**Feedback on the Development of the Australian Mental Health Care Classification – Public Consultation Paper 1 – January 2015**

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

**General Comments:**

The scope of which services and populations are to be included in the classification are not well articulated in the paper. This needs to be clearly stated, as due to the geographical and resourcing diversity of Queensland it is unlikely that all mental health services will ‘fit’ with the homogeneous ideal. There has been little attention to areas where the clients/ services will be unique to the population.

A concern is that the proposed definition of mental health care focusses on diagnosis and treatment of a mental disorder. There is 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. The definition is also not articulating the range of systemic work that would be required to work with a child or adolescent, although it is welcomed that the family and carer support was included. The wording of the definition also does not fit well within a developmental framework as it focusses on functionality (with no definition of what this would mean, for example for a 3 year old).

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 cannot be underestimated in relation to cost and time.

**Consultation questions**

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

* There is a lack of specific child and adolescent scope of work undertaken internationally in classification of mental health care particularly in relation to areas such as infant mental health and specialities like child and youth forensic mental health services, which have none that we are aware of.
* NZ 2003 study states their classification work is applicable to child and adolescent population but doesn’t clearly articulate the applicability or relevance to children of varying ages from infant through to adolescent, whose mental health needs would vary significantly.
* There appears to be limited applicability to community based mental health services (which make up the bulk of our CYMHS services in Queensland). The focus appears to be on inpatient and residential services primarily.
* Important factors are: age; setting; legal status; ethnicity; family factors; outcomes; comorbidity; demographics (particularly rural and remote settings); living situation; length of stay or care type

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

* It is essential that we identify the differences in requirements and the provision of mental health services to infants, children, adolescents and their families. An adult centric model will not capture this adequately.
* De-centralisation of mental health services (MHS) in Qld and other States - this impacts directly on access to specialist services within MHS. Therefore cost drivers / care bundles / phases of care/ may not be consistent e.g., specialist services such as early psychosis / forensic, which exist only in larger services.
* Challenges to ensure resource homogenous in child and youth setting
* Need to recognise systemic work with infant s, children and adolescents incorporating their families, care providers and other critical stakeholders such as the education system. Social factors, family functioning and physical health status will all impact on the treatment options and outcomes.

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

* Consideration of systemic e.g., patient / consumer based needs to include family / parents / carers / siblings as this accounts for significant / substantial work within CYMHS . Non recognition of this will be a critical oversight.
* The advantages and disadvantages of a discrete classification system for the mental health population which may be influenced by a range of drivers/factors/systems which impact on the ability to be slotted consistently into categories in a consistent manner as detailed in the principles. That is, mutually exclusive classification with class definitions and assignments being clear, consistent and unambiguous; classification being about to be applied consistently across different settings; minimising local interpretation etc.

**4. Are there further data or other limitations of which the AMHCC should be aware?**

* Outcomes data collection tools are broad and not necessarily capturing detail to the level that might be needed for discrete classification system.
* Outcomes data collection tools are out of scope for some specialist mental health service components (such as Early Years) or not valid for the work of specialist mental health service components (such as Forensic) - acknowledge that work is currently being undertaken in both of these components.

**5. Are there any other key considerations that should be taken into account in developing the AMHCC?**

* Need to ensure an individual, recovery focus approach that takes into account systems around an individual and support factors may make the development of discrete classification less reliable statistically – in terms of reliability and consistency for reporting.
* Although there are broad categories there was no mention of family functioning, developmental and functional impairment, socioeconomic status and a range of other factors that define complexity in the child and youth setting and can significantly reduce the through put within the CYMHS system. There appear to be gaps in the content regarding CYMHS related variables for defining complexity and costs.

**6. Are there other costs drivers that should be considered in the development of the AMHCC?**

* Need to be mindful of the systemic and complexity issues related to family supports, geographical location, SES, legal and indigenous status and other systems such as family/carers/siblings/school/work )and the intensity of system supports based on consumer need and engagement by consumer/systems.

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

* Variation in access to specialist program elements based upon geography (specialist programs such as: perinatal and infant mental health; early psychosis; mobile teams; inpatient units; day programs; forensic services; Evolve therapeutic services etc. may not exist across all geographical areas (eg. Rural, regional etc. - impacts)
* Outcome measures may not capture above specialist program elements or they may not be delineated well by services whom do not have distinct separate specialist program elements articulated in their staffing profile.

**8. Is there any further evidence that should be considered in testing the proposed architecture?**

Again there needs to be emphasis on working with children and adolescents. For example Table 2 in the data domains for Phases of Care in the Mental Health Costing Study, focusses on the ‘single patient’ concept and the pre-existence of a psychiatric disorder, very much an adult model. Few if any young people can be successfully treated in isolation from their family or care support systems. This also does not reflect the preventative work that CYMHS will engage in to reduce the likelihood of young people having enduring mental health issues.

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

Key issues significant to the child and youth population that impact on costings are

* the developmental age of the young person
* the family system and functionality of same
* the educational system and the interface with the mental health system
* the involvement or not of statuary bodies such as child protection or juvenile justice
* SES and social impacts relevant to the family
* Adversity such as abuse and neglect, trauma, physical or intellectual impairment, chronic illness, obesity, cultural issues, homelessness, substance abuse and poor social networks
* Consultation Liaison (CL) services which are a core component of CYMHS services and it is not clear how CL will be identified within the classification, as these services often do not deal directly with a client, but may support the general health and family systems.
* Specialist clinical roles are also vital to CYMHS, i.e. EdLinQ and Multicultural Mental Health Co-ordinators, whose role involves a large component of consultation liaison, it is not clear how the classification system will capture this activity.

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