The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), welcomes the opportunity provide feedback on the Consultation Paper *Development of the Australian Mental Health Care Classification.*

The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) has been dedicated to advancing the mental health and emotional wellbeing of Australian infants, children, adolescents and their families for over 20 years.

**Responses to consultation questions:**

**What are the most important factors to draw from international experiences in classifying mental health care?**

New Zealand was the only country that indicated applying classifications across child and adult mental health services in the international examples provided. Could further consultation with child and adolescent mental health services in Australia and New Zealand provide indications about the developmental appropriateness of classification systems?

In addition, the inclusion of age and ethnicity in the New Zealand classification would be important in the Australian context and would be an important focus for future scoping.

**What are the most important considerations in the national context?**

It will be important to ensure that classification systems take into account developmental needs of children and recognise that child mental health issues cannot be treated in isolation from the family and extended support networks (eg. early childhood services, schools etc).

**Are there any other principles that should be considered in developing the AMHCC?**

There is an acknowledgement that *‘At each level of the classification, children categories are mutually exclusive and jointly exhaustive of their parent.’* It should also be noted that the reverse is also true for parents with a mental illness (with dependent children) and this should be acknowledged. For example, Principle 2 (Clinical meaning) could group parents with a mental illness (with dependent children) as a group with similar characteristics needing similar treatment (eg. treatments and services provided to parents along with support offered to family members, children, carers/young carers at different phases of care).

Principle 4, acknowledges the importance of being based on patient/consumer characteristics. It is important that characteristics such as age and development, caregiving responsibilities (eg. parenting or carers/young carers) are also included data elements.

**Are there other cost drivers that should be considered in the development of the AMHCC?**

There is acknowledgement in UQ recommendations that costs are driven by multiple factors and list some examples. However, examples listed focus on consumer related drivers, but do not account for social factors that could also be cost drivers such as relationships, caregiving responsibilities, trauma, support networks, social adversity, geographic location (rural and remote),family violence, disability, safety, involvement of statutory services, family law and the social determinants of health. For this reason, social, relationship and community factors should be incorporated into cost drivers for both child and adult mental health services.

**Are there any further considerations in relation to the proposed architecture?**

The proposed architecture is not clear for a child’s mental health presentation. Practical examples would need to be added to aid the reader to understand this in practice.

The data domains focus on the individual and there is no recognition of the systemic context or family functioning being important for child and family health.

**Which psychological interventions, if any, may be of significant in understanding the cost of care?**

Systemic, family therapy and family psychological interventions are increasingly being promoted through mental health standards and legislation and will be important interventions to consider in understanding the cost of care. These interventions are generally routine practice in child and adolescent mental health services and are increasingly common in adult mental health services. Parents, children and carers often require family interventions in addition to individual focussed interventions. These may include psychoeducation, family therapy and preventative assessment and intervention. Similarly, costs associated with consultation, liaison and interventions within relevant community settings and serivces such as school, early childhood education and care, disability services, child protection and family support services will be important considerations in understanding the cost of care.

**Are there particular aspects or areas of the AMHCC that should be prioritised in its development, or aspects that should be developed at a later stage?**

It is not clear how the proposed model would work for child and adolescent mental health services where the majority of children and young people are supported in community settings. Also, how the model will work for the many children accessing services that have mental health issues that do not reach diagnostic classification levels. Currently the model does not appear to include preventative or early intervention strategies that are provided within a number of adult and child mental health services and community settings.

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