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The IAR Project Team
Mental Health Division, Mental Health Access Branch
Health Systems Policy and Primary Care Group
Department of Health
GPO Box 9848
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Submitted to: MH.IARProjects@health.gov.au

Dear Sir/Madam,

Response to Consultation Draft - National Initial Assessment and Referral for Mental Healthcare – Child and Adolescent

The *National Initial Assessment and Referral for Mental Healthcare for children and adolescents* consultation is designed to collect feedback from the draft Child (5-11 years) and Adolescent (12-17 years) versions of the Initial Assessment and Referral (IAR) Guidance and Decision Support Tool (DST). These decision aids are designed to assist primary care physicians to recommend the most appropriate level of treatment within a stepped care model of mental health..

As a member of the Expert Advisory Group (EAG) and the IAR Child and Adolescent working groups, the APS is broadly supportive of the tools as they stand and acknowledges the care and consideration provided by highly experienced practitioners into the development process. We commend the use of a stepped care model and the informed, systematic approach underlying the logic of the tools. Our survey response includes comments and suggestions from our members to ensure that the EAG has access to the broadest possible feedback. We acknowledge that the EAG and working groups may have already considered many of these issues.

The APS welcomes the opportunity to provide input into the development of the child and adolescent versions of the tools and thanks the Department of Health for the invitation. If any further information is required from the APS I would be happy to be contacted through my office on (03) 8662 3300 or by email at z.burgess@psychology.org.au

Kind regards,

Dr Zena Burgess, FAPS FAICD
Chief Executive Officer

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Contact information
Questions 1-3

Clarity of the instructions for domain ratings and rules

4. Are the general instructions for rating the domains and overarching rules for rating clear? If not, why, and how can clarity be improved?

Yes, we believe that in general, the instructions are clear. However, it was not immediately apparent to naïve users that these are designed to be online tools. Although we do acknowledge that this may become clear when the IAR is released, particularly to users who are already accustomed to the adult version. An additional statement regarding the relationship between the individual domain ratings and the overall score/recommendation would be helpful here, rather than at the end.

The APS also suggests that the decision tree diagram be made available to interested parties via the website or other repository and be linked or described in the lift-out, rather than included in full. Although this is important to show that care and consideration has resulted in the ultimate design of the tool, many users may find it confusing without specific training which may ultimately detract from the aim of the tool.

Best practice screening and assessment

5. Do the initial assessment domains consider the key elements that you think should be considered when informing a decision about mental healthcare treatment need and service intensity for children and adolescents? If not, what else should be included?

Overall, the initial assessment domains capture the main considerations required in the determination of the appropriate level of mental health care. The APS suggests, however, that there are six main considerations which would serve to further refine the IAR tools for adolescents and children. Specifically:

- **Child - Domain 4**: There needs to be further guidance provided as to the implementation of the domain criterion for children and adolescents with developmental disabilities. There is research that points to behavioural and emotional problems being evident early in children with developmental disabilities and that these concerns tend to persist over time[1]. Mental health concerns are often overlooked in this population due to diagnostic 'overshadowing' and it is important that there is clear guidance given for this population who are more likely to experience mental ill health but less likely to access professional treatment[1]. There are resources available to assist in the diagnosis of adults with mental ill health and intellectual disabilities [e.g. 2]. It may be helpful to identify whether or not a similar resource exists for children.
- **Child - Domain 4**: This Domain seeks to distinguish between children's development and mental health where the two are intertwined. Significant issues arise within the current service systems when we attempt to categorise children's mental wellbeing as either a developmental concern or a mental health concern. Separation of the two means that children with developmental concerns can be excluded from mental health services and vice versa.
- **Child - Domain 4**: It is also possible that co-occurring conditions may be undiagnosed in children presenting with "behaviour concerns" because they require thorough transdisciplinary diagnostic assessment and intervention to address developmental, learning, communication and mental health needs[3]. This puts the onus on the caregiver to seek the appropriate treatment for their child, typically from a number of sources. It is important that the IAR recognises that a child may have undiagnosed or unrecognised co-occurring conditions which may be difficult to assess in a primary care setting.
- **Adolescent – Domain 3**: This Domain should also include sexual development[4]. In addition, social-emotional skills are an important contributor and predictor of overall wellbeing and should be included in the IAR. The OECD has undertaken a large multi-site, international study to investigate the importance of social-emotional skills on a broad set of life outcomes, including mental health[5].
- **Adolescent – Domain 4:** We suggest a revision of the term 'developmental delay' in adolescents. This is a term commonly used in early childhood but not in the context of adolescents as a 'delay' suggests that these adolescents will eventually "catch up". Instead, we suggest a similar definition such as that used by the National Disability Insurance Scheme and be reserved for children under six years of age [see 6].
- **Child and Adolescent – Domain 6**: The IAR tool should be used in a trauma-informed manner. It is important that the necessary psychosocial history is taken in a way to minimise re-traumatisation. As discussed below, successful communication between mental health professionals is necessary so that relevant information does not need to be repeated.

The role of clinical judgement in the Decision Support Tool

6. The IAR Decision Support Tool is designed to guide clinical decisions but does not replace clinical judgement. Is the role of clinical judgement clear? If not, how could this be made clearer?

An additional statement regarding the importance of clinical judgement could be included in the first section (i.e. Page 4 of both the child and adolescence lift-outs) to help emphasise its importance. In addition to drawing attention to the aim of the tool, the APS would suggest it may be useful to mention that other health professionals, such as psychologists, could provide assistance and support to primary care physicians when determining the best level of care for an individual child or adolescent.

Appropriateness of the levels of care

7. The Levels of Care provide advice on the clinical services and supports likely to be required at each level of care. Should any of the levels be modified, or any additional clinical services and supports be included? If so, which ones and why?

Although acknowledged on pages 23 and 23 of the Child and Adolescent lift-outs respectively, the critical importance of supporting the family to create the best possible environment for the child to flourish should be emphasised[7]. As per best practice guidelines for early childhood intervention for children with developmental delays and disability, service provision must include opportunity for capacity building of parents and caregivers in childhood[8]. Such a focus is central to support 'whole of family care' in 'family-centred practice'[9] to "strengthen family members' wellbeing and improve their individual and collective outcomes"[7(p. 129)], rather than having this listed as 'other clinical services' for Levels 3 and above. An additional sentence emphasising the importance of focussing on the family at all levels of care may suffice.

We would also advocate for appropriate recognition of the difficulty of accessing all the levels of stepped care for children and adolescents in rural and remote areas, as well as for children and adolescents from culturally and linguistically diverse backgrounds. Although we appreciate the tool cannot address these issues, the use of the tool in primary care settings may help to highlight these gaps in the current system.

Appropriateness of the included assessment tools

8. Standard assessment tools can help to build certainty in assessment and are included in the IAR Guidance as optional additional tools to use – but are not mandatory. Are the standard assessment tools included in the IAR Guidance sufficient and appropriate? Should other standard assessment tools relevant to the domains be included? If so, which ones and why?

As previously mentioned, there is a risk of under recognising mental ill health in children with developmental disabilities. The APS would like to ensure that the measures included will adequately suit this particularly vulnerable population. Although the Strengths and Difficulties Questionnaire may be suitable for use in child populations with an intellectual disability[10], the additional use of a more targeted measure such as the Developmental Behaviour Checklist [see 11] may be more appropriate for this population[10].

Consider issues with a version of IAR for children and adolescents

9. Do you anticipate any issues (e.g., implementation, acceptance, uptake) to be faced by users (e.g., referrers, services, etc.) with the introduction of new versions of IAR for children and adolescents?

The APS cannot foresee issues with the implementation of different versions of the IAR. If anything, the fact that the adult version is already being used should facilitate the uptake of the child and adolescent versions.

On a related note, however, a number of our members commented on the fact that the age range of the child version may run the risk of downplaying the critical role of early childhood mental health. There is a wealth of scientific literature which emphasises the importance of the first two years in development and later health and well-being. For example, the *First Thousand Days Report*[12] describes the relationship of stressful experiences in the first year of life in contributing to anxiety and depressive symptoms in children aged four[13]. Furthermore, early childhood trauma is very clearly associated with poor health and wellbeing in adult life[12,14]. Our concern is that limiting the use of the tool to children over the age of five may give the impression that infant mental health is not important.

Although difficult to operationalise, we advocate for at least some recognition of the importance of infant mental health in the Child and Adolescent IAR tools or consideration of the development of an early childhood version.

Additional resources and supports required to implement the IAR Guidance and Decision Support Tool

10. What resources and supports do you anticipate you, or your service, will require to implement the IAR Guidance and Decision Support Tool?

The APS does not anticipate that our members will require any additional resources or tools apart from (1) being made aware of the tools and the rationale behind them, and (2) the provision of opportunities to work collaboratively with primary care physicians in the implementation of the tools. As discussed below, APS members are likely to be part of collaborative multi-disciplinary teams who care for children and adolescents in a variety of settings. Psychologists are well placed to implement and provide advice on all levels of the stepped care approach, including evidence-based prevention programs, as well as support to appropriately assess children's development and mental health needs. In addition to being part of the Expert Advisory Group, the APS would be happy to collaborate with the working group and other health professionals to aid the uptake and implementation of the tools.

Other activities that should be linked to the National IAR project

11. Are you aware of existing activities at the local, regional, state, or national level wherein this work should be integrated or linked with the National IAR project? If yes, please outline.

The APS supports initiatives which aim to provide well-coordinated mental health care. The context of the IAR tools is important and the collaborative nature of person-centred care should be emphasised. For example, the use of this tool may be supported by case conferencing with other allied health practitioners to enable communication and identify any concerns and issues with other professionals. It is essential that this type of multidisciplinary teamwork is supported by the MBS to provide the best targeted and coordinated care.

If it is not already planned, we suggest the National IAR project be well integrated with the Head to Health Support for Children[15].

Additional feedback

12. Please feel free to include any additional feedback or comments on the consultation drafts.

The APS has some minor suggestions which may assist in strengthening the IAR tools:

- *Child lift out - Page 11* – suggest that 4 = Very high risk of harm, could be reformulated to avoid the repetition of the current plan and intent, i.e.:
    a. History of suicide attempt(s).
    b. Current suicidal ideation with plan and intent.
    c. History of life threatening and dangerous self-injurious behaviours that are prominent in the current presentation.
- *Child lift out – Page 11* – the linked resource regarding mandatory reporting of child sex offences may need to be reconsidered as it appears to be out of date.
- *Child lift out - Page 13* – we suggest that there are well accepted definitions of 'intellectual disability' included in DSM-5 and ICD.
- *Child lift out - Page 13* – we note that brain injury is often differentiated from intellectual disability in clinical care so we suggest that the sentence could read "However, there are other causes of intellectual disabilities, such as chromosomal disorders, exposure to toxins during pregnancy, and oxygen deprivation"
- *Child and Adolescent lift outs - Page 17* – the 'Practice Point – Bullying' includes mention of 'informal supports' that a child or adolescent might require. In this context, we suggest that informal appears unsystematic when, for example, schools and youth organisations can address bullying in formal ways.
- *Child and Adolescent lift outs - Page 22* – minors cannot provide informed consent but can 'assent' to receiving care.
- *Child and Adolescent lift outs - Pages 24-26* – we assume 'peer support' is meant, rather than 'peer work'.

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