Physical safety interventions

MH000-23 Seclusion

Note: Seclusion involves the consumer being alone in a room or area from which free exit is prevented. Refer to state/territory health authority for local definitions.

MH000-24 Isolation

Time out

Excludes: time out given in a locked room (MH000-23, p.17)

MH000-25 Physical restraint - by staff

Excludes: that involving use of device (MH000-26, p.17)

with acute sedation (MH000-27 p.17)

MH000-26 Physical restraint – using device

Mechanical restraint

Note: Application of a device to part of or all a person's body in order to restrict that person's free movement.

Excludes: use of devices (tray table, slider belts etc) used to prevent falls – omit code

MH000-27 Acute sedation

Intramuscular or intravenous injection of sedative or tranquilizer, given to relieve severe, acute symptoms causing an emergency situation in which safety is threatened.

Includes: any necessary physical restraint by staff (without device)

Other therapy or interventions

Assistive products

Assistive products – any product (including devices, equipment, instruments, technology and software) especially produced or generally available preventing, compensating, monitoring, relieving or neutralising impairments, activity limitations, and participation restrictions (ISO9999)

Includes: Assistive products for:

- personal medical treatment
- training in skills
- orthoses and prostheses (external)
- personal care and protection (eg personal hygiene, stoma care, incontinence)
- personal mobility
- furnishings and adaptations to homes and other premises
- communications and information (eg glasses, hearing aids, emergency alarms)

Excludes: interventions involving assistive or adaptive device, aid or equipment, classified elsewhere:

- assessment of need for device (96024-00, p.6)
- counselling or education regarding device (xxxxx-xx, p.x)
- review only of device (96025-00, p.6)
- skills training in use of device (96142-00, p.34)

96092-00 Application, fitting, adjustment or replacement of other assistive product

Provision of assistive product

Programming of assistive product

Includes: instructions on use of how to care for assistive product

96094-00 Removal of assistive product

Excludes: that with replacement (96092-00, p.13)

Nutritional support interventions

Includes: assessment or review of client's tolerance/progress to dietary intake

Note: Interventions that support the proper dietary intake and assimilation of nutriments for proper body functioning and maintenance of health.

Excludes: assistance with food intake (96163-00, p.35)

nutritional/dietary:

- assessment alone (96026-00, p.6)
- counselling or education (MH200-xx, p.22)

skills training in:

- food intake (96140-00, p.33)
- shopping and preparation of food (96143-00, p.34)

96095-00 Therapeutic diet support

May include:

- adaptation of food for swallowing
- menu planning
- education on physical issues regarding diet or interventions

Note: Involves making recommendations about diet, identifying client preferences, ordering of items which constitute a therapeutic diet and ensuring meals or menus provided are appropriate.

96096-00 Oral nutritional support

Note: Involves supplementation of therapeutic diet, enteral or parenteral nutrition with oral nourishing fluids and/or foods

96097-00 Enteral nutritional support

Note: Involves making recommendations on enteral nutrition and ordering of nutrients or necessary equipment

96098-00 Parenteral nutritional support

Note: Involves making recommendations on parenteral nutrition, either alone or in combination with enteral or oral nutrition and ordering of nutrients or necessary equipment

Hydrotherapy

96153-00 Hydrotherapy

Note: The external use of water, hot and/or cold, in the therapeutic treatment of disease or injury.

Therapeutic ultrasound

96154-00 Therapeutic ultrasound

Stimulation therapy

96155-00 Stimulation therapy, not elsewhere classified

Therapeutic laser treatment NOS

Includes: electrical neuromuscular nerve stimulation [EMS]

functional electrical stimulation [FES]

interferential therapy [IFT]

transcutaneous electrical nerve stimulation [TENS]

repetitive transcranial magnetic stimulation [rTMS]

Note: The therapeutic application of a device (electrical, laser or ultrasound) which excites or induces functional activity in a body part with the aim of promoting healing and reducing pain

Hyperbaric oxygen therapy

Hyperbaric oxygenation

Includes: 100% oxygenation

that to wound

96191-00 Hyperbaric oxygen therapy, □ 90 minutes

13020-00 Hyperbaric oxygen therapy, > 90 minutes and □ 3 hours

13025-00 Hyperbaric oxygen therapy, > 3 hours

Drainage of respiratory tract

96157-00 Nonincisional drainage of respiratory tract

Manual clearance of respiratory secretions (suctioning)

Postural drainage

Sputum clearance/mobilisation (by manual hyperinflation)

Includes: active cycle of breathing technique [ACBT]

forced expiration technique [FET]

that using techniques/devices such as:

- percussion
- shaking
- vibrator

Note: Postural drainage – positioning allowing gravity to assist drainage of secretions from lungs and to increase ventilation

Exercise therapy

96138-00 Exercise therapy, respiratory system [breathing]

Recruiting lung units (by manual hyperinflation)

Note: Exercise to increase tidal volume and thoracic excursion and assist in loosening secretions and/or improve breathing pattern

96139-00 Exercise therapy, cardiorespiratory/cardiovascular system

Cardiac rehabilitation programme

Note: Exercise programme aimed at achieving maximum cardiac and respiratory function

96129-00 Exercise therapy, total body

Exercise therapy NOS

General exercise therapy such as exercise classes, swimming

Note: specific codes exist for Exercise therapy for individual body parts. Refer to ACHI block [1876] if this extra detail is required.

EDUCATION, COUNSELLING AND SKILLS TRAINING

Note: The following extension (-00 to -02) is for use with codes MH200-MH501. There are instances where the extension of -02 *Skills training* does not apply, and this is noted at the specific code.

The extensions represent a hierarchy, where *counselling* may include some form of education, and *skills training* may include both counselling and education.

00 Education

Note: *Education* – instruction and guidance with the aim of enhancing the client's knowledge, awareness or understanding of their illness or issue for the purpose of monitoring, managing, maintaining or improving their health outcomes.

Includes: the provision of:

- advice
- information
- resources (educational material)

01 Counselling

Note: *Counselling* – alleviating emotional, physiological, psychological, social and/or occupational consequences of a client's illness or issue through the establishment of a supportive or therapeutic relationship. Counselling encompasses the provision of empathetic acceptance, clarification,

interpretation, problem solving and support. This activity is less directive than formal psychotherapy, with generally no structured techniques.

Psychoeducation - A specific form of educative counselling tailored specifically to clients, to help them understand the facts about their illness and to access or learn strategies to deal with the illness. Psychoeducation may be provided to individuals with a mental health condition, or to carers and family.

Motivational interviewing - a directive, client-centered counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence.

Includes: education component

02 Skills training

Note: *Skills training* - Individually tailored and group learning environments designed to facilitate the acquisition of skills consistent with mental health wellness and independence in activities of everyday life. {Alternative definition has been proposed and decision has yet to be made about which to use. The alternative definition is: Skills training is characterized by a formal rehabilitative process that involves a schedule of instruction, active supervised practice by the client, evaluation of progress, and so on. It may be applied to a variety of functional areas ("skills") including physical and psychological skills.}

Includes: education and counselling component

Excludes: psychological skills training (……p. x)

Education, counselling or skills training related to health issues

MH200-xx Nutrition or diet

Note: the extension of -02 *Skills training* does not apply to this code

MH201-xx Self-care or self-maintenance

Includes activities of daily living, such as:

- caring for body parts (teeth, hair etc)
- dressing [clothing]
- eating and feeding
- sleeping
- toileting
- washing oneself

Excludes: that for:

- health maintenance or recovery activities (MH202-xx, p.22)
- home management activities (MH400, p.x)
- mobility (xxxxx-xx, p.x)
- nutrition or diet (MH200-xx, p.22)
- use of assistive products (xxxxx-xx, p.xx)

MH202-xx Health maintenance or recovery activities

Includes:

- applying bandages or dressings
- diagnostic testing/monitoring (for conditions such as asthma or diabetes)
- management of disease or condition
- foot/leg care
- personal health behaviours (eg regular exercise)
- risk factors for health (eg obesity, blood pressure, diabetes)
- self injection
- stoma care

Excludes: exercise therapy (96129-00, p 20)

training in management of medication delivery systems (MH205-xx, p.23)

training in use of assistive products (MH205-xx, p.23)

MH203-xx Body position, mobility, movement, or transfers

Ambulation and gait training

Mobility or body positioning training such as:

- bed mobility
- sitting out of bed
- standing balance

Posture management

Sensory motor skills training

Training in methods to improve integrated movement awareness such as Feldenkrais method, tai chi, yoga

Transfers to/from bed/chair/shower/car etc

Excludes: exercise therapy (see p.32-33)

that where the primary purpose is to train in the use of assistive products (96142-00, p.34)

MH204-xx Medication or treatment

Includes:

- action/effect of medications
- compliance
- management of medication regime
- prevention of adverse drug reactions

Excludes: that regarding harmful use of substance (MH210-xx, p.23)

that for use of medication delivery systems (MH205-xx, 23)

MH205-xx Use of assistive products

Ambulation and gait training using assistive products

Habilitative or rehabilitative training in the use of assistive products

Mobility training with aids

Training in use of medication delivery systems

Note: ***For explanation of*** *'Assistive products' see p.x*

MH206-xx Communication and language

Includes:

- fluency
- speech
- spoken / non-spoken communication
- voice
- written / non-written language

MH207-xx Learning, knowledge and cognition

Includes:

- literacy or numeracy
- sensory, sensorimotor, or sensorineural function
- memory, orientation, perception or attention

Excludes: psychological skills training in memory, orientation, perception or attention (MHxxx-xx, p. 28)

MH208-xx Hearing loss or aural disorder

Excludes: that for use of hearing device or auditory aid (MH208-xx, px)

MH209-xx Visual loss or ocular disorder

Excludes: that for use of visual aid or prosthesis (MH208-xx, p.x)

MH210-xx Harmful use of substance

Building motivation

Engagement for treatment

Motivational interviewing (use extension -01 *Counselling*)

Includes:

- alcohol consumption
- drug use
- smoking

MH211-xx Mental health condition

Psychoeducation for mental health condition (use extension -01 *Counselling*)

Motivational interviewing for eating disorders (use extension -01 *Counselling*)

MH212-xx Other specific health condition

Psychoeducation for significant illness (use extension -01 *Counselling*)

Genetic counselling (use extension -01 *Counselling)*

Excludes: that for mental health conditions (MH211-xx, p.23)

MH213-xx Other health related issue

Includes:

- advanced directives (living wills)

Education, counselling or skills training related to psychological or psychosocial issues

Excludes: that using a specific method of psychotherapy - see Index: Psychological skills training, or Psychotherapy

MH300-xx Adjustment to psychosocial event

Includes:

- care transitions (eg foster care)
- life stage transitions
- redundancy, retirement
- school adjustment (eg primary to high school)
- significant life event NOS

Excludes: psychoeducation for individual or family adjustment to illness - (xxxxx-xx, or xxxxx-xx, p.x)

grief or bereavement (xxxxx-xx, below)

that to alleviate an immediate crisis situation (xxxxx-xx)

MH301-xx Gambling or betting addiction

Motivational interviewing for gambling (use extension -01 *Counselling*)

Note: the extension of -02 *Skills training* does not apply to this code

Excludes: preventative education or counselling (96066-00, p.x)

MH302-xx Behaviour issue

Motivational interviewing (use extension -01 *Counselling*)

Includes:

- aggression
- mood
- anxiety
- distress

MH303-xx Relationship issue

Includes:

- couples / marriage
- family interactions
- child peer relationships
- parent-child relationships
- social interactions

Excludes: that using a behavioural, cognitive behavioural, interpersonal or psychodynamic approach in:

- couples therapy (96178-00, p.28)
- family therapy (MH000-84, p.28)
- interpersonal psychotherapy (96177-00, p.26)

MH304-xx Crisis situation or event

Crisis intervention counselling (use extension-01 *Counselling*)

Supportive debriefing (use extension-01 *Counselling*)

Note: Counselling aimed at reversing the state of decompensation or decreasing the level of arousal until the client can return to their normal level of coping after a crisis or critical incident. As soon as this is achieved, responsibility for the problem is handed back to the client. Ongoing counselling, problem-solving, or other forms of psychotherapy or psychosocial therapy may then be undertaken.

The extension of -02 *Skills training* does not apply to this code

Crisis resulting from events such as:

- cultural or spiritual crisis
- financial problems
- housing problems
- job loss
- natural disasters
- relationship breakdown
- sudden death
- violence or abuse

Excludes: ongoing counselling following crisis situation counselling (see Index: Counselling by specified type)

ongoing psychotherapy or psychosocial therapy (see Index: Psychotherapy, by specified type)

MH305-xx Physical abuse, violence or assault

Counselling regarding:

- domestic violence
- sexual abuse

Note: the extension of -02 *Skills training* does not apply to this code

Excludes: that to alleviate an immediate crisis situation (MH304-xx, p.25)

MH306-xx Grief / bereavement

Note: Grief/bereavement refers to the feelings of sadness and depression following the loss or death of a significant other. Anticipatory grief refers to the feelings of loss and sadness prior to and in expectation of death.

The extension of -02 *Skills training* does not apply to this code

Includes loss or grief in response to:

- antenatal or postnatal loss of infant
- loss or death of a significant other
- physical and mental illness
- redundancy or unemployment
- relationship breakdown

Excludes: that following sudden death or suicide (see MH304-xx *Crisis situation or event*, p.25)

MH307-xx Other psychological or psychosocial issue

Education, counselling or skills training related to social or environmental issues

MH400-xx Home management

Includes:

- housekeeping/maintenance
- liaising with services (eg utilities, maintenance)
- safety procedures around the home
- shopping, menu planning and meal preparation

MH401-xx Financial management

Includes:

- budgeting
- dealing with creditors
- estate planning (wills) and enduring powers
- income or welfare support

MH402-xx Occupation or vocation

Includes:

- available support services
- disclosure and stigma (eg regarding HIV status)
- employment/unemployment
- pre-employment suitability or options
- rehabilitation in a client's environment
- retrenchment/redundancy

MH403-xx Schooling or training

Includes:

- performance issues

- securing resources (eg tutors)
- strategies to overcome barriers

MH404-xx Accommodation or housing

Includes:

- liaising with housing services

MH405-xx Parenting issues

Includes:

- antenatal and postnatal education (use extension -00 *Education*)
- positive parenting techniques
- practical parenting (eg: diet and nutrition, discipline, caring for children, etc)

Excludes: assistance only (96169-00, p.34)

parent-child relationship issues (MH303-xx, p.x)

psychological skills training in parenting techniques (xxxxx-xx, p.x)

MH406-xx Leisure or recreation

Includes:

- liaising with facilities (eg: sports clubs, youth clubs)

MH407-xx Other social or environmental issues

Education, counselling or skills training related to other issues

MH500-xx Cultural or religious issues

MH501-xx Other

Driver training

Counselling NOS

Education NOS

Skills training NOS

Transport training (eg use of public transport, taxis, planning journeys)

PSYCHOLOGICAL INTERVENTIONS

Psychological skills training

Note: Tailored interventions designed to support the acquisition and development of cognitive and behavioural skills (including coping skills) consistent with improved personal and interpersonal functioning. The training may be associated with a program of psychotherapy.

Includes: focused psychological strategies

Excludes: skills taught as a part of structured psychotherapy (eg Cognitive behaviour therapy) – see Index: Psychotherapy, by type

MH000-86 Psychological skills training for emotional self regulation

Skills training may include:

- anger management
- impulse control
- limit setting
- meditation
- mindfulness
- relaxation techniques
- self-hypnosis

xxxxx-xx Psychological skills training for memory, orientation, perception or attention

Skills training may include:

- self-hypnosis
- meditation
- mindfulness
- cognitive remediation therapy (CRT)
- memory skills training

MH000-88 Psychological skills training for social skills

Skills training may include:

- assertiveness
- conflict resolution
- enhancing self-esteem

96114-00 Psychological skills training for executive skills

Skills training may include:

- stress management
- time management
- activity scheduling
- problem solving
- goal planning

- creative thinking
- decision making
- organization
- planning

xxxxx-xx Psychological skills training in parenting techniques

Skills training may include:

- appropriate consequences
- attunement
- directed play
- limit setting
- modeling
- parent coping
- positive attending
- relationship building
- supportive listening

Excludes: skills training in practical parenting (MH405-02, p.26)

96001-00 Psychological skills training, NOS

Psychotherapeutic programs

Note: The use of a recognized, structured, published psychotherapy method or technique.

Excludes: specific skill training or components of such interventions, such as relaxation training, problem solving or focused psychological strategies - see *Psychological skills training* p. x.

96101-00 Cognitive behaviour therapy [CBT]

May include components like:

- cognitive restructuring
- desensitisation (graded exposure) (exposure therapy)
- relapse-prevention
- relaxation
- response-prevention
- rational emotive therapy
- role play/rehearsal
- structured problem solving
- treatment adherence

Note: This code includes instances where cognitive or behaviour therapy is used separately.

Excludes: cognitive behavioural approach in:

- couples therapy (96178-00, p.28)
- sex therapy (96179-00, p.28)
- systems therapy (96102-00, p.27)

MH000-78 Dialectical behaviour therapy [DBT]

Note: [to be inserted]

96177-00 Structured interpersonal psychotherapies [IPT]

Interpersonal psychotherapy

May include components like:

- role playing techniques
- developmental therapy
- assertion therapy
- process experiential
- transactional therapy

Note: Interpersonal psychotherapy [IPT] aims to clarify and resolve one or more interpersonal difficulties experienced by a client. These difficulties include: role disputes, social skills deficits, prolonged grief reactions or role transition. IPT builds skills primarily in the communication and interpersonal domains.

Excludes: interpersonal psychotherapeutic approach in:

- couples therapy (96178-00, p.28)
- sex therapy (96179-00, p.28)
- systems therapy (96102-00, p.27)

96100-00 Psychodynamic therapy

May include components like:

- client-centred }
- insight-oriented } approach / technique
- psychoanalytical }
- supportive/expressive }

Excludes: psychodynamic approach in:

- couples therapy (96178-00, p.28)
- sex therapy (96179-00, p.28)
- systems therapy (96102-00, p.27)

96183-00 Narrative therapy

Note: Interventions that assist a client to resolve problems by enabling them to deconstruct the ideas and beliefs they have about their lives and relationships, and to understand the difference between internalised stories and self.

This therapy is centred on the premise that people's lives and relationships are shaped by the stories that people tell and engage in to give meaning to their experiences. People construct certain habits and relationships that make up ways of life by staying true to these internalised stories.

xxxxx-xx Acceptance and commitment therapy (ACT)

Note: [to be inserted]

MH000-80 Solution-focused therapy

***Note*: to be inserted**

MH000-81 Gestalt therapy

***Note*:** a form of psychotherapy that focuses on gaining awareness of emotions and behaviours in the present rather than in the past.

MH000-82 Personal construct therapy

***Note*:** [to be inserted]

MH000-83 Play therapy

***Note*:** a form of psychotherapy usually used for children that uses play situations to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.

96102-00 Systems therapy

Includes: that using:

- behavioural
- cognitive behavioural
- interpersonal
- psychodynamic

} approach

Excludes: family therapy (MH000-84, p.28)

couples therapy (96178-00, p.28)

xxxxx-xx Multisystemic therapy (MST)

Note: MST interventions target the individual family, peer, school and community factors identified as contributing to and maintaining problematic behaviour

96178-00 Couples therapy

Marriage therapy

Includes: that using:

- behavioural
- cognitive behavioural
- interpersonal

} approach

Note: Couples therapy is a form of psychological therapy used to treat relationship distress for both individuals and couples.

Excludes: where only one member of the couple is receiving therapy, code to the specific type of psychotherapy (see Index, Psychotherapy, by type).

MH000-84 Family therapy

Note: Family therapy looks at the family as a system of interacting elements with its own rules, beliefs, needs and roles. This therapy helps a client discover how their family operates, their role in the system and how it affects them in their relationships within and outside the family.

Includes: that using:

- systems therapy
- strategic family therapy
- behavioural
- cognitive behavioural
- interpersonal
- psychodynamic

} approach

96179-00 Sex therapy

Includes: that using:

- behavioural
- cognitive behavioural

} approach

- interpersonal }
- psychodynamic }

96185-00 Supportive psychotherapy, not elsewhere classified

Supportive psychotherapy NOS

Note: Supportive psychotherapy includes activities aimed at establishing and/or enhancing the therapeutic relationship using measures such as active or empathetic listening, praise, encouragement, understanding and reassurance and advice.

Unlike other forms of therapy, supportive psychotherapy does not aim to produce major change in the client. While behavioural treatments aim to alter the way clients act, cognitive behavioural therapy the way people think and act, and psychodynamic therapy the patterns of their defences, supportive psychotherapy aims not to change, but rather to strengthen their existing coping mechanisms.

Excludes: that as a part of :

- other psychotherapy – see Index: Psychotherapy, by type
- any other intervention – code the specific intervention

96103-00 Clinical hypnosis

Hypnotherapy

96104-00 Music therapy

Note: Interventions using music designed to enhance and/or maintain the physical , emotional, psychosocial, behavioural, sensory, cognitive, communication, cultural, spiritual, developmental, musical and/or related needs identified during the assessment/evaluation process.

96181-00 Art therapy

Note: Interventions using art media, images or the creative art process to help a client deal with their problem(s).

96182-00 Bibliotherapy

Note: Interventions using literature (books, newspapers etc) to help a client deal with their problem(s).

xxxxx-xx Drama therapy

Note: Interventions using drama/theatre techniques (role-play, mime etc) to help a client deal with their problem(s).

96180-00 Other psychotherapies or psychosocial therapies

Eclectic psychotherapy

Eye movement desensitisation and reprocessing [EMDR]

Psychodrama

Rapid eye movement densensitisation [REMD]

Self therapy

Somatic therapy

Biofeedback

96152-00 Biofeedback

Note: Process by which the physiologic activity of a client can be translated into electric signals of a visual or auditory system. Examples of the kinds of biological feedback that can be provided include information about changes in skin temperature, muscle tonicity, cardiovascular activities, blood pressure and brain wave activities.

CLIENT ASSISTANCE

Note: Interventions where the purpose is only to provide assistance to the client and any therapeutic treatment such as counselling, education, skills training or exercise therapy for example is not involved.

96163-00 Assistance with activities related to self-care or self-maintenance

May include assistance with:

- washing oneself
- dressing [clothing]
- eating and feeding
- caring for body parts (teeth, hair, nails etc)
- toileting

96164-00 Assistance with activities related to health maintenance

May include assistance with:

- diagnostic testing/monitoring (for conditions such as amputation stumps, asthma, diabetes etc)
- foot/leg care (such as cutting or filing of non pathological toenails)
- oral hygiene
- stoma care
-

MH000-91 Assistance with medication

- loading of dosette

96165-00 Assistance with application of assistive or adaptive device, aid or equipment

Note: For the list of assistive or adaptive devices, aids or equipment see p.13.

96166-00 Assistance with activities related to body position/ mobility/movement

Assistance with ambulation

96167-00 Assistance with activities related to transfers

May include assistance provided to client with transfers to/from:

- bath/shower
- bed
- chair
- floor
- toilet
- vehicle

96168-00 Assistance with activities related to home management

May include assistance provided to client with activities such as:

- housekeeping/maintenance
- shopping, menu planning and meal preparation
- safety procedures around the home

96169-00 Assistance with activities related to parenting

Assistance provided to client with:

- infant feeding
- settling of infant

Excludes: that involving:

- parenting education (MH405-00, p.26)
- psychological skills training (xxxxx-xx, p.31)

xxxxx-xx Assistance with social or recreational activities

May include assistance provided to client with:

- accessing social events
- making and maintaining social connections
- participating in recreational activities

xxxxx-xx Assistance with accommodation, education or employment

May include assistance provided to client with:

- obtaining and maintaining housing tenancy
- accessing employment programs
- accessing education programs

xxxxx-xx Other assistance activity

May include assistance provided to client with:

- legal issues
- general support or caring

OTHER INTERVENTIONS

Note: May include interventions that are performed without the direct involvement of the client (i.e. Indirect interventions).

Planning and review

Note: Planning and review may involve all persons involved in the care including other service providers, the client and their carers, family, or significant others. This involvement may be via telephone calls or video conferencing to community team, GP, or other service provider.

MH000-92 Formal case review

Note: This review is a formal process whereby a client's case is discussed by a multi-disciplinary group of mental health clinicians within a specific recurring timeframe (eg every 3 months). They may be provided with more than one service provider in attendance and the client may or may not have participated. This case review meets the requirements for regular review set out in the National Mental Health Standards.

MH000-34 Intake review meetings

Note: This review meeting, or case conference, is undertaken to discuss the initial intake assessment and to formulate an initial treatment plan.

MH000-35 Care planning

May include:

- behaviour plans
- crisis management plan
- individual service plan

Note: This includes the development, creation, monitoring, revision and review of a formal documented care plan, with or without the client or carers present. This may also include any planning that occurs immediately prior to the delivery of a service to a client (such as the accumulation of material or resources necessary for the treatment of the client).

MH000-36 Other review meetings

May include:

- discharge planning case conferences
- ad-hoc review
- other case discussions

Service co-ordination activities

Note: *Service co-ordination* - involves arrangement, facilitation and co-ordination of a range of services necessary to meet identified needs of the client.

MH000-93 Consultation with other health care providers

Consultation and advice for:

- family doctor (GP)
- pharmacist
- interagency planning with transfer

MH000-30 Contact with other agency to facilitate accommodation

MH000-31 Contact with other agency to facilitate other requirement

May include:

- interpreter services
- schools
- referral information from courts or legal system

96108-00 Advocacy

Note: Representation or defence of the client's interests to facilitate access to and use of services.

MH000-96 Legal duties

May include attendance at or preparation for:

- court
- psychiatric review board
- Workers Compensation Board

96107-00 Other service co-ordination activity

May include:

- liaising with emergency services (in crisis situation)

Client escort

96171-00 Accompanying or transportation of client

Escort of client to other service provider or agency within or outside health care facility

Carer or family activities

MH000-97 Carer or family support

Assistance, advice or support provided to:

- carers
- family (parents, siblings, partners)
- friends and other significant persons
- child of parent with mental illness

Family meetings

Excludes: psychoeducation or counselling regarding:

- mental illness (MH036-xx, p.x)
- other health related issue (MH037-xx, p.x)

relationship counselling (96081-xx, p.19)

family therapy (MH000-84, p.28)

Cultural or spiritual interventions

96187-00 Pastoral / cultural ministry

Introducing the service

Pastoral conversation

Spiritual/emotional support

Visit by cultural or spiritual guide

96109-01 Pastoral ritual/worship

Baptism/initiation

Blessing/naming

Eucharist/ministry of word

Prayer NOS

Rites for the dying

NON-PATIENT ATTRIBUTABLE ACTIVITIES

Note: The following codes have been included in the Second Edition of the Mental Health Manual to allow capture of 'non-patient attributable' activities undertaken in mental health service organisations (e.g., research, professional development, administration). As these are not 'interventions' that are attributable directly to a particular client, these codes are not included in ACHI. The use of these codes is optional.

xxxxx-xx Administration

May include:

- attendance at meetings
- clinical report writing
- clinical record keeping
- arranging appointments
- service coordination, staff rostering
- preparation of audits or reviews
- staff recruitment and orientation

xxxxx-xx Professional development

May include:

- attendance at courses, conferences, workshops

xxxxx-xx Provision of supervision and training

May include:

- preparing and giving lectures
- leading tutorials or workshops
- mentoring
- evaluating
- reporting to educational institution

xxxxx-xx Research activities

May include:

- data collection, analysis and reporting
- development of proposals and ethics committee submissions
- research project planning and management
- subject recruitment

xxxxx-xx Travel

*Excludes:*accompanying or transportation of client (96171-00, p.x)

xxxxx Other non-patient attributable activities