Department of Health

Child and Adolescent Day Program (CADP) Services
Discussion paper, December 2013

Purpose

To review the current structure and business processes for child and adolescent day programs (CADP) within Queensland Mental Health Services. This document provides an opportunity to identify issues and compare statewide CADP services with the long term goal of developing a standardised business process that will assist in capturing CADP specific data to support clinical practice and continuity of care, development of an appropriate evidence base and service evaluation and reform.

Background

The Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy outlines the way forward to identifying and a range of contemporary service options for adolescents to replace the extended treatment services currently delivered through the Barrett Adolescent Centre.

This work is strategically led by a Chief Executive Oversight Committee and a Project Steering Committee, supported by a number of working groups. As part of the process, stakeholders have sought information regarding child and adolescent day programs, particularly in relation to comprehensiveness and comparability of available data. In July 2013, Child and Youth Mental Health Services that currently deliver day programs participated in a meeting to discuss their data collection practices and identify issues associated with capturing the of treatment delivered within complex service models.

Subsequent to this meeting the Information and Performance Unit, Mental Health Alcohol and Other Drugs Branch were tasked with identifying and comparing (at a high level) the current service structure and business processes utilised by mental health CADP.

Child and Adolescent Day Programs

There are three Hospital and Health Services (HHS) within Queensland Mental Health that have Adolescent Day Program services – Townsville, Darling Downs, and West Moreton. Mater Health Services also provides a publicly funded CADP, and is the only site that has both children and adolescents attending.

All day program services across the state are run for mental health consumers only and generally inpatient and community consumers access the same group activities, however some HHS, such as Darling Downs, also run separate programs for inpatient and community. Some consumers will move between being inpatient and community clients (and vice versa), whilst continuing contact with the day program.

A typical day for the day program commences with a meeting, group walk, and various school subjects, broken up by meals and then therapy or other group activities. All services are generally worked around the school sessions.

Consumer categories

Across the services there are a three common scenarios in which consumers are seen.

Community case managed consumers who link in with the day program services.

For these consumers the Principal Service Provider (PSP) is a staff member from a community mental health team, generally a Community Child and Youth Mental Health Service (CCYMHS) and the day program staff are identified as Other Service Providers (OSP). Three sites have consumers in this category – West Moreton, Townsville and Toowoomba.

Community consumers who are case managed by the day program teams.

For these consumers the PSP is a day program staff member. All four sites have consumers in this category. Some sites identified that consumers who are to be managed solely via the day program are often consumers coming from the inpatient unit after discharge.

A subset of this category relates to consumers for who only attend the 'school' day program services. There are very few of these consumers in this subset, and Mater has no consumers in this category.

In some sites, consumers are returned to the CYMHS teams during school holidays for case management.

Inpatient consumers who attend day program services/activities.

For these consumers the PSP is usually the inpatient staff, with day program staff identified as OSP in some cases.

Resources and operating hours

Table 1 provides an overview of the hour of operations and summary of type of resources available for each HHS.

Table { SEQ Table * ARABIC }: Hours of service and available resources

HHS	Hours of Operation	Staffing	Acute beds
Townsville	8am to 4.30pm (Mon to Fri	Clinical and Administration	8 beds onsite
Mater Health Services	8am to 4.30pm (Mon to Fri)	Clinical and Administration	12 beds onsite (child and adolescent beds)
Darling Downs	9am to 3pm (Mon to Fri)	Clinical and Administration	8 beds onsite
West Moreton[1]	9am to 6pm (Mon to Fri)	Clinical and Administration (sourced from extended treatment service)	Accesses acute inpatient services from Logan Hospital.

Notes:

a. *Following the closure of the Barrett Adolescent Centre Extended Treatment Services, the day program will cease operation in 2014. Replacement services are being identified through the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy.*

Department of Education, Training and Employment (DETE)

Day program school activities are run by DETE and Queensland Health staff either for individual consumers or through group activities (e.g. fitness group). School staff operate on site and in most cases DETE provides resources to mental health consumers only.

Mater Health Services have a Hospital School utilised by all hospital patients. It is run by DETE and a dedicated mental health liaison teacher provides handover for mental health consumers attending either the day program and inpatient services.

Data collection practices

Each HHS has a dedicated day program team and treating unit set up within the Consumer Integrated Mental Health Application (CIMHA) to capture consumer information and activity data. Each operates under their own locally defined business processes (which vary across the state).

There is considerable confusion around how best to capture the services provided, who should be capturing it and at what point (largely due to the multiple service providers involved in the consumers care and not having a specific framework for day program data collection). Measuring community/ambulatory domains is complex as there is no standard way of capturing the intensity of treatment that occurs in a day program. Further, the consumer is often treated by a team, not by one individual clinician.

In a number of cases where the consumer is being primarily managed within another area of the service (i.e. inpatient and other community teams) their Provision of Service (POS) activity is not being consistently captured in such as way that will enable identification of the involvement of the day program team (i.e. there is no/limited activity data to show they are attending a day program, but rather only identifies involvement of other teams, such as the primary case management team).

This is compounded by the inability to accurately capture POS activity for groups run by the day program due to the variety of PSPs and teams that their consumers are captured under. In addition to this difficulty occurs when allocating intervention types as it is felt that they don't accurately capture the services being provided. For example; Where consumers are in transition from inpatient to the day program and on to a community setting; there is confusion as to how to record activity where a staff members accompanies the consumer to support them because of anxiety, until they are confident on their own.

When a consumer moves between being an inpatient and a community client (or between mental health networks), their service episodes are ended and re-commenced against the new service type. This usually occurs when the primary care of a client is taken over by another service type.

Concerns have been raised from some services that their day program service is similar to how an inpatient unit operates rather than a community team and therefore it is harder to capture activity i.e. whole team involved in treatment of services not specific individuals. A suggestion was made that changing the 'category' day programs services were captured under should be considered as it was felt that they didn't fit well into either community/ambulatory or inpatient categories.

Data analysis, results and discussions

The following analysis of 2012-13 data from the Consumer Integrated Mental Health Application (CIMHA) is for all consumers who:

- were under the primary care the adolescent day program, or
- who had a POS recorded where a staff member of a day program participated.

Across the state, 384[1] distinct consumers were able to be identified in CIMHA (see Table 2). Of these, 56.3% accessed Mater, 15.6% accessed Townsville, 14.1% of accessed West Moreton and 14.1% accessed Darling Downs services.

Table { SEQ Table * ARABIC }: Consumers accessing adolescent day programs, 2012-13

	Hospital and Health Service				
	Townsville	West Moreton	Darling Downs	Mater	Statewide
Number of consumers	10	9	9	36	64

It is important to note that the number of identified consumers, and subsequent analysis, is likely to be an underestimation of consumers accessing services due to the data collection issues outlined above. Additionally, due to the comparative number of consumers that are identified as accessing Mater Health Services CADP, the statewide analysis is strongly influenced by the Mater's profile.

The following data analysis relates to consumers who meet the definition above.

Services accessed

The data shows that consumers are accessing either a day program only or a combination of community and inpatient programs simultaneously. Based on how day program data was entered[2], seven different types of interactions (referred to as 'program type'), outlined in Table 3, were identified. Overall, the majority of consumers were accessing both day program and CCYMHS (62.5%), with the exception of West Moreton who had no consumers in this category, but a higher proportion of consumers accessing day program only or day program and other community services. Data shows that 15.6% of consumers were accessing both CADP and inpatient services and only 7.8% were accessing only the CADP. Due to small numbers in each group, caution in interpretation is required.

[1] Three consumers from Mater and two consumers from Townsville are excluded because they had POS Interventions with a consumer duration equalling zero.

[2] For example, if a consumer's POS data only involved day program staff then they were linked to the 'day program only' category, if their POS data was linked to both day program and Community CYMHS staff then they are included in 'day program and CCYMHS' category and so on.

Table { SEQ Table * ARABIC }: Distribution of day program consumers accessing additional services, 2012/13

Program type	Consumers accessing Program Type					
	Hospital and Health Service				Statewide	
	Townsville	West Moreton	Darling Downs	Mater	No. consumers	Total Program (%)
CADP only	10.0%	33.3%	n.a.	2.8%	5	7.8%
CADP & CCYMHS	60.0%	n.a.	66.7%	77.8%	40	62.5%
CADP, CCYMHS & adolescent inpatient	n.a.	n.a.	22.2%	13.9%	7	10.9%
CADP & other community	n.a.	44.4%	n.a.	n.a.	4	6.3%
CADP, CCYMHS & other community	30.0%	11.1%	n.a.	2.8%	5	7.8%
CADP, adolescent inpatient & other community	n.a.	11.1%	n.a.	n.a.	1	1.6%
CADP, CCYMHS, adolescent inpatient & other community	n.a.	n.a.	11.1%	2.8%	2	3.1%

Notes:

a. n.a. – not applicable

b. HHS proportions refer to day program consumers in this program type as a proportion of day program consumers in the HHS.

c. Statewide 'Total Program' refers to day program consumers in this program type as a proportion of day program consumers across the State.

d. Due to rounding, totals may not sum to 100%.

Consumer profile

Table 4 shows the sex and age distribution of consumers accessing CADP. Overall, 47.1% of consumers accessing CADP were 15 to 17 years of age, with a further 35.2% aged between 10 and 14 years. Only 39.3% of consumers accessing these services were male. There is difference in the age profile of males and females attending CADP, with more than half (52.6%) of females being aged 15 to 17 years, whilst more than half of males (53.3% were aged 14 years or less.

Table { SEQ Table * ARABIC }: Age and sex profile, 2012/13

Age Groups	Female	Male
0 – 5 years	1	1
5 – 9 years	8	17
10 to 14 years	72	63
15 to 17 years	122	59
18+ years	29	12
Statewide	{ =SUM(ABOVE) }	{ =SUM(ABOVE) }

Notes:

a. Age is calculated as at the first POS contact date with CADP in the reference period.

Table 5 shows the age distribution against the different diagnostic categories. In 2012-13, 46.1% of consumers had identified anxiety and depression and a further 21.1% had behavioural and emotional disorders. There was a difference in the profile across females and males, with the majority of females (53.9%) being seen for anxiety and depressive disorders, whilst for males there was a relatively even split between anxiety and depression (34.2%) and behavioural and emotional disorders (33.6%). The majority of consumers with eating disorders and self-harm and suicidal ideation were female.

Table { SEQ Table * ARABIC }: Age and diagnosis profile, 2012/13

Diagnostic Groups	Age groups					
	0 – 5 years	5 – 9 years	10 – 14 years	15 – 17 years	18+ years	Proportion of Total
Anxiety and Depression	-	8	55	103	11	46.1%
Behavioural and emotional	1	14	50	16	-	21.1%
Eating Disorders	-	-	3	9	1	3.4%
Medical	-	-	1		-	0.3%
Mental and behavioural disorders due to substance use	-	-	-	5	2	1.8%
Mental disorder, not otherwise specified	-	-	3	3	-	1.6%
Other	1	-	3	9		3.1%
Other Mental Health	-	2	14	7	7	7.8%
Psychosis	-	-		9	13	5.7%
Self-harm and suicidal ideation	-	-	3	6	2	2.9%
Unknown	-	1	3	14	5	6.0%
Total	2	25	135	181	41	

Notes:

a. Age is calculated as at the first POS contact date with CADP in the reference period.

b. Diagnosis is the most recent Principal Diagnosis recorded (as at the last POS for the reference period)

Activity profile

Table 5 provides a summary of POS provided and average duration of POS for consumers of CADP. Overall, consumers received 3.7 hours of care across 145.2 POS. As Table 5 shows there is significant variability across HHS. The low hours of care indicates substantial underreporting of activity.

Table { SEQ Table * ARABIC }: Summary of POS activity, 2012/13

HHS	No. of Consumers	No. POS	Average POS per Consumer	Annual POS duration per Consumer (hrs)			
				Average Duration	Max	Median	Min
Townsville	10	1,300	130.0	3.1	6.2	3.0	0.3
West Moreton	9	355	39.4	5.2	9.7	4.0	2.3
Darling Downs	9	957	106.3	2.3	5.0	2.0	0.8
Mater	36	6,679	185.5	3.8	9.5	4.0	0.0
Statewide	64	9,291	145.2	3.7	9.7	3	0.0

Notes:
a. *No. POS refers to all POS for consumers of a CADP, where those POS were identifiable as related to CADP.*
b. *Annual POS duration refers to the number of hours of care a consumer received in relation to a CADP.*
c. *Duration of 0.0 is due to rounding and means that the annual duration was less than 3 minutes.*

Table 6 outlines the different modalities utilised to deliver POS to CADP consumers. As would be expected the majority of POS (72.6%) were delivered 'in person'. There was variation across HHS in regards to the other delivery modes utilised, with Mater and West Moreton having a higher proportion of POS delivered with a mode of 'other', whilst Darling Downs had above the average amount of activity delivered via telephone.

Table { SEQ Table * ARABIC }: POS Delivery Mode, 2012-13

Delivery Mode	Delivery Mode					
	Hospital and Health Service				Statewide	
	Townsville	West Moreton	Darling Downs	Mater	No. POS	Total POS (%)
In Person	84.8%	67.3%	74.7%	70.0%	6,743	72.6%
Videoconference	n.a.	n.a.	0.2%	0.0%	2	0.0%
Telephone	8.8%	7.6%	14.5%	5.8%	666	7.2%
Electronic Mail	0.5%	2.5%	2.3%	1.3%	125	6.3%
Postal/Courier Service	n.a.	n.a.	0.5%	0.1%	9	0.1%
Other	5.0%	22.5%	7.7%	22.9%	1,746	18.8%

Notes
a. *n.a. – not applicable*
b. *HHS proportions refer to number of POS as a proportion of total POS recorded for day program consumers in the HHS.*
c. *Statewide 'Total POS (%)' refer to number of POS as a proportion of total POS recorded for day program consumers across the State.*
d. *Due to rounding, totals may not sum to 100%.*

Table { SEQ Table * ARABIC }: Consumer Participation in POS, 0212-13

Participation	Hospital and Health Service				Statewide	
	Townsville	West Moreton	Darling Downs	Mater	No. POS	Total POS (%)
Consumer Participated	77.9%	42.5%	60.4%	42.2%	4,556	49.0%
Consumer Did Not Participate	22.2%	57.5%	39.6%	57.9%	4,735	51.0%

Notes
a. *n.a. – not applicable*
b. *HHS proportions refer to number of POS as a proportion of total POS recorded for day program consumers in the HHS.*
c. *Statewide 'Total POS (%)' refer to number of POS as a proportion of total POS recorded for day program consumers across the State.*
d. *Due to rounding, totals may not sum to 100%.*

Consumer participation variations were also analysed and presented in the Table 6. It is observed that the percentage of consumers who participated in the POS activities were marginally less than those of not participated (49.04.1% vs 50.96%). The results indicated that the participation rates vary among the services.

National processes

Advice was sort from each jurisdiction via the Mental Health Information Strategy Standing Committee National Minimum Data Set Subcommittee. In summary the adolescent day programs remain an area of variable practice both within and among state jurisdictions, due to a combination of model of delivery and reporting differences. The differences seem mostly related to the model of care developed for the Adolescent Day Program (ADP), for example, exclusively attended by bed-based patients, a mix, or all community-based patients. While national collections are mandated (via National Minimum Data Set (NMDS)) variance is likely to continue due to jurisdictional differences in the way these services are delivered.

Table { SEQ Table * ARABIC }: Summary of national collection practices,

Collection Setting Type	New South Wales	Victoria	Western Australia	South Australia	Tasmania
Community/ambulatory	✓	✓	✓	✓	✓
Inpatient	✓		✓		

Notes
a. A tick indicates the setting that information is collected against.

Next Steps

Provide information to the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Project

Engage key stakeholders and liaise with the Statewide Adolescent Extended Treatment and Rehabilitation Implementation project group to develop standardised data collection practices to address issues identified throughout this paper.

Finalisation of the draft Model of Service should occur within the Office of the Chief Psychiatrist (OCP) utilising the clinical network as this will assist with determining data collection processes.