The Child and Adolescent Mental Health Information Development Expert Advisory Panel (CAMHIDEAP) comment on the IHPA consultation paper: Development of the Australian Mental Health Care Classification: Public consultation paper 2, November 2015

The National Mental Health Information Development Expert Advisory Panels were established by the Department of Health to provide clinical and technical advice to the Mental Health Information Strategy Standing Committee (MHISSC) on issues and priorities that guide the development of the national mental health information agenda.

The Expert Panels comprise the National Mental Health Information Development Expert Advisory Panel (NMHIDEAP) and specialist panels brought together for specific issues or populations such as the Child and Adolescent Mental Health Information Development Expert Advisory Panel (CAMHIDEAP).

The primary function of the panels is to provide advice on the continued implementation, use and modification of routine outcome measurement in Australia's specialist mental health services, particularly in regard to training, service and workforce development issues and advice on analysis and reporting of National Outcomes and Casemix Collection (NOCC) data to advance the understanding and application of outcomes and casemix concepts. The Expert Panels are also tasked with providing advice on emerging issues pertaining to the information development agenda in mental health, including activities that enhance the capacity of the mental health sector to improve service delivery. The membership of CAMHIDEAP is drawn from those with expertise in clinical mental health, information development and use, and system improvement as clinicians, parents (or carers) and consumers. As well as providing advice through formal jurisdictional processes, the CAMHIDEAP provides leadership to the sector on issues concerning outcomes, benchmarking, and the implementation of information related system changes.

The following comments on the "Development of the Australian Mental Health Care Classification: Public consultation paper 2, November 2015" is provided by CAMHIDEAP. It is cognisant and supportive of the submission by the NMHIDEAP, of which CAMHIDEAP is an integral member. This submission will not repeat the overarching points made in the NMHIDEAP submission but will provide further specific details, particularly relevant to child and adolescent mental health services (CAMHS). When it comes to advancing the success of Australia's mental health information agenda, attending to routine outcome measurement, and understanding of the particular issues of children, adolescents and their families, details are important.

Costings study data

1. Page 13 of the consultation paper provides information about the volume of data gathered during the IHPA costings study, noting that following data cleaning, there were

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approximately 21,000 episodes of care used in the AMHCC modelling process. CAMHIDEAP notes that the paper does not provide detail about the number of episodes of care that were in the 0 -17 age band. Of equal importance is to have information about the number of episodes within the different developmental bands within the child and adolescent age range i.e. Infants, pre-schoolers, primary school aged children, and adolescents. It is our understanding that the volume of CAMHS data was relatively low and the CAMHS sample used in modelling may not be representative of, or generalizable to, CAMHS consumers more broadly. CAMHIDEAP is therefore concerned that there may be insufficient empirical CAMHS data to support the AMHCC as described in the consultation paper, but is unable to ascertain this from the information provided. The AMHCC consultation paper reports discarding 73% of mental health ambulatory episode information collected in order to develop a model. We do not know the size or representativeness of the CAMHS sample within that severe pruning. CAMHIDEAP notes that a supplementary technical paper, supporting the consultation paper, was released just a couple of days before the closing date for submission of comment on the AMHCC. There was not sufficient time for CAMHIDEAP to review this supplementary technical paper to determine whether it addressed any issues identified by CAMHIDEAP.

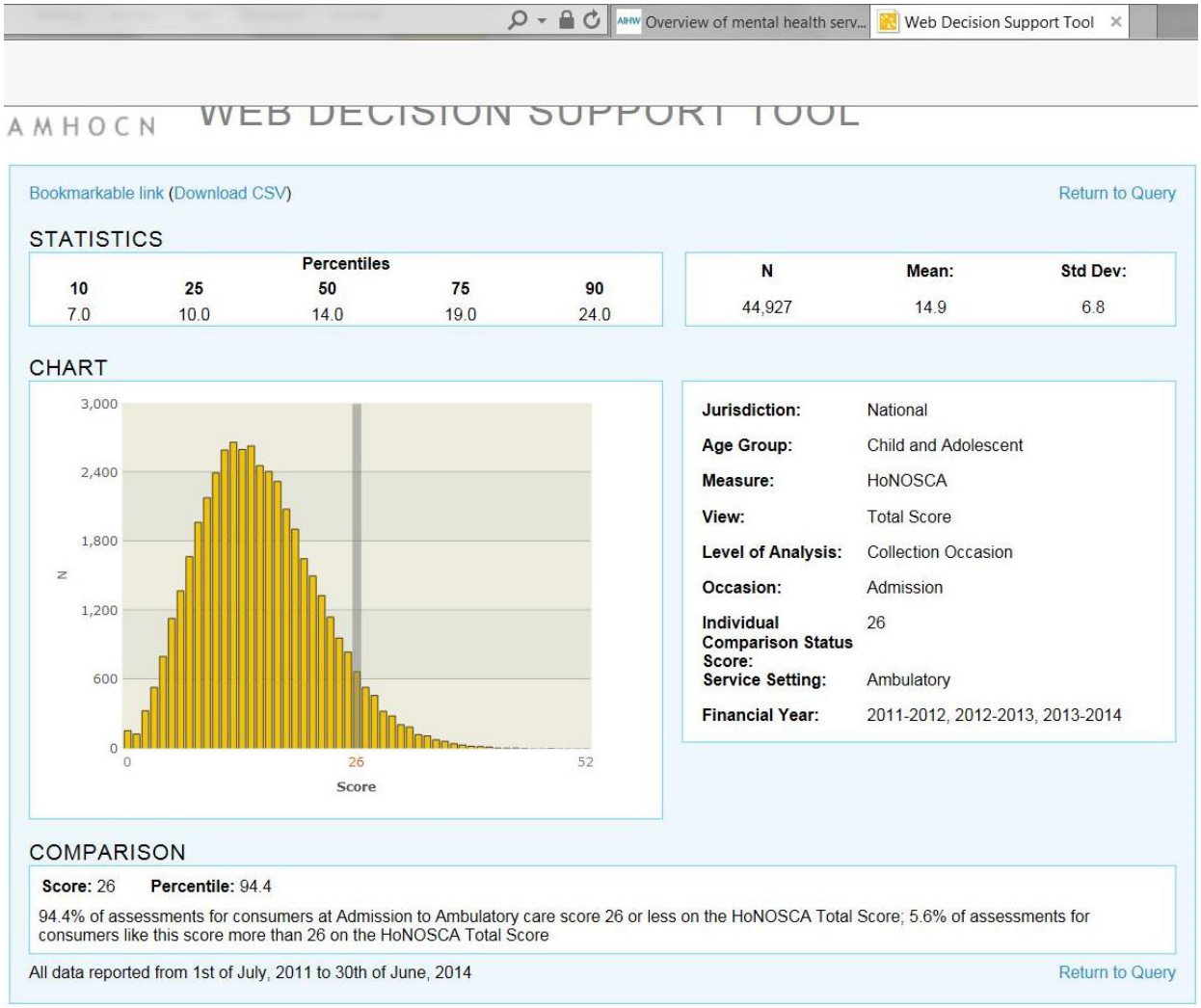
2. CAMHIDEAP notes that p.26 of the consultation paper recognises some of the cost variables that need to be considered in relation to CAMHS. The paper indicates that …"These included, but were not limited to, the interface between mental health care services and other government agencies, the impact of the mental health of primary carers and other social considerations." The paper goes on to say ....."However, it is important to note that not all of these variables are suitable for inclusion in a classification system which seeks to explain the costs of service delivery by the mental health sector, rather than the total economic cost of individuals' illness over time." This appears to be a misreading of the information previously provided. CAMHIDEAP notes that the significant collaborative and partnership activities undertaken with organisations such as education providers, community services or out of home care services are an integral part of routine clinical practice and can be directly attributable to a consumer when determining costings of service provision. This is not about the cost to other sectors, but fundamentally about the cost of providing effective care. To exclude, for example, costs associated with providing the evidence based practice of working with parents and teachers as key therapeutic recipients for a child with conduct disorder, is to both underestimate the true cost of treatment while accidentally privileging sub optimal treatment approaches. To be very clear, this is about the cost of effective mental health treatment, not about the long term economic cost of an illness. This panel has been engaged in these issues for a long time and we do understand the difference. CAMHIDEAP is aware that IHPA has used the HoNOS suite of measures as a proxy tool to inform the costings for the "other" liaison work that may be required for a consumer. CAMHIDEAP queries the validity of using the HoNOSCA for this purpose. The involvement of others is typically not 'liaison' but, in the majority of situations, 'treatment'. HoNOSCA per se does not provide direct information about the complexities that may serve as barriers to simple treatment. If IHPA has evidence that it does, then we would expect to see that evidence presented.

3. CAMHIDEAP has significant concerns about the AMHCC exclusion of work associated with carers and family members. CAMHIDEAP cannot stress strongly enough that this is basic good clinical practice and is a significant and vital part of current service delivery in CAMHS. Exclusion from

the AMHCC implies that this has less value and there is a real risk that services may choose to not undertake this work in the future. CAMHS across Australia has a protocol and measures for consumers and for parents (carers). Ensuring that their voice is routinely attended has been a challenging journey that we have largely structurally achieved in this country. While there is room for improvement in the rates of follow up with children and parents, the risk of the AMHCC conveying that only clinician views will be attended in questions of funding runs the risk of substantial culture damage.

4. CAMHIDEAP notes that mental health services across Australia variably gather information about a number of variables (e.g. trauma, a child's home environment and family structure) that can significantly impact upon a child or adolescent's mental health, increasing the complexity of the presentation and, as a result, the services that are provided to the child and his or her family. The AMHCC does not appear to have explored, or at least documented, the feasibility, validity or utility of any other variables. CAMHIDEAP would expect to see a detailed exploration of this issue with each and every jurisdiction. Only with an empirical examination can the potential of addressing the relationship of complexity to costings be explored.

5. Appendix B of the consultation paper indicates that the weightings for HoNOSCA are lower than those of the HoNOS. The absence of tenchnical infomrmation makes it difficut to comment on the validity of such weightings. The screen shot provided below from the Australian Mental Health Outcomes and Classification Network (AMHOCN) web Decision Support Tool (wDST) demonstrates that 94.4% or children and adolescents, at admission to ambulatory services, score below the AMHCC 'high complexity' threshold score. CAMHIDEAP believes that this raises some concerns about the face validity of the classification. CAMHS arond Australia are targetted to the severe and complex presentatons, and do not enter into the work that can be addressed by clinicans and agencies working in less intrusive and intensive approaches. Work with the population norms provided through the Strengths and Difficulties Questionnaire indicate that the clear majority of those seen by CAMHS are in the top precentile for mental health difficulties compared with the general population. On what basis, and with what cost differential, is the AMHCC suggesting that 94% of the most severe and complex child and adolescent mental health problems be funded at a lower level?



6. Higher HoNOSCA scores as compared with HoNOS scores are also required to reach that proposed AMHCC 'high complexity' threshold. CAMHIDEAP notes that HoNOSCA total scores do not provide a full picture of the presentation of a child or adolescent. In addition, the nature of the instrument is such that children typically have lower HoNOSCA scores than adolescents but this is not the same as demonstrating the complexities are lower. There is serious risk inherent in the application of the AMHCC that there would be a disincentive for services to see children who do not meet the AMHCC 'high complexity' threshold HoNOSCA score because they would not receive as much funding. Additionally, any factors that typically contribute to high complexity in a clinical and lived experience sense may be overlooked. For example, consider two children with similar HoNOSCA scores; however, only one child has a parent undergoing an active episode of mental illness. Within this scenario, examples of complicating factors include: the availability of the parent (or other carers), to attend to the therapeutic work for the child; the tendency for the child to be 'lost' in the focus on assisting the parent; the compounding of distress and guilt within the family unit; the likelihood that the 'caring' role for the child will complicate their temporal and emotional availability for treatment; and the interaction between the challenges that accompany an active mental illness in a parent with the array of factors that can affect most children's development (e.g. impact of separate living arrangements, parental absence, disharmony, family violence, disruption to friendships and schooling). It can be

anticipated that factors such as these create more work in the assessment and treatment of that child yet HoNOSCA will neither instantly nor adequately reflect this. The AMHCC operationalisation of 'high complexity' will overlook these actual complexities, and services may find themselves providing ineffective and truncated treatment in the face of this being classified as not reaching AMHCC 'high complexity' status.

7. CAMHIDEAP understands that weightings for service delivery in rural and remote settings and for indigenous consumers are attributed to a service as a whole and not linked to an individual consumer. CAMHIDEAP notes that, when considering costing, there are often quite different mixes of clinical staff between metropolitan and rural and remote services, requiring different associated support. CAMHIDEAP recommends that these rural and remote weightings and indigenous consumer weightings are made explicit in the AMHCC documentation. The lack of technical details currently renders it difficult to ascertain the appropriateness of this weighting. Furthermore, given that CAMHS clinical work more often than not requires involvement of other family members, the weightings may be different to that obtained where the consumer is presumed to be an independent individual.

8. CAMHIDEAP understands that IHPA also considered weightings for the use of interpreters in service delivery. CAMHIDEAP acknowledges that while the collection of interpreter data was inconsistent in the costings study, it is an important cost factor in service delivery. Typically to provide effective mental health care we need to use the most highly trained interpreters, at higher cost than interpreters used for physical health care. CAMHIDEAP recommends that specific project work be undertaken by IHPA to understand the cost impacts of the use of interpreter services and that this should then be included in the AMHCC. The lack of technical details currently renders it difficult to ascertain the appropriateness of this weighting. Furthermore, given that CAMHS clinical work more often than not requires the involvement of other family members and where interpreters need to understand the dynamics of family interactions, the weightings may be different to that obtained where the consumer is presumed to be an independent individual.

Phase of care

9. CAMHIDEAP has significant reservations about the overall suitability of phase of care for use in CAMHS. CAMHIDEAP believes that there are an excessive number of phases of care and the descriptions of the phases do not have relevance to the provision of care in child and adolescent mental health services. For example, the assessment work undertaken to ensure a child is ready for discharge is considerably more involved than the initial assessment undertaken when a child is first admitted to a service. The lack of relevance of the definitions of phase for CAMHS would make it difficult for clinicians to understand when change of phase should occur.

10. The phases of care, as described, articulate expected “doses” of treatment. CAMHIDEAP notes that this is contrary to clinical evidence based practice and could lead to over servicing. This disconnection from good clinical practice is also at odds with national policies and standards e.g. the requirement for 3 monthly reviews is set out in the *National Standards for Mental Health Services*. The AMHCC needs to decide if it is in competition, or if it is going to be congruent, with

the *National Standards for Mental Health Services*. The CAMHIDEAP recommendation is that the AMHCC must be congruent with the National Standards.

Alignment to national policies

11. CAMHIDEAP would also like to see how the AMHCC aligns to policy directions articulated in the *National Framework for Recovery Oriented Mental Health Services* which notes on page 9 that "……The focus on people's lived experience, and on the needs of people who use services rather than on organisational priorities, offers a new and transformative conceptual framework for practice and service delivery." CAMHIDEAP notes that the AMHCC does not take into account any consumer or carer outcome perspectives.

12. CAMHIDEAP also notes the relevance of other national policy initiatives e.g. the *National Mental Health Service Planning Framework* and other initiatives for youth mental health and suicide prevention. CAMHIDEAP recommends that the AMHCC should demonstrate alignment to these national initiatives.

13. CAMHIDEAP notes that there is not sufficient information that clearly describes the relationship between phase of care and episode of care, the key component of the *Mental Health National Outcomes and Casemix Collection*. No data about the relationship between the two, or the RIV offered by phases over episodes, appears to have been reported.

14. CAMHIDEAP notes the recommendations of the *NOCC Strategic Directions Final Report*, particularly in regard to the potential discontinuation of use of the CGAS and the FIHS. The consultation paper notes that "….Due to low sample size there was insufficient evidence to support the inclusion of either as a variable at this stage." CAMHIDEAP notes that it is keen to move forward with the recommendation regarding use of the CGAS and FIHS and would urge IHPA to undertake work that would determine whether these tools would be included in the AMHCC or not. The number of ambulatory episodes included in the modelling is only 27% of the collected sample according to the consultation paper. It is unclear what numbers of both children and adolescents are included, but the inability to comment on CGAS or FIHS worryingly suggests that the CAMHS population is a very small proportion of that already highly pruned sample. The representativeness of the sample by factors such as age bands, rurality, jurisdiction and presenting problems remains an overarching concern of CAMHIDEAP.

Implementation

15. CAMHIDEAP notes that the implementation of the AMHCC should not create more work than a service is actually funded to do. Phases of care, data infrastructure changes and training needs all have associated financial and time costs. Without financial support or an indication of which other activities should be foregone, reduced clinical service provision may prove to be the main source of time.

16. CAMHIDEAP notes that there will be a need for significant workforce training in using the AMHCC. A comprehensive training plan will need to be developed by IHPA in consultation with stakeholders.

17. CAMHIDEAP is also engaged in the development of processes and adaptation of measures for the important areas of infants and pre-schoolers, and with youth. It would be of benefit to ensure that developments in these areas are able to be appropriately included in the AMHCC.

Summary

18. CAMHIDEAP notes that there is insufficient technical information provided in regard to CAMHS to enable adequate review of the modelling underpinning the AMHCC. Therefore the AMHCC is limited in allowing CAMHIDEAP to provide comprehensive comment on its suitability with children and adolescents. CAMHIDEAP would be keen to see the data that has informed the development of the AMHCC, including the unknown source of the weightings for HoNOSCA.

19. CAMHIDEAP notes the risks for the implementation of the current draft AMHCC in CAMHS:

    - CAMHS is a smaller part of the mental health sector. If the costings model is not correct then there is a risk that small and specialist programs may disappear as a result of funding anomalies e.g. eating disorders clinics. Eating disorders in young people are characterised by challenges to do with engagement in both problem recognition and treatment approach. The young person, and often one or both parents, will often see a much lower level of problem than is indicated by their body mass index or history. Symptom severity is an important but limited part of the picture in understanding the cost of treatment. Re-starting services in response to new policy initiatives e.g. the *5th National Mental Health Plan* currently in development, is cost intensive. Have the costs of these critical yet small services disappeared in the 73% pruning of the sample? What may have been construed as 'outliers' may actually have reflected a small number of highly targeted models. The consultation paper does not provide any data on this.

    - As noted in point 3, the absence of costings associated with key components of CAMHS work (i.e. with parents and carers) can result in services only being funded for what is specifically identified in the classification.

    - Similarly, the 'high complexity' HoNOSCA threshold score (as noted in point 5) may result in service provision that is limited to only a small percentage of those currently using CAMHS, especially for ambulatory services.

    - The AMHCC presents a significant shift away from a focus on the outcomes of care to a focus on funding and casemix. Services may choose not to invest in work that helps understand service provision related to outcomes. Funding is important but CAMHIDEAP would suggest that we fund services to achieve effective outcomes, not just to have efficient pricing.

    - With the draft AMHCC, there is a risk of emphasising inpatient care to the detriment of community based care and interventions for children and adolescents may suffer as a result.

20. CAMHIDEAP would welcome the opportunity to provide a more robust analysis of the draft classification on receipt of more age-specific data detail from IHPA and would be keen to

continue providing advice on the development of an AMHCC that enables activity based funding to be grounded in the clinical approaches required in child and adolescent mental health.

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18 December 2015