



Feedback on the Development of the Australian Mental Health Care Classification – Public consultation Paper 2

Children's Health Queensland Hospital and Health Service (CHQ HHS)
Child and Youth Mental Health Service (CYMHS).

General Comments:

Children's Health Queensland Child and Youth Mental Health Services (CHQ CYMHS) found it particularly challenging to articulate informed comments on the Public Consultation Paper due to a lack of background knowledge, not provided or assumed, within the discussion paper.

CHQ CYMHS believe their understanding would have been enhanced if they were afforded the opportunity to consider the technical specifications supporting the proposed classification system, if they had a better understanding of the child and adolescent population included within the pilot and costing studies, the number of children and young people that were represented, the demographics of this population and how the weightings were devised. CHQ CYMHS has concerns regarding the current face validity of the model, how it aligns with National Standards for Mental Health Services and recovery principles and do not see enough evidence that it has been sufficiently developed in consultation with and understanding the needs of the infant, child and adolescent population.

CHQ CYMHS is unclear how this model fits services and populations that are more geographical and resource diverse, rural and remote areas, indigenous populations, culturally and linguistically diverse populations, infant mental health, how the 'mental health phases of care' were identified and how they reflect current contemporary evidence informed practice, how fluid care can be at various times. There appeared to be little consideration for the role of promotion, prevention and early intervention in targeted at risk young people, which is a core component of CYMHS work. As well as the range of systemic work that is required to support the mental health needs and recovery of infants, children and adolescents.

An emphasis should be placed on the importance and impact on costs of the systemic factors when treating infants, children, adolescents and their families. The implications of working with blended and separated families, kinship carers or other care providers within the child protection system as well as mental health legal status in ambulatory care cannot be underestimated in relation to cost and time.

Consultation questions

1. Are the variables included in the draft AMHCC V 1 relevant to clinicians, health professionals, service managers and other stakeholders?

- The aim for the new classification to include specialised mental health care is an important one. Specialised services have in the past been required to fit into mainstream models to which they are not necessarily suited.
- For example, outcome measures for child and adolescent forensic mental health services (where services are provided to young people detained in detention centres), are still inappropriate for example in terms of measuring substance use progress and general mental health progress. In the context of detention the environment creates an altered reality due to the structures that exist in detention that are non-existent in the community.
- There is confusion with staff as to what is going to happen with activity based funding. Will there still be activity based funding after the 2016-17 financial year? Will it be dropped by the federal government in favour of an indexation of funding? Will activity based funding be taken up by the states or not?
- The interface between these decisions and the emphasis on compliance with developing KPIs, at a state and national level, needs to be utmost in the mind when managing these processes – the impact on clinical staff is significant.
- It is unclear how consultation liaison services fit within this model and or for outreach teams and services that support other mental health services in managing the mental health care of its population. Therefore an example may be telepsychiatry, where a metropolitan mental health service may provide telepsychiatry, conduct mental health specialist assessments and reviews with young people and their families – however this work is not attributed to the individuals providing the care, as they are considered secondary service providers, and the data is attributed to the hospital and health service in which the consumer is attached to. Unsure of impact on continual funding and progression of these contemporary best practice services.
- The AMHCC consultation document acknowledges the very technical nature of the classification document, however has not provided the technical specifications to fully understand the model, and at the same time has stated the importance of a broad consultation process. It is believed that the average clinician and stakeholder will struggle to understand the classification model as it stands and it is unclear how this will be translated into practice.
- This will be a whole new language for clinicians and stakeholders and what it means for consumers, for young people and families. Given that it is connected to funding there will be an expectation that they will have an understanding of what dollars are connected to what level of complexity.

- It is really important to clearly explain the benefits the changes will make to the delivery of services to consumers and carers in plain English.
- It is unclear how HoNOSCA) outcomes inter-rater reliability will be addressed and operationalised across teams, services and jurisdictions, to ensure it is consistent. Unclear of the HoNOSCA complexity ratings and the impact this focus may have on teams and services, especially if funding or costs are associated.
- The definitions of the phases are too general and frequency of contact is the only other defining characteristic of a phase, which is really concerning. If frequency of contact is a key characteristic that defines the phases of care what service models / programs are they aligned more to e.g., inpatient, day programs?
- Unsure how the identification of five phases of care were established, why not seven or ten? Consumers within each of the phases of care can have very different care requirements.
- Parents in specialist child and youth services that are receiving a range of services from support through to specialist care – how will they be costed? Child and Adolescent services work holistically with a family – not an individual. This is inclusive of schools, Child Protection System, Family Court, Youth Justice and a range of NGOs who augment to Child Protection System.
- Where does targeted early intervention fit in this model? E.g. Working with Children of Parents with a mental illness who are at risk, but do not have a mental illness?
- The variables are probably more relevant to service managers, funding bodies and policy developers than clinicians as historically the latter group has not had a great interest in cost drivers of service delivery. The language of the model is not clinician friendly, let alone consumer friendly. The categories might make statistical sense, however their clinical relevance is not properly explained.
- This is reliance on current levels of the relevant data collection including Outcomes, age etc being high. Are current rates of valid data collection reflecting that this will work? E.g. what is the current proportion of valid HoNOS Outcomes collection nationally?
- Will outcomes be required at every change of Phase of Care? It was understood from recent webinars that it was not the intention to increase clinician burden, but this seems as though it will have a significant impact.

2. Are there other variables that should be considered in later iterations of the AMHCC?

- Outcome measures for infants 0-3 currently do not current exist in terms of the NOCC collection – therefore how is complexity captured for infants. The needs of a 2 year old are very different from that of a 16 year old.
- Outcome measures for child and adolescent forensic mental health clients within detention centres are not appropriate for measuring MH improvements and reduction in substance use for example.

- Are three age groups enough? CHQ CYMHS would suggest that the 0-17 year age group be broken down into further groups e.g., 0-3, 4-12, 13-17. It is really important to ensure a developmental framework is embedded in the model. Big differences between ages.
- Given that diagnosis is used in other funding models, one would suspect that in the future it may be linked to this classification model – impact this would have?
- The consultation document recognises that there are drivers for CYMHS that are not clearly able to be incorporated. It is considered extremely important to focus on these with expert CYMHS / CAMHS clinical reference groups to ensure they are captured. The implication of the wording is that these drivers are too complex to identify clear linear causal paths to fit with the model. Does this not invite very clearly separate endeavours to understand and incorporate these drivers. Failure to do so will result in reduced capacity of CYMHS to fulfil its current core functions due to funding cuts (as demonstrated in the WA context). Ultimately consumers suffer and the state will absorb the financial cost of increased costs in the adult sector moving forward. The economy will also absorb this cost in terms of productivity loss and again the state in terms of welfare payments. Longitudinal and systemic thought needs to be applied to identify both intended and unintended consequences – it is not clear that this is incorporated into the model.
- Mental Health Status and legal status in the community is an indicator of complexity – this does not appear to be incorporated in the current models (just in the inpatient setting). For CYMHS the legal status of a child in the context of child protection issues and family court involvement are as significant drivers of resource utilisation as well as mental health act status.

3. Do the final classification groups have relevance to clinicians, health service managers and other stakeholders?

- In regards to mental health phases of care, it may be considered a useful concept but would need further information regarding them and how they align to evidence based practice. For some services, it is envisaged that it would give recognition to the high flow through of clients and the fact that most clients in the acute stage are receiving a resource intensive service.
- The classification for mental health legal status would also seem to be a reasonable measure with readily accessible data.
- Recent episodes of care across five years would seem to be a good addition to the classification. This could be a useful measure in a setting where there is a rotating door for admission (detention centres). However might be difficult to identify phases of care in a consistent way that provides reliable data, it may well be a complex thing to resolve.
- The Phases of Care don't appear to fit with range of services provided to Child and Adolescent populations being seen.
- Some statewide services have clients that are attached to a different Mental Health Service (MHS) to the MHS they are employed by. Who gets the funding?

- Codes and the descriptors are not user friendly.
- The weightings and thresholds for acute and community are different. No clear explanation or evidence of how the ratings are weighted.
- There appears to be a disconnect between day to day clinical practice – how will this work when even (page 13) those missing Phase of Care were excluded.
- Potential for gaming of the data to increase funding.

4. Are the priorities for the next stages of development of the AMHCC appropriate?

- The document makes some very good points about the distinction between adult mental health services and child and youth mental health services. For example, CYMH services involvement with family, patient, teachers, community resourcing, cultural support etc. this is quite a complex area to design into the classification. It is not clear from the discussion document how much CYMHS consultation there has been in the pilot and costing study and how they will be engaged for future consultations.
- There are no specialist Child and Adolescent services named in the pilot phase. It would probably be valuable to include at least one. Without doing this, it challenges the validity of the model. Our opinion is that this is a critical oversight.
- There is no evidence that the 0-4 cohort have been considered in this consultation paper or the modelling. There are specific service delivery drivers for this age group that must be considered, again in consultation with a specialist clinical reference group that has currency of practice.

5. Are there any other issues which should be taken in to account in the next stages of development?

- Who will be consulted and when? How will consumers and carers of the CYMHS population be consulted?
- How do we progress capturing systemic work to ensure this core component of CYMHS work is incorporated into the model?
- How does this reflect the delivery of CYMH / CAMH services – the clinical context – process appears to be more aligned to a technical perspective rather than service-delivery perspective?
- How does indigenous models of care, CALD etc. fit with what is proposed?
- What is the detail e.g. is there a limit to length of stay in phase of care? If so, are there financial penalties? Is the intent to be using this aggregated data to benchmark or use as KPIs? If so what are the potential consequences of this for services and ultimately consumers and families?

- Not clear how the document translates to funding in a way that reflects the day-to-day clinical reality.
- There appears to be limited pilot sites with large child and adolescent services and CHQ would be happy to provide an additional pilot site should a specialist CYMHS service be required within Queensland.

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