Women's & Children's Healthcare Australasia submission in response to IHPA's public consultation on the development of the Australian Mental Health Care Classification—February 2015

http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/sub-recieved-mental-health

Thank you for the opportunity to provide comment in response to the above Consultation Paper on the framework for the Australian Mental Healthcare Classification.

Children's Healthcare Australasia (CHA) is the peak body for hospitals providing paediatric health care across Australia and New Zealand, while its sister organisation, Women's Healthcare Australasia (WHA) is the peak body for hospitals providing maternity and women's health services across Australia. Together, these organisations represent more than 100 hospitals in these 2 sectors of healthcare, including the majority of women's services involved in providing mental health care to women during the perinatal period and children's services providing child and adolescent mental health care.

The consultation paper was circulated widely to senior executives within our member hospitals. The following responses reflect their collated feedback.

In general terms, our members support the work being undertaken to develop an Australian Mental Healthcare Classification (AMHCC). The challenge of doing so is recognized. On the one had the classification needs to be comprehensive and able to support funding, while on the other it needs to be flexible and nuanced, and clinically relevant and not become a barrier to the provision of appropriate mental health care. A few of our members advised that they are participating in the costing studies associated with this project and will be happy to support this work through that project.

Perhaps the biggest concern of CHA members is that the definition proposed to underpin the classification is focused on diagnosis and treatment of a patient's 'mental disorder'

> *Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical function relating to a patient's mental disorder.*
>
> *Mental health care:*
> - *is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health;*
> - *is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and*
> - *may include significant psychosocial components including family and carer support.*

Child & adolescent mental health experts are concerned that this definition risks excluding the important preventative work that their services are doing on a daily basis to intervene

early in the life of a child identified as being at significant risk of developing mental disorders with the goal of restoring the child to a normal developmental pathway and to the prospect of mental health as they grow into adults. CHA is comfortable with the description of mental health care in the second half of this definition, and particularly welcome the recognition that family and carer support is a critical factor. The definition would be more inclusive of child & adolescent mental health care if the first paragraph were amended to provide for care that includes interventions to promote/support mental health in a child/adolescent identified as being at risk of a mental disorder.

We recommend the definition be amended to read something like the following:

> *Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical function relating to a patient's mental disorder and/or to a patient's identified risk of developing a mental disorder*

The key concern of WHA members, particularly the Women's Hospitals is that perinatal mental health care is complicated by the need to simultaneously provide obstetric and midwifery care to both the woman who is experiencing perinatal mental ill health and to her fetus/baby. This poses significant challenges in the provision of services, as there are no mental health services in Australia organised to provide obstetric or midwifery care to that cohort of patients, and conversely few maternity service providers have dedicated mental health care services. This may be more of a management/administrative issue than one of classification development. Yet it highlights the need to think broadly of the range of contexts in which mental health care is provided, and to recognise that the patient receiving care is not an isolated individual.

Consultation questions

1. What are the most important factors to draw from international experiences in classifying mental health care? (*See pages 11 – 16)*

We recognize that UQ undertook a review of international literature and classifications related to mental health care and that there are examples in England, Canada, New Zealand and elsewhere that are worthy of consideration.

However, it appears that few of the existing classifications (with the exception of the New Zealand approach) provides a robust model for classifying child and adolescent mental health care. The System for Classification of In-Patient Psychiatry (SCIPP) developed in Ontario, Canada, for example, explicitly states that it relates to adult inpatient mental health services.

CHA supports the commitment reflected by the New Zealand classification to include age as one of the important elements for grouping patients with similar characteristics and costs. The mental health care needs of a 3 year old child, a 10 year old child or a 14 year old adolescent vary significantly, as do the mental health care interventions that are

appropriate to children at different developmental stages. While age is not a fully robust proxy for developmental capacity, it is a workable basis for clustering patients.

We also support the proposal (captured in the New Zealand classification) to be inclusive of both admitted and non-admitted settings, child & youth mental health care and forensic mental health services. One of the key activities of Child & Adolescent Mental Health Services in Australia relates to forensic mental health, including care of children who are victims of family violence, neglect or abuse, children held in youth detention as part of the criminal justice system, and children with significant co-morbidities such as physical disabilities or rare genetic disorders.

2. What are the most important considerations in the national context? (*See pages 11 – 16)*

It is essential in developing the Australian classification that attention is paid to the differences in the needs of, and provision of mental health services to, children and adolescents compared with adults. In particular CHA's members are concerned to see that the new Classification once developed:

- Caters for the fact that children's mental health needs and treatments differ not only from adults but from one another depending on the developmental age of the patient.
- Recognises that mental health care for children and adolescents involves care/support being provided not only to the individual child/adolescent but to their family/carers. Social factors, family functioning as well as organic/somatic co-morbidities all influence the interventions and therapies employed.
- Provides a basis for classifying care that is provided to children/adolescents that includes early intervention in a child at risk of developing a mental disorder but who does not yet have a diagnosed disorder. Such care is a critical part of child & adolescent mental health services.

3. Are there any other principles that should be considered in developing the AMHCC? (*See pages 17 – 19)*

CHA members support the principles listed, particularly principle 2 (clinical meaning/relevance) and 4 (patient/consumer based).

CHA particularly endorses the commitment for the classification to be meaningful and relevant across different settings of care flagged under Principle 4. The artificial administrative and funding barriers between hospital inpatient and community based mental health services presents a daily challenge to clinicians working to achieve the best possible outcomes for children and young people experiencing mental health issues and their families. A unifying classification would be an important first step to supporting redesign of some of these arrangements to make collaborative care between clinicians in different settings much easier and support greater 'wrap around' care for children and their families requiring mental health care.

There is, however, a need to articulate one important additional principle: that of care being inclusive of family/carers. It is not clinically effective nor evidence based to treat children and adolescents in isolation from their families/carers, except in the relatively rare circumstance where a child or adolescent has no relatives or known carers. If the classification is to be used to underpin funding arrangements, then it will only add value over existing limited AR-DRG codes by recognising that in the child and adolescent mental health space at least, care is necessarily provided to not only the patient but to the parents/carers on whom the child is dependent. Without such an approach, rates of readmission and the burden of unresolved mental illness can be high.

4. Are there further data or other limitations of which the AMHCC should be aware? (*See pages 17 – 19)*

Two CHA members, the Sydney Children's Hospital Network and the Lady Cilento Children's Hospital advised that they will be taking part in the upcoming costing study. They are happy to advise on data issues as part of that project.

5. Are there any other key considerations that should be taken into account in developing the AMHCC? (*See pages 17 – 19)*

6. Are there other cost drivers that should be considered in the development of the AMHCC? (*See pages 18 – 24)*

We note that the UQ researchers concluded that "mental health costs are driven by multiple factors, including (but not limited to) diagnoses, complications and co-morbidities, symptoms severity and function".

While these drivers are equally relevant in child and adolescent mental health as they are in adult health, there are a number of additional cost drivers In child & adolescent mental health services including:

- the developmental stage of the child being treated
- the child's intellectual capabilities,
- somatic co-morbidities, AND
- systemic factors – including the family, social, environmental and other factors influencing the child's life, development and mental condition

It is difficult to overstate the importance (and impact on costs) of the systemic factors when treating children and adolescents. For example, a clinician might spend double the time gaining consent to treat a child whose parents have opposing views on their care than the clinician would in gaining consent from an adult patient. The younger the child the more problematic this can be.

There needs to be some analysis of the ways in which these factors impact on mental health care costs and help predict costs for different cohorts of children & adolescents.

7. Are there any further considerations in relation to the proposed architecture? (*See pages 25 – 30)*

CHA recognises the challenge of coming up with a comprehensive and mutually exclusive structure for an area of healthcare that involves a high degree of qualitative decision-making and considerable flexibility and adaptation to the needs of individual patients.

CHA strongly supports the proposal that the AMHCC be "setting and provider agnostic" but are not convinces the proposed structure will achieve this.

Members support the recognition that the classification should be based upon the consumer (Level1) but reiterate the point made earlier, that the in child and adolescent mental healthcare, the child must be assessed and treated in the context of their family and other social circumstances if care is to be effective. Further, the child or adult patient is not credibly a level in the classification structure.

Re Level 2 - Agreed that individual patients may have one or more episodes of illness (Level 2) but CAHMS clinicians are concerned to ensure that development of the detail behind this would include children and adolescents identified as being at risk of mental illness (e.g. through developmental delays) as well as those with a confirmed illness or illness symptoms.

For example, a 5 year old child who starts school without 'normal' language skills may not have symptoms of mental illness at that time. But without early identification and intervention to support the development of language necessary to participate fully in the educational and social environments of school life, many children develop significant mental illness symptoms within the first few years of school. It will be important that the classification does not preclude identification and treatment of such children through focusing only on mental illness once manifested.

Still on level 2 - Recognition of the need to cross reference to non-mental health related episodes at Level 2 is also highly relevant in CAMHS, especially with such illnesses as eating disorders.

Level 3 – Episodes of Care, as admitted or not is straight forward, but there was some confusion among our members as to why the Phases of Care are presented as a lower level in the classification to Episodes. If the Phase of Care (Level 4) is defined as:

> "a prospective assessment of a patient's needs defined by patient characteristics and the associated goals of care (the 'patient journey') rather than solely by the physical location of treatment (e.g., acute unit, rehabilitation unit) or the treating clinical team (e.g., acute team, rehabilitation team)"

then it would seem logical that the Phases of care concept would precede Level 3 which identifies where the care is provided and by whom.

8. Is there any further evidence that should be considered in testing the proposed architecture? (*See pages 25 – 30)*

Regarding the Data domains for Phases of Care in the mental health costing study (as outlined in Table 2), our members supported the addition of an initial assessment category, and the proposed change of terminology from 'maintenance" to "consolidating gain".

However, again, members urge the developers to consider the specific issues related to the care of children and adolescents with mental health needs or illnesses. The two key factors already raised above remain relevant in this context:

- the typology as presented in Table 2 remains focused on a single patient, when very few children or adolescents can be treated in isolation from their parents/carers
- the typology is based upon the assumption of the pre-existence of a psychiatric disorder when a great deal of CAMHS care involves intervention/treatment to help prevent an at risk child/adolescent from developing a psychiatric disorder.

Many of our members expressed concern that "the real world of mental health care for children and adolescents is messier" than the classification structure currently implies. For example, CAMH experts within our membership pointed to the fact that in children and adolescents, acute and functional gains phases are often inter-related, making it difficult to categorise care as belonging to one or the other phase. There are also cases where care can involve extended episodes of care, focused on preventing self harm or suicide long enough that the child or adolescent's brain reaches the next level of maturity.

9. Which psychological interventions, if any, may be of significance in understanding the cost of care? (*See pages 25 – 30)*

The key issues that affect the cost of delivering mental health interventions in Child and Adolescent Mental Health Services include the following:

- the developmental age and maturity of the patient
- the family environment for the child/adolescent
- the role of the child's school
- the involvement or not of statuary bodies such as child protection or juvenile justice
- the extent or not of social adversity of the child and their family/carers.

A number of risk factors around social adversity have been identified, including;

- family factors – e.g. family violence and disharmony, divorce, custody disputes, etc).
- life events and situations – e.g. physical, sexual and emotional abuse, neglect, homelessness, trauma
- community factors – e.g. isolation, lack of support services
- school context – e.g bullying, peer rejection, inadequate behaviour management

These need to be reflected in classification and in the designation of treatment interventions. Responding effectively to the mental health implications for children presenting with one or more of the above circumstances requires interventions that extend well beyond care co-ordination or treatment of the individual child/adolescent in isolation.

The developmental stage and intellectual capabilities of the child is also important here as this impacts on how the child copes within his or her environment. For example, a crisis can be triggered by school-related stressors, which can often be related to the child being in the wrong school (e.g. where there is a mismatch between high school demands with regard to the developmental stage and intellectual capabilities).

Consultation and liaison is a vital role of CAMHS: this includes primary and secondary consultations to other stakeholders re needs as well as care coordination and development of interventions for all of the relevant systems in a child's life. These interventions may not include direct contact with the child or family, but add significant value and must be costed.

10. 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? (*See pages 31 – 32)*

11. Are there any further considerations that should be taken into account when developing the AMHCC? (*See pages 31 – 32)*

CHA understands that 2 children's hospitals have been invited to participate in the upcoming costing study. We welcome their involvement. While these services are more likely to have the capacity to participate and assist in the analysis, CHA urges the developers to recognise that paediatric mental health services are also being delivered in regional centres sometimes by paediatric units and sometimes by adult mental health services administered separately from paediatric units. It will be important for cost drivers of child and adolescent mental health to be analysed in some depth, and for such analysis to consider the range of settings (hospital, community, primary health, telehealth) in which such care is provided.

The distinctive features of child and adolescent mental health outlined in our submission above require careful consideration in the development of the classification as well as in the analysis of the cost drivers for appropriate care. There are significant differences between the provision of mental health care to adults and that which is necessarily provided to developing, dependent and sometime socially or emotionally deprived babies, children and adolescents.

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