Australian Government

CONSULTATION DRAFT

NATIONAL GUIDANCE

Initial assessment and referral for mental healthcare

Adolescent Lift Out

Initial Assessment and Referral - Adolescents

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Initial assessment and adolescents

The Initial Assessment and Referral (IAR) Guidance and Decision Support Tool (DST) – Adolescent Version is designed to assist general practitioners and clinicians to recommend the most appropriate level of care for an adolescent seeking or requiring mental health support. The adolescent version is focused on adolescents aged 12-17 years of age. In addition to the adolescent version, the following versions are also available for use:

- IAR Guidance and Decision Support Tool (children, aged 5 – 11)
- IAR Guidance and Decision Support Tool (adults, aged 18 – 65)

Whilst age is used to indicate the broad appropriateness of each tool, for each group, the final decision about the most appropriate tool must be based around developmental considerations and is the discretion of the clinical user.

The IAR is an initiative of the Australian Department of Health and brings together information from a range of sources including Australian and international evidence and advice from a range of leading experts. The IAR is designed to assist the various parties involved in the assessment and referral process, including:

- General Practitioners (GP) and other clinicians seeking to determine the most appropriate care type and intensity for individuals.
- Providers and intake teams/services responsible for undertaking initial assessments which may involve making recommendations on the level of care required.

The IAR Guidance and Decision Support Tool assumes that clinicians using the Guidance and DST have existing core competencies relating to best practice engagement and mental health assessment of adolescents. Clinicians are encouraged to utilise the resources available through headspace National. headspace National provides up-to-date and evidence-based resources and learning opportunities focused on youth mental health and assessment: https://headspace.org.au/health-professionals/information-and-guidelines/

The initial assessment domains

The initial assessment process recommended in this Guidance identifies eight domains (see Table 1) that should be assessed when determining the next steps in the referral process for an adolescent referred to a mental health service. The eight domains fall into two categories:

- *Primary Assessment Domains (Domains 1 to 4):* These cover Symptoms Severity and Distress, Risk of Harm, Functioning and Impact of Co-existing Conditions. Primary Assessment Domains represent the basic areas for initial assessment that have direct implications for decisions about assignment to a level of care.
- *Contextual Domains (Domains 5 to 8):* These cover Service Use and Response History, Social and Environmental Stressors, Family and Other Supports, and Engagement and Motivation. Assessment on these domains provides essential context to moderate decisions indicated by the primary domains.

Initial assessment should consider the adolescent's current situation on all eight domains. Each domain looks at specific factors relevant to making decisions about a level of care that is most likely going to be suitable for the adolescent's mental health treatment needs. The selection of the domains, and factors covered in each domain, aims to capture a limited number of key areas that a clinician would consider when determining the most appropriate services for an adolescent referred for care.

Table 1: The primary and contextual initial assessment domains

DOMAIN 1 **Symptom severity and distress**	• current and past symptoms and duration, • level of distress attributable to a mental health condition, • experience of a mental health condition, and • are symptoms improving/worsening, is distress improving/worsening, are new symptoms emerging?
DOMAIN 2 **Risk of harm**	• suicidality – current and past suicidal ideation, attempts, • intentional, non-suicidal self-harm – current and past, • impulsive and dangerous/risky behaviours with the potential for harm to self or others (including risks associated with use of alcohol and other drugs), • harm caused by abuse, exploitation, or neglect by others, and • unintentional harm to self or others arising from severe symptoms or self-neglect.
DOMAIN 3 **Functioning**	• the adolescents' ability to fulfil usual roles/responsibilities appropriate to their age, developmental level, and cultural background, • the adolescent's functioning within the family or home environment, in educational or vocational settings, and with friends or peers, and in the community, • the adolescent's ability to undertake basic activities of daily living appropriate to their age and developmental level (e.g., self-care, mobility, toileting, feeding, and personal hygiene).
DOMAIN 4 **Impact of co-existing conditions**	• physical health conditions, • cognitive impairment, intellectual disability, developmental delay, and learning and communication disorders, and • substance use/misuse
DOMAIN 5 **Service use and response history**	• whether the adolescent/family has previously sought help from or been referred to mental health services and related supports (including specialist or mental health inpatient services), • if the adolescent is currently engaged with services and supports, and • their progress or benefit from past or current services and supports.
DOMAIN 6 **Social and environmental stressors**	Assessment on this domain should consider the degree to which any or all the following factors are relevant to the adolescent's current circumstances and the referral decision: significant transitions, peer group stress, trauma or victimisation, family or household stress, socio-economic disadvantage, performance related pressure, and legal issues.
DOMAIN 7 **Family and other supports**	This domain considers whether personal supports, including emotionally nurturing relationships, practical supports, and social supports are present in the adolescent's environment and their potential to contribute to improved mental health.
DOMAIN 8 **Engagement and motivation**	This domain considers the adolescent and their parent/caregiver's awareness of the mental health condition and their capacity and willingness to engage in or accept assistance.

Glossary for rating the initial assessment domains - Adolescents

The Glossary includes a hierarchical ranking of factors relevant to each domain to guide judgements about problem severity.

The Glossary provides a rating system that grades each domain on a 5-point rating scale of severity, where:

0 = No problem

1 = Mild problem

2 = Moderate problem

3 = Severe problem

4 = Very severe problem

Specific criteria are outlined for assessing each domain, designed to serve as a checklist of factors to consider when judging the extent to which a problem is present.

General Instructions for Rating the Domains

- Initial assessment is undertaken across eight domains that aim to describe clinical severity and service needs using a 5-point scale, ranging from 0 to 4. Higher ratings indicate increased severity of problem and need for higher (more intensive) levels of care.
- Within each domain, each rating is defined by one or more descriptors which are designated by alpha characters (a, b, c etc.). Only one of these descriptors need to be met for a rating to be assigned to the adolescent.

Overarching Rules and Guide to Ratings

- Within each domain, if more than one descriptor applies to the adolescent, the descriptor with the highest rating should be selected.
  - Example one: if 3-b, and 3-c apply, but 4-a is also present, the rating selected is 4.
  - Example two: if 2-a and 2-b apply, but 3-c is also present, the rating selected is 3.
- Unless stated otherwise, rate the adolescent's current situation, defined as their most typical over the past month. This recognises that personal and social circumstances can change.
- Use all available information in making your rating. This may include clinical interview and information gathered from the adolescent's family, referrers, or other informants.
- While terms vary, the rating scale for each domain follows the general format:

0 = No problem

1 = Mild problem

2 = Moderate problem

3 = Severe problem

4 = Very severe problem

- The coding of ratings as numerals is not intended to imply that an overall composite score can be used for making decisions about the adolescent's service needs. The numbers should be regarded as just shorthand for summarising severity.
- Guidance is given for each domain on examples of problems that should be considered for specific ratings (the 'descriptors'). Consider these as examples only rather than an exhaustive list of all factors relevant to the domain. Therefore, at times, referring to the underlying rating format may be helpful.
- If there is uncertainty in the ratings, do not rate up. Seek additional information that will allow you to rate with certainty. Where uncertainty remains even after the additional information is obtained, the adolescent should be supported to access an appropriate clinician for a comprehensive assessment.
- This tool should not be used without clinical oversight, and is used to guide, not replace, clinical judgement.
- It should not be used as a screening tool because it cannot be used without some form of personalised assessment.

Domain 1 – Symptom severity and distress

Severity of current symptoms and associated levels of distress are important factors in assigning a level of care and making a referral decision.

This domain considers symptoms broadly to include both internalised (emotional) problems experienced by the adolescent themselves (e.g., anxiety and depressive symptoms) as well as externalised behaviours observable by or impacting on others (e.g., poor anger or impulse control). Symptoms may be associated with distress, but this is not always the case. Symptoms may potentially be indicative of a particular diagnostic condition, but a diagnosis is not required.

Assessment of an adolescent on this domain should consider:

- current and past symptoms and duration,
- level of distress attributable to a mental health condition,
- experience of a mental health condition, and
- are symptoms improving/worsening, is distress improving/worsening, are new symptoms emerging?

0 = No problem in this domain

1 = Mild

a. Currently experiencing mild anxiety symptoms (e.g., fearful, worry, difficulty concentrating without significant avoidant behaviour, body image issues, unexplained somatic symptoms like headache and stomach pain) but likely to be at sub-diagnostic level. Symptoms have typically been experienced for less than 3 months (but this may vary).
b. Currently experiencing mild mood difficulties (e.g., sadness, fatigue, reluctance to participate in activities the adolescent previously enjoyed, apathy) but likely to be at sub-diagnostic level. Difficulties have typically been experienced for less than 3 months (but this may vary).
c. Mild behavioural symptoms (e.g., irritability, distractibility, overactive, difficulty completing tasks, loses temper, oppositional, interpersonal difficulties, disrupted sleep) but at sub-diagnostic level.
d. Currently experiencing other mental health condition associated with mild distress.

2 = Moderate

a. Currently experiencing moderate anxiety symptoms (e.g., excessive worry, panic, difficulty concentrating with significant avoidant behaviour, overly concerned about body image or weight, extreme shyness, unexplained somatic symptoms like headache and stomach pain) that have typically been present for 3 months or more (but this may vary). Symptoms are at a level that would likely meet diagnostic criteria.
b. Currently experiencing moderate mood related symptoms (e.g., excessive sadness, exhaustion, loss of interest and pleasure, reluctance to participate in activities the adolescent previously enjoyed, apathy) that have typically been present for more than 3 months (but this may vary). Symptoms are at a level that would likely meet diagnostic criteria.
c. Moderate behavioural symptoms (e.g., impulsivity, agitation, hyperactivity, defies age-appropriate rules or social norms, significant difficulty getting along with others, angry or aggressive outbursts, sleep disturbance). Symptoms are at a level that would likely meet diagnostic criteria.
d. Currently experiencing other mental health condition associated with moderate levels of distress.
e. History of a diagnosed mental health condition earlier in childhood that has not responded to treatment, with continuing symptoms but only causing low to moderate levels of distress.

3 = Severe

a. Severe anxiety related symptoms that are present most of the time.
b. Severe mood related symptoms that are present most of the time.
c. Significant behavioural symptoms that cause substantial disruption and distress that are often uncontrollable.

d. Currently experiencing other mental health condition (e.g., complex trauma, eating disorder, obsessive compulsive disorder) – symptoms are associated with high levels of distress, are present much of time or are difficult to control.
e. Symptoms suggestive of an early form of a severe mental health condition (e.g., odd thinking/ behaviour/speech, abnormal perceptions, short periods of elevated mood, decreased need for sleep).
f. Has been treated by a specialist community mental health service or admitted to hospital for a mental health condition in previous 12 months.

4 = Very severe

a. Very severe and pervasive anxiety symptoms that are present virtually all the time and symptoms are poorly controlled.
b. Very severe and pervasive mood related symptoms that are present virtually all the time and symptoms are poorly controlled.
c. Extreme behavioural symptoms that are present in most activities and almost never capable of being controlled.
d. Currently experiencing other mental health condition (e.g., disordered thinking, extreme mood variation, obsessions, extreme avoidant behaviour, severely disordered eating and associated physical symptoms, extreme interpersonal difficulties) – symptoms are severe, present virtually all the time and are poorly controlled.
e. Highly unusual and bizarre symptoms/behaviours that are indicative of a severe mental illness (e.g., hallucinations, delusions, abnormal perceptions). Symptoms may be ongoing, or of more recent or sudden onset.

Domain 2 – Risk of Harm

This domain considers the adolescent's potential to harm themselves or others, or to be harmed by others.

Recent Australian and international evidence indicates that suicide risk prediction is a flawed, imprecise, and misleading activity in mental healthcare that contributes to both over and under prediction of suicide risk. This domain is not about predicting the adolescents that are likely to attempt or complete suicide or other forms of harm but instead should be used to guide evaluation of current risk to inform the most appropriate response and/or referral. This domain is focussed on examining:

- suicidality – current and past suicidal ideation, attempts,
- intentional, non-suicidal self-harm – current and past,
- impulsive and dangerous or risky behaviours with the potential for harm to self or others (consider and include risks associated with use of alcohol and other drugs),
- harm caused by abuse, exploitation, or neglect by others, and
- unintentional harm to self or others arising from severe symptoms or self-neglect.

PRACTICE POINT- MANDATORY REPORTING

Mandatory reporting laws aim to identify incidents of child abuse and neglect, and to assist the individual children and adolescents involved. The laws require selected groups of people to report suspected child abuse and neglect to government authorities. Laws exist in all Australian jurisdictions. However, the laws are not the same across all jurisdictions. Differences exist in who must report, what types of abuse and neglect must be reported, and who the report is made to.

It is important to note that any person is lawfully entitled to make a report if they are concerned for a child or adolescent's welfare, even if they are not required to do so as a mandatory reporter.

Users of the IAR-DST should be familiar with signs of abuse and/or neglect, and their legal responsibilities with regards to mandatory reporting. Visit: the Australian Institute for Family Studies for more information: https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect

0 = No identified risk in this domain

1 = Low risk of harm

a. No current suicidal ideation but may have experienced ideation in the past (with no previous intent, plan, or attempts).

b. Occasional non-suicidal self-injurious acts in the recent past and not requiring any treatment.

c. May have engaged in behaviours in the past that posed a risk to self or others, but no current or recent instances.

d. Currently at low risk of harm from abuse, exploitation, or neglect by others.

2 = Moderate risk of harm

a. Current suicidal ideation, without plan or intent. But may have had intent, plans, or attempts in the past unrelated to current episode or current life stressors.

b. Frequent non-suicidal self-injurious acts in the recent past and not requiring any treatment.

c. Current or recent behaviours that pose a non-life-threatening risk to self or others.

d. Currently at some risk of harm from abuse, exploitation, or neglect by others.

e. Intermittent lapses in self-care that may lead to harm.

3 = High risk of harm

a. Current suicidal ideation with intent and history of suicidal attempts. No plan or strong reluctance to carry out plan, strong protective factors, and a commitment to engage in a safety plan including involvement of family, significant others, and services.

b. Frequent non-suicidal self-injurious acts in the recent past and requiring treatment.

c. Recent or current dangerous or risky behaviours to self or others that have had or are likely to have a serious impact.

d. Significant risk of, or recent experience of, abuse, exploitation, or neglect by others.

e. Clearly compromised self-care ability that is ongoing to the extent that indirect or unintentional harm to self is likely. This includes indirect harm to self, associated with conditions such as anorexia nervosa.

4 = Very high risk of harm

a. Recent suicide attempt or current suicidal intention with plan and means to carry out. Few or no protective factors.

b. History of life threatening and dangerous self-injurious acts that are prominent in the current presentation.

c. Evidence of current severe symptoms (e.g., hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions, impulsivity) with behaviour that is likely to present an imminent danger to self or others.

d. Extremely compromised self-care ability to the extent that there is real and present danger, and experiencing harm related to these deficits. This includes indirect harm to self and medical risks associated with conditions such as anorexia nervosa and bulimia.

Domain 3 – Functioning

This domain considers functional impairment caused by or exacerbated by the mental health issues. While some types of disabilities being experienced by the adolescent may play a role in determining what types of support services may be required, they should generally not be considered in determining mental health service intensity within a stepped care continuum.

Assessment of an adolescent on this domain should consider the impact of the mental health issues on:

- the adolescents' ability to fulfil usual roles/responsibilities appropriate to their age, developmental level, and cultural background,
- the adolescent's functioning within the family or home environment, in educational or vocational settings, and with friends and peers, and in the community,
- the adolescent's ability to undertake basic activities of daily living appropriate to their age and developmental level (e.g., self-care, mobility, toileting, feeding, and personal hygiene).

0 = No problems in this domain

1 = Mild impact

a. Mildly diminished ability to function in one or more of their usual roles (e.g., at home, in educational or vocational settings or with friends/peers), but without significant or adverse consequences.

b. Mental health issues contribute to brief and transient disruptions in one or more areas of functioning.

2 = Moderate impact

a. Moderate functional impairment in more than one of their usual roles (e.g., at home, in educational or vocational settings or with friends/peers) to the extent that they are occasionally unable to meet the requirements of those roles.

b. Mental health issues contribute to occasional difficulties with basic activities of daily living but without threat to health.

3 = Severe impact

a. Significant difficulties with functioning, resulting in disruption to many areas of the adolescent's life most of the time (e.g., limited participation in educational and/or vocational activities, deterioration in or some withdrawal from relationships with friends/peers) but the adolescent can function independently with adequate treatment, family, and community support.

b. Mental health issues contribute to difficulties with basic self-care (hygiene, eating, appearance) on a frequent, consistent basis but without threat to health.

4 = Very severe to extreme impact

a. Profound difficulties with functioning, resulting in major disruption to virtually all areas of the adolescent's life (e.g., unable to participate in educational or vocational activities, complete withdrawal from friends/peers).

b. Mental health issues contribute to severe and persistent self-neglect that poses a threat to health.

Domain 4 – Impact of co-existing conditions

Increasingly, individuals are experiencing and managing multi-morbidity (coexistence of multiple conditions including chronic disease).

This domain considers the extent to which other conditions contribute to (or have the potential to contribute to) increased severity of the mental health condition and/or compromise the adolescent's ability to participate in the recommended services and supports.

Assessment of an adolescent on this domain should consider the presence, and impact of, three possible coexisting conditions:

- physical health conditions,
- cognitive impairment, intellectual disability, developmental delay, and/or learning and communication disorder, and
- substance use/misuse

Where the adolescent has more than one of the coexisting conditions, consider the condition which has the most impact.

PRACTICE POINT- DEFINITIONS OF INTELLECTUAL DISABILITY, COGNITIVE IMPAIRMENT, DEVELOPMENTAL DELAY, AND LEARNING AND COMMUNICATION DISORDERS

The terms intellectual disability, cognitive impairment, and developmental delay have no universally agreed definitions. For the purposes of this guidance, the below definitions will apply

Cognitive impairment – A description of a person's current functioning regarding learning, communication, attention, memory, thinking and problem solving. Cognitive impairment can be temporary or permanent, and mild, moderate, or severe. Cognitive impairment can affect what the person can understand and how they relate to others and interpret the environment.

Intellectual disability – A disability characterised by significant limitations in both intellectual functioning and in adaptive behaviour, which covers many everyday social and practical skills. This disability originates before the age of 18. Most intellectual disabilities are caused by genetic factors. However, there are other causes of intellectual disabilities, such as brain injury or being born prematurely.

Developmental delay – A developmental delay is when a child or adolescent's social and/or communication skill development is not at the level expected for their age and has a significant effect on their ability to engage in daily routines and activities.

Learning and communication disorders – learning and communication disorders may affect how a child or adolescent comprehends, recalls, understands and/or expresses information. These disorders are often dynamic and can improve overtime. The impairment caused by these disorders might be minimal or significant and vary from person to person.

0 = No problem in this domain

1 = Minor impact

a. Physical health condition(s) present but are stable and do not have an impact on the concurrent mental health condition of the adolescent.
b. Cognitive impairment, intellectual disability, developmental delay, and/or learning and communication disorder present but has no or minimal impact on the adolescent's mental health condition and capacity to participate in services.
c. Occasional episodes of substance misuse, but any recent episodes are limited, are not currently causing any concerns, and do not impact on the concurrent mental health condition of the adolescent.

2 = Moderate impact

a. Physical health condition present and impacting significantly on the mental health of the adolescent or their ability to participate in services.
b. Mild cognitive impairment, intellectual disability, developmental delay, and/or learning and communication disorder with the potential to impact on the mental health of the adolescent or their ability to participate in services.
c. Occasional substance use impacting on, or with the potential to impact on, the mental health of the adolescent.

3 = Severe impact

a. Physical health condition present and requires intensive medical monitoring and is seriously affecting the mental health of the adolescent (e.g., worsened symptoms, heightened distress).
b. Cognitive impairment, intellectual disability, developmental delay, and/or learning and communication disorder that impacts significantly on the mental health condition and impedes the adolescent's ability to participate in services.
c. Frequent substance use that poses a threat to health or represents a barrier to mental health related recovery or occasional use of substances that are extreme risk.

4 = Very severe impact

a. One or more significant physical health conditions exist which are poorly managed or life threatening, and in the context of a concurrent mental health condition.
b. Severe cognitive impairment, intellectual disability, developmental delay, and/or learning and communication disorder that impacts significantly on the adolescent's mental health and impedes their ability to participate in services.
c. Regular and uncontrolled substance use occurs that poses a severe threat to health.

Domain 5 – Service use and response history

This domain considers the adolescent and their family's previous use of services and supports focussed on mental health related assistance for the adolescent. The initial assessment on this domain should consider:

- whether the adolescent/family has previously sought help from or required mental health services and related supports (including specialist or mental health inpatient services),
- if the adolescent is currently engaged with services and supports, and
- their progress or benefit from past or current services and supports.

Definition of the term services and supports - When considering this domain, relevant services and supports refer to developmentally and culturally appropriate evidence-informed services focussed on the adolescent's mental health (such as a psychological service delivered by a GP or allied mental health professional, or other behavioural services) rather than the personal supports provided by friends, family, or social networks. Consider both the adolescent and their family's use of previous services and supports but do not include those services and supports that are relevant to, but not focussed on, the mental health of the adolescent.

0 = No problem in this domain

a. Has not previously sought help from or required a referral to a mental health service.
b. In a current service arrangement that is appropriate and of benefit to the adolescent.

1 = Excellent progress from previous service use

a. Previously sought help for earlier mental health condition and experienced benefit with no need for ongoing services.

2 = Moderate progress from previous service use

a. Previously accessed services and was generally able to achieve and maintain benefit from the service with some need for ongoing services.

3 = Minor progress from previous or current service use

a. Previously accessed services with only minor benefit.
b. Currently accessing services but is not experiencing the expected response despite intensive and structured supports delivered over an extended period.

4 = Negligible progress with previous or current service use

a. Previously accessed services with negligible or no benefit despite intensive, structured, and specialist supports delivered over an extended period.
b. Currently accessing services but is deteriorating despite intensive, structured, and specialist supports delivered over an extended period.

Domain 6 – Social and environmental stressors

This domain considers the extent and severity of a range of factors in the adolescent's environment that might contribute to the onset or continuation of the mental health condition.

Significant environmental stressors and adversity can lead to increased symptom severity and/or compromise the capacity of the adolescent and their family to participate in or benefit from the recommended resources and/or services. Furthermore, understanding the complexities the adolescent is experiencing (or has experienced) may alter the type of service offered or indicate that additional service referrals are required (e.g., a referral to a social support service).

Assessment on this domain should consider the degree to which any or all the following factors are relevant to the adolescent's current circumstances and the referral decision:

- significant transitions (e.g., disruption to educational or vocational activities, parental separation/divorce, death of loved one, romantic breakup, transitions relating to gender or sexual identity),
- peer group stress (e.g., bullying at school, conflict with or isolation from peer group, loss of friendships),
- trauma or victimisation (e.g., emotional, physical, psychological, or sexual abuse, exploitation, racial abuse, witnessing or being a victim of violence, family and domestic violence, intimate partner violence, natural disaster, exposure to suicide in family, school, community or peer group, human rights abuses, loss),
- family or household stress (e.g., household drug or alcohol abuse, parent mental illness),
- socioeconomic disadvantage (e.g., poverty, parental unemployment, insecure housing),
- performance related pressure (e.g., unrealistic role expectations or responsibilities, schooling or work demands), and
- legal issues (e.g., juvenile justice system or family court involvement, enforced separation from family).

Evidence points to the contribution made by historical childhood adverse events to longer term mental health development. Assessment on this domain should consider the adolescent's history but **only** record higher ratings where earlier experiences are impacting on the current situation and require additional specific resources and/or services.

PRACTICE POINT – CHILDHOOD EXPERIENCES OF TRAUMA

The Adverse Childhood Experiences (ACEs) are stressful events or circumstances that people may experience throughout their childhood. They may relate to childhood physical, sexual, or emotional abuse, physical or emotional neglect, exposure to family violence, parental substance use, parental mental illness, parental separation or divorce, or parental incarceration.

A summary of the evidence and impacts by Emerging Minds reiterates that:

"Exposure to ACEs does not mean poor outcomes are inevitable. There are known protective factors that, if present and reinforced in a child's life, can build the child's resilience, and reduce the impacts of adversity. Nurturing relationships form the basis of healthy brain development, effective early learning, and a child's capacity to positively respond and adapt to life challenges. Many adults who experienced significant adversity in their childhood have gone on to have successful lives and happy relationships – (Marie-Mitchell & Kostolansky, 2019; Traub & Boynton-Jarrett, 2017).

How a person responds to trauma is highly variable, and many individuals who have been exposed to ACEs will not require a mental health service. Immediate assignment of a level of care based on the experience of trauma alone, is problematic and should be avoided. The ACEs study demonstrated a strong relationship between a person's exposure to ACEs and their physical and mental health throughout their lives. Researchers have established a dose-response association for ACEs – for instance, four or more ACEs are associated with increased risk of adverse impacts.

PRACTICE POINT – BULLYING

Bullying can impact on the mental health of children and adolescents. Children and adolescents who experience bullying can experience feelings like shame, fear, embarrassment, anger, and worry. There is a marked increase in risk of poor mental health outcomes, self-harm and suicidal ideation and behaviours among people who experience bullying, particularly if the experience of bullying is severe and/or prolonged.

Bullying, whilst common, is not a normal part of 'growing up' and an initial assessment with a child or adolescent should explore the child or adolescent's experience of bullying and the impacts of these experiences.

Bullying should be considered in the context of social and environmental stressors (Domain 6). The impacts of bullying on the child or adolescent (if present) will be captured in Symptoms Severity and Distress (Domain 1), Risk of Harm (Domain 2), and Functioning (Domain 3).

When considering the level of care, consideration should be given to the informal supports that a child or adolescent might require outside the formal mental health system- social, school, family and community supports are generally important for children and adolescents experiencing bullying.

0 = No problem in this domain

1 = Mildly stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are having, or are likely to have, only minor impact on the adolescent's mental health.

2 = Moderately stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are having, or are likely to have, a moderate impact on the adolescent's mental health.

3 = Highly stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are having or are likely to have a severe impact on the adolescent's mental health.

4 = Extremely stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are extreme and are having, or are likely to have, an enduring impact on the adolescent's mental health.

Domain 7 – Family and other supports

This domain considers whether personal supports, including emotionally nurturing relationships, practical supports, and social supports are present in the adolescent's environment and their potential to contribute to improved mental health. This domain does not include or consider professional or paid supports. Personal supports include:

- family/primary caregivers,
- supports within the school environment, and
- supports within the community (e.g., cultural connections, elders, religious leaders, sporting groups, neighbours etc).

For adolescents, stable, supportive, and ongoing relationships with family are of primary importance, however assessment on this domain should also consider access to support from other sources, including within the school, friendship groups and the broader community. A lack of supports might contribute to the onset or continuation of the mental health condition.

0 = No problem on this domain

a. Family/primary caregivers and other personal supports are highly supportive and are meeting the adolescent's developmental, material and/or emotional needs.

1 = Well supported

a. Family/primary caregivers and other personal supports are available to the adolescent and are adequately meeting most of the adolescent's developmental, material and/or emotional needs at most times.

2 = Limited supports

a. Family/primary caregivers have limited capacity or availability to respond appropriately to the adolescent's developmental, material and/or emotional needs.
b. Other personal supports are available for the adolescent but only partially compensate for needs not met within the family.

3 = Minimal supports

a. Family/primary caregivers are very limited in their capacity or availability to meet the adolescent's developmental, material, and/or emotional needs.
b. Few other personal supports are available to the adolescent and/or there are serious limitations in capacity, or availability of those supports so that developmental, material and/or emotional needs are mostly unmet.

4 = No supports

a. Family/primary caregivers are completely unable to meet the adolescent's developmental, material, and/or emotional needs.
b. The adolescent has no access to other supports that could compensate for needs not met within the family.

Domain 8 – Engagement and motivation

This domain considers the adolescent and their parent/caregiver's awareness of the mental health condition and their capacity and willingness to engage in or accept assistance.

Many adolescents do not have the agency or resources required to independently seek and access services and supports. In these situations, the engagement and motivation of the parent/caregiver takes precedence, and the parent/caregiver sub-scale is used. The parent/caregiver sub-scale considers:

- the parent/caregiver's awareness of the adolescent's mental health condition, and
- the parent/caregiver's capacity and willingness to support the adolescent to participate in the recommended services and supports, or

Conversely, where the adolescent has the capacity to exercise decision-making control of their healthcare decisions, it is the engagement and motivation of the adolescent that takes precedence (adolescent sub-scale). The adolescent sub-scale considers:

- the adolescent's capacity and willingness to participate in the recommended services and supports.

PRACTICE POINT – INFORMED CONSENT

Clinicians have a legal and ethical obligation to ensure they have obtained informed consent from adolescents before performing any healthcare intervention. To give informed consent, a person must be fully informed of, understand, and comprehend the risks and benefits of any treatment (including the risk associated with no treatment).

The process of gaining consent for treatment of minors differs significantly from that of adults and is more complex and varied. Involvement of both the parent/guardian and minor in providing consent for the referral and service is preferable. Where a parent or guardian is giving consent on behalf of a minor for assessment and referral using the IAR-DST, efforts should be made to ensure the minor is as involved as possible in decision-making.

In some instances, consent must be given by the relevant parent or guardian, whereas in others, it may be possible for a person under 18 (a mature minor) to consent to some decisions, in some circumstances. A mature minor is an adolescent who is assessed as having capacity to make specific decisions, based on their maturity, understanding and intelligence. Such that they may not need consent of both parents. This is considered when there are allegations of parental abuse, where on balance the risk of engagement of the parent will lead to negative potential impact on the adolescent.

Some states have specific legislation governing informed consent of minors in healthcare. It is the responsibility of all healthcare providers to know and understand their legal obligations in whichever state or territory they are practising.

PRACTICE POINT – CHECKING IN WHERE ENGAGEMENT OR MOTIVATION IS LOW

A follow up check-in helps to determine if the recommended information, resources, and/or services are being utilised and are perceived as being helpful. "Checking in" or asking the parent/caregiver to "check back" are important when engagement and/or motivation is low.

The check-in should explore the following questions:

- Is the adolescent and/or parent/caregiver engaging with the recommended information, resources, and/or services? If the adolescent and/or parent/caregiver is not engaging it is important to re-examine motivation and explore reasons for lack of engagement (domain 8).

- Does the adolescent and/or parent/caregiver think that the recommended information, resources, and/or services are/were helpful**?**
- Is there evidence of deterioration or changing risk of suicide or harm to self, to others or from others?
- Is the adolescent or family experiencing new or worsening social and environmental stressors?

Discuss, and document next steps determined in collaboration with the adolescent or parent/caregiver. Next steps might include:

- Continue
- Build in additional supports
- Initiate a referral to an escalated level of care

PARENT/CAREGIVER SUB-SCALE

Use the parent sub-scale where the adolescent does not have the capacity to exercise decision-making control of their healthcare decisions.

0 = Optimal

a. The parent/caregiver has a good awareness of the adolescent's mental health issue and impacts and is motivated about and capable of participating fully in the recommended services and supports.

1 = Positive

a. The parent/caregiver has a developing awareness of the adolescent's mental health issue and impacts and is mostly capable of participating in the recommended services and supports.

2 = Limited or mixed

a. The parent/caregiver has a limited awareness of the adolescent's mental health issue and impacts, is unsure about whether they will participate in the recommended services and supports and/or has limited capacity to do so.

b. There is significant divergence between the parents/caregivers in the level of engagement and/or commitment to participation in recommended services and supports.

3 = Minimal

a. The parent/caregiver has minimal awareness of the adolescent's mental health issue and impacts and is unable to participate in the recommended services and supports without considerable practical and/or emotional assistance to participate.

4 = Disengaged

a. The parent/caregiver has no capacity to support participation in services and supports or avoids potentially useful and available supports.

ADOLESCENT SUB-SCALE

Use the adolescent sub-scale where the adolescent has the capacity to exercise decision-making control of their healthcare decisions. In most instances, when working with a mature minor (see informed consent practice point above) the use of the adolescent sub-scale will be appropriate.

0 = Optimal

a. The adolescent is motivated about participating in the recommended services and supports.

1 = Positive

a. The adolescent is mostly willing to accept and participate in the recommended services and supports.

2 = Limited

a. The adolescent is hesitant to accept and participate in the recommended services and supports.

3 = Minimal

a. The adolescent is very reluctant to accept and/or participate in services and supports.

4 = Disengaged

a. The adolescent is refusing to accept or participate in the recommended services and supports.

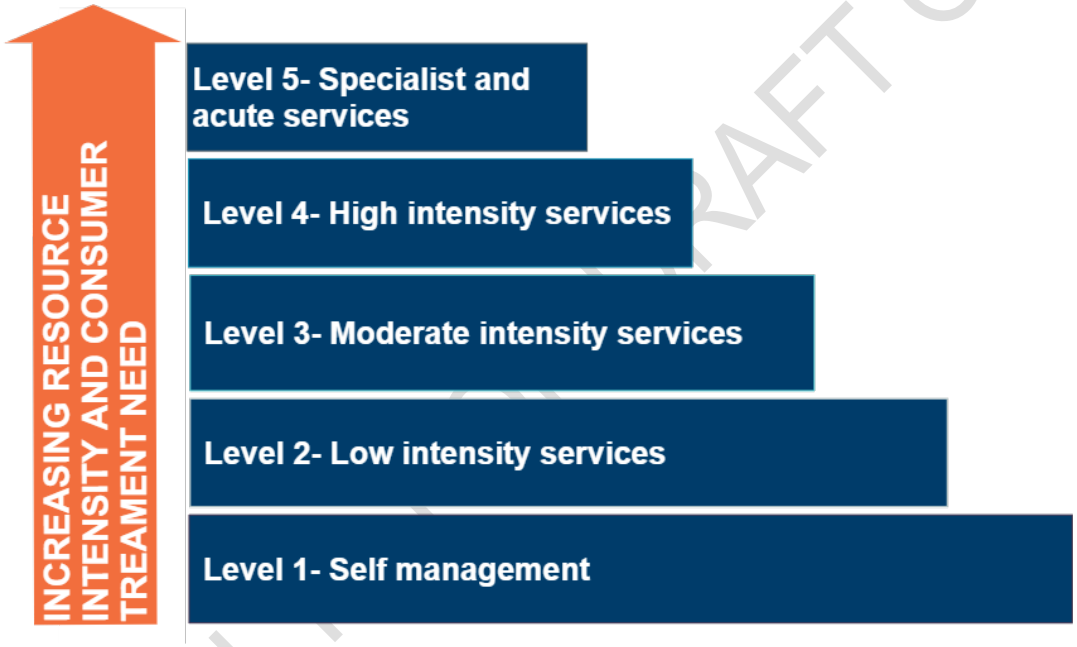
Levels of Care – Adolescents

This section provides a description of the different levels of care. The information gathered through the initial assessment is used to recommend a level of care and inform a referral decision. The levels of care are not intended to replace individualised assessment and care - rather to provide information to guide decision making.

It is important to emphasise that the proposed referral criteria are offered only to guide judgements about the recommended level of care. Each presenting adolescent, their parent/caregiver, and family will have unique requirements that must always take precedence in decision making.

There are 5 levels of care (depicted in Figure 1), each are differentiated based on the intensity of the mental healthcare available at each level. In some regions of Australia, there may be a gap in services available at some or all levels of care. The determined level of care applies irrespective of service availability. Referrers may need to take a flexible approach (e.g., use of tele-health services or bundling services as part of a care package) to achieve the required service intensity.

Figure 1 – The 5 Levels of Care



An important additional consideration is the type and appropriateness of the resources and/or services being recommended. Users of the Decision Support Tool should actively consider and incorporate decisions about resource or service type and appropriateness when considering resource and/or service options that are personalised to the unique needs of each adolescent.

When making a resource recommendation and/or referral decision at any level of care, consider the type of resources and/or service options that account for the perspectives and preferences of the adolescent, such as:

- culturally appropriate and safe services (such as social and emotional wellbeing services available through Aboriginal Community Controlled Health Organisations),
- age-appropriate services,
- services specific to the adolescent's diagnosis (where applicable) such as evidence-based dialectical behavioural therapy for borderline personality disorder,
- specialist sexuality and gender diversity resources and/or services,
- if the adolescent has multiple service needs, consider options for integrated services and service models.
- services able to sensitively incorporate social and environmental supports (e.g., specialist family violence services).

When making a resource recommendation and/or referral decision at any level of care, consider the circumstances of the adolescent and family and the appropriateness of resources and/or services options, such as:

- readiness of the adolescent and parent/caregivers
- the priorities of the adolescent and the parent/caregivers
- cost
- location
- availability of in-language, interpreter, and/or translator services
- digital literacy of the adolescent
- the availability of technology (e.g., internet connection, telephone)
- the practical and emotional support needs of the adolescent, their parent/caregiver, and family.

The recommended levels of care are focussed on the mental health related resources and/or services likely to be required by the adolescent. However, the mental health and well-being of the adolescent, parent/caregiver and family are often interrelated. Sensitively offering the parent/caregiver and family members an opportunity to discuss the resources and/or services that they might benefit from is important.

PRACTICE POINT- INVOLVING CHILDREN AND ADOLESCENTS IN DECISION MAKING

Supported decision-making strategies for initial assessment and referral:

- Make sure the child or adolescent and their parent/caregiver are provided with information using their preferred way of receiving information (e.g., written/verbal/visual, English/other language, with/without a support person). Take care to provide information to the child or adolescent that is age and developmentally appropriate.
- Make sure the child or adolescent and their parent/caregiver are provided with information about the range of services and supports available (including the option of no service) and encourage the child or adolescent and parent/caregiver to contribute their own options, ideas, solutions, and expectations. This might include culturally important activities, or self-care strategies.
- Ensure the child or adolescent and their parent/caregiver can express any concerns or fears about the options (e.g., cost, travel, previous positive or negative experiences).
- Be prepared to talk about the pros and cons of each option (e.g., intensity, length of service engagement, and commitment required, waiting periods, potential impact on symptoms).
- Check in, to ensure the child or adolescent and parent/caregiver has understood the information provided and ensure enough time for any questions.

For more information and advice about supported decision-making and children, visit:

https://emergingminds.com.au/resources/supporting-childrens-participation-through-shared-decision-making-in-child-mental-health-care/

For more information and advice about supported decision-making and adolescents, visit:
https://orygen.org.au/Training/Resources/General-resources/Clinical-practice-points/Shared-decision-making/Shared-decision-making?

Level 1 - Self-Management

Definition: Services at this level are designed to provide self-help resources to support the adolescent in managing any distress or symptoms and maintain functioning without the direct involvement of a mental health professional. A younger adolescent may require parent/caregiver assistance, prompting and encouragement to engage with self-management recommendations.

This level of care generally involves evidence-informed, age-appropriate, and culturally safe online resources and other forms of self-help. A summary of the evidence-based online mental health resources and self-help services is available through the Head to Health website

Care environment: Services are easily accessible and available online, via telephone or in the community. Services may also be available in integrated settings (e.g., within schools, vocational settings, and general practice).

Core clinical services:

This level of care is focussed on resources that can be accessed and self-managed by the adolescent, or their parent(s)/caregiver(s). Clinical services are generally not required, however where they are involved, they should include:

- psychoeducation (in both written and verbal forms) and information via a GP for both the adolescent and parent/caregivers. The GP may also consider developing a MHTP (if consistent with Medicare Benefits Schedule eligibility requirements).
- wellbeing and/or preventative programs within the school, vocational or other community setting.
- be focussed on monitoring, with capability to step up into a higher level of care if required.

Other clinical services that may be required:

- lifestyle supports (e.g., sleep hygiene, exercise, and nutrition programs).
- parenting programs and family focussed wellbeing programs.

Support services:

- specific community, social, recreational, and school supports relevant to the wellbeing of the adolescent
- online information and resources
- peer work for the adolescent and/or parent/caregiver.
- services and supports focussed on connections with community and culture.

Additional services, if needed, are focussed on advocating for and coordinating additional services and supports required by the adolescent and family relevant to the wellbeing of the adolescent and their family including school-based and community-based, housing, legal, financial, and other supports.

Referral criteria:

An adolescent suitable for this level of care typically has minimal or no risk factors, is usually experiencing mild symptoms/low levels of distress, and where present, this is likely to be in response to a stressful environment. Symptoms have typically been present for a short period of time (less than 3 months but this may vary). The adolescent is generally functioning well and should be motivated to pursue self-management options. Adolescents experiencing a lack of motivation/engagement should not be referred to this level of care because these problems will work against involvement in self-management strategies. Where the adolescent has accessed services before, they are likely to have had a moderate to excellent response to the previous service experience.

Complexity indicated by significant problems in Risk, Functioning or Co-existing Conditions should be considered as contraindications for referral to Level 2 care and trigger a referral to Level 3 or higher.

Level 2 - Low Intensity Services

Definition: Low intensity services are designed to be accessed quickly (without the need for a formal referral e.g., through a third-party service or provider), easily (through a range of modalities including face-to-face, group work, telephone, and online services) and typically involve few or short sessions. In contrast to Level 1, Low Intensity Services usually require some direct, individually tailored engagement with a mental health professional to support the adolescent and/or their parent/caregiver.

Care environment: Services are easily accessible and available online, over the telephone or in the community. Services may also be available in integrated settings (e.g., within schools, vocational settings, community services, and general practice).

Core clinical services:

- psychoeducation (in both written and verbal forms) and information via a GP for both the adolescent and parent/caregivers. The GP may also consider developing a MHTP (if consistent with Medicare Benefits Schedule eligibility requirements).
- evidence-informed, age-appropriate and culturally safe low intensity services (including online, telephone and face-to-face low intensity psychological services, or brief interventions delivered by mental health professionals). Includes both individual and group work.
- school and vocational supports.

Other clinical services that may be required:

- lifestyle supports (e.g., sleep hygiene, exercise, and nutrition programs).
- parenting programs and family focussed wellbeing programs.

Support services:

- specific community, social, recreational, and school supports relevant to the wellbeing of the adolescent
- peer work for the adolescent and/or parent/caregiver.
- services and supports focussed on connections with community and culture.

Additional services, if needed, are focussed on advocating for and coordinating additional services and supports required by the adolescent and family relevant to the wellbeing of the adolescent and their family including school-based and community-based, housing, legal, financial, and other supports.

Referral criteria:

An adolescent suitable for this level of care typically has minimal or no risk factors, is usually experiencing mild symptoms/low levels of distress, and where present, this is likely to be in response to a stressful environment. Symptoms have typically been present for a short period of time (less than 3 months but this may vary). The adolescent is generally functioning well but may have problems with motivation or engagement or limited/minimal/no family and other supports – both of which contraindicate a referral to Level 1 care.

Complexity indicated by significant problems in Risk, Functioning or Co-existing Conditions should be considered as contraindications for referral to Level 2 care and trigger a referral to Level 3 or higher.

Level 3 - Moderate Intensity Services

Definition: Moderate intensity services generally provide structured, reasonably frequent, and individually tailored service delivery (e.g., a defined number of psychological sessions delivered regularly).

Care environment: Typically, community locations (e.g., consulting rooms, outreach into schools) or if appropriate, via telephone or videoconference (e.g., for people in remote communities), and clinician assisted e-therapies. Services may also be available in integrated settings (e.g., within schools, vocational settings, community services, and general practice).

Core clinical services:

A comprehensive biopsychosocial assessment (if not already undertaken) is required for all adolescents suited to this level of care.

- GP mental health assessment (and development of a MHTP).
- evidence-informed, age-appropriate, and culturally safe psychological services.
- diagnosis specific services where indicated (e.g., eating disorder clinics, alcohol, and other drug services).
- school and vocational supports to minimise functional impairment and maximise functional recovery.

Other clinical services that may be required:

- family focussed education and/or family therapy
- community psychiatry - psychiatrist opinion and management plan
- lifestyle supports (e.g., sleep hygiene, exercise, and nutrition programs).
- parenting programs and family focussed wellbeing programs.
- family-focussed care coordination services (if more than 2 services are involved in providing care and supports to the adolescent and/or family).

Support services: additional services are likely to be needed and may include:

- specific community, social, recreational, and school supports relevant to the wellbeing of the adolescent
- peer work for the adolescent and/or parent/caregiver.
- services and supports focussed on connections with community and culture.

Additional services, if needed, are focussed on advocating for and coordinating additional services and supports required by the adolescent or family relevant to the wellbeing of the adolescent and their family including school-based, housing, legal, financial, and other supports.

Referral criteria:

An adolescent requiring this level of care is likely to be experiencing mild to moderate symptoms (that would meet criteria for a diagnosis). Symptoms have typically been present for 3 months or more (but this may vary). Initial assessment would usually indicate problems present in Risk of Harm, Functioning or Impact of Co-existing Conditions but not at very severe levels, which should trigger consideration of a referral to Level 4 or 5. Adolescents experiencing moderate to severe symptoms with mild to moderate problems associated with Risk, Functioning and Impact of Co-existing Conditions are usually suitable for this level of care.

Level 4 - High Intensity Services

Definition: High intensity services including periods of intensive service that usually involve multi-disciplinary support and family-focussed care coordination as multiple services are likely to be involved. Level 4 is usually designed to support adolescents experiencing severe symptoms, significant functional impairment and/or risk factors.

Care environment: Typically, face-to-face services in community locations (e.g., consulting rooms) or outreach to the adolescent and family within their home or other environment (including school, vocational settings, community services, and general practice).

Core clinical services:

A comprehensive biopsychosocial assessment (if not already undertaken) is required for all adolescents suited to this level of care.

- GP mental health assessment (and development of a MHTP).
- evidence-informed, age-appropriate, and culturally safe psychological services provided by a mental health professional.
- community psychiatry - psychiatrist opinion, referral, management plan and treatment.
- diagnosis specific services where indicated (e.g., eating disorder clinics, alcohol, and other drug services, services for adolescents with at risk mental states like psychosis).
- family-focussed care coordination services (if more than 2 services are involved in providing care and supports to the adolescent and/or family).
- school and vocational supports to minimise functional impairment and maximise functional recovery.

Other clinical services that may be required:

- family focussed education and/or family therapy.
- lifestyle supports (e.g., sleep hygiene, exercise, and nutrition programs).
- parenting programs and family focussed wellbeing programs.

Support services: additional services are likely to be needed and may include:

- specific community, social, recreational, and school supports relevant to the wellbeing of the adolescent
- peer work for the adolescent and/or parent/caregiver.
- services and supports focussed on connections with community and culture.

Additional services, if needed, are focussed on advocating for and coordinating additional services and supports required by the adolescent or family relevant to the wellbeing of the adolescent and their family including school-based, housing, legal, financial, and other supports.

Referral criteria:

An adolescent requiring this level of care usually has significant symptoms and/or significant problems with Functioning. An adolescent with a severe presentation is likely to be experiencing moderate or higher problems associated with Risk of Harm, Functioning, and Impact of Co-existing Conditions. Where problems are assessed as very severe in symptom, risk or functioning domains, a referral to Level 5 care should be considered.

Level 5 - Acute and Specialist Community Mental Health Services

Definition: Specialist mental healthcare usually includes intensive team-based specialist assessment and service (typically state/territory mental health services) with involvement from a range of different types of mental health professionals, including case managers, psychiatrists, social workers, occupational therapists, psychologists and drug and alcohol workers. This level also often includes more intensive care provided by GPs working in partnership with acute and specialist teams.

Care environment: Typically, community locations with outreach to the adolescent within their home or other environment. This level may also involve specialist mental health inpatient care within a hospital environment, community based intermediate care, sub-acute unit, or crisis respite centre.

Core clinical services:

For this level of care, the adolescent and family are likely to benefit from psychiatric assessment and care, specialist behavioural programs, crisis management, and therapeutic services using pro-active engagement strategies provided by a multi-disciplinary specialist team with outreach capability. Care should be provided in close collaboration with General Practice.

Support services: Additional services are likely to be needed and may include:

- specific community, social, recreational, and school supports relevant to the wellbeing of the adolescent.
- peer work for the adolescent and/or parent/caregiver.
- services and supports focussed on connections with community and culture.
- parenting programs and family focussed wellbeing programs.
- family focussed education and/or family therapy.
- family-focussed care coordination services (if more than 2 services are involved in providing care and supports to the adolescent and/or family).

Additional services, if needed, are focussed on advocating for and coordinating additional services and supports required by the adolescent or family relevant to the wellbeing of the adolescent and their family including school-based, housing, legal, financial, and other supports.

Referral criteria:

An adolescent requiring this level of care usually has significant symptoms (e.g., severe symptoms and/or extreme behavioural problems) or problems in functioning independently across multiple or most everyday roles and/or is experiencing:

- significant risk of suicide, self-harm, self-neglect, or vulnerability.
- significant risk of harm to others.

The Decision Support Tool – Adolescents

In mental healthcare, complex decisions are made every day that are based on multiple pieces of evidence drawn from a variety of sources. The same process is applied to referral decisions, where the referring practitioner must consider the adolescent's mental health needs, consider their circumstances, choices, and preferences, and guide them to the best available referral option. Many clinicians undertake this process in a global way that is not usually broken down into step-by-step decision making.

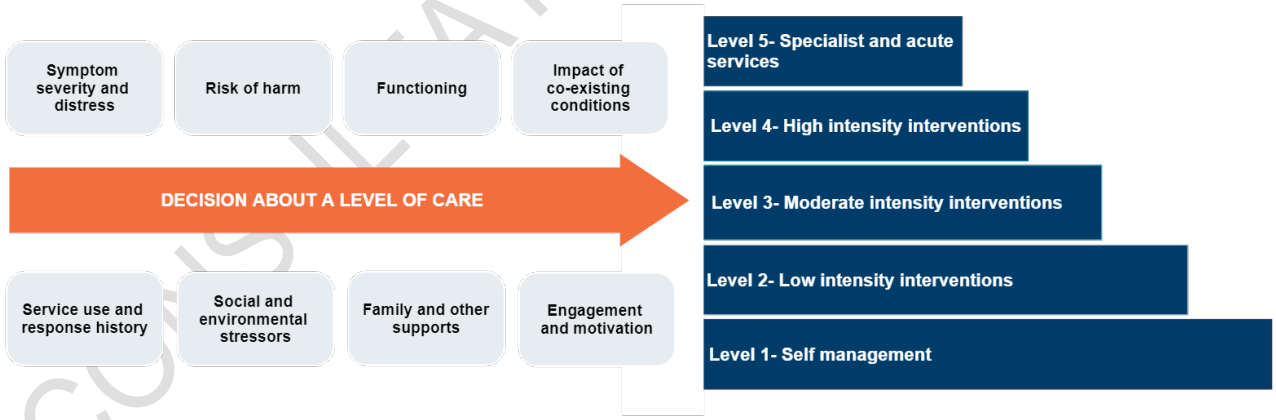
The approach described in this Guidance aims to unpack the referral decision process into its component parts and describe a logic for determining the recommended level of care for an adolescent presenting for assistance with a mental health problem.

Assessment on the eight domains provides the starting point. The next step is to define levels of care, based on different levels of resource intensity. Section 3 of the guidance outlines the schema for conceptualising resource intensity, based on five levels of care. The model is offered as a practical approach to guide thinking about referral options rather than a picture-perfect reflection of the mental health service system.

The third and final step concerns the 'bridge' between the assessment of a presenting individual on the domains and consideration of a recommended level of care. Each adolescent will present with a unique set of circumstances, such that arbitrary and inflexible rules that apply to all are not appropriate. The assessment domains are interactive with the implication that a decision about the goodness of fit between the adolescent's intensity of needs and referral to a level of care needs to consider all assessed domains and their component factors in combination.

An adolescent's presenting issues on each domain can interact in different ways. As an example, an adolescent presenting with mild to moderate symptoms (Domain 1) but no significant problems on any of the contextual domains (Domains 5-8) is likely to require a different level of care from an adolescent with mild to moderate symptoms but extensive social and environmental stressors or a history of poor response to previous treatment. The challenge for referral decision making is portrayed in Figure 2.

Figure 2: Mapping assessments on 8 interactive domains to 5 levels of care



Decision Support Tool Logic

Figure 3 summarises the proposed logic that underpins the decision support tool. It shows how ratings of the domains using the glossary rating guide, and interactions between the domains, can be applied to guide referral decisions.

A step through of the logic

Like most decision support tools that aim to describe complex relationships, the initial impression for many who examine the logic may be that it is complex, or difficult to fathom at first glance. However, there is an underlying simplicity to the proposed approach to guiding decision making that is described below, by dissecting the clinical decision support tool into sections.

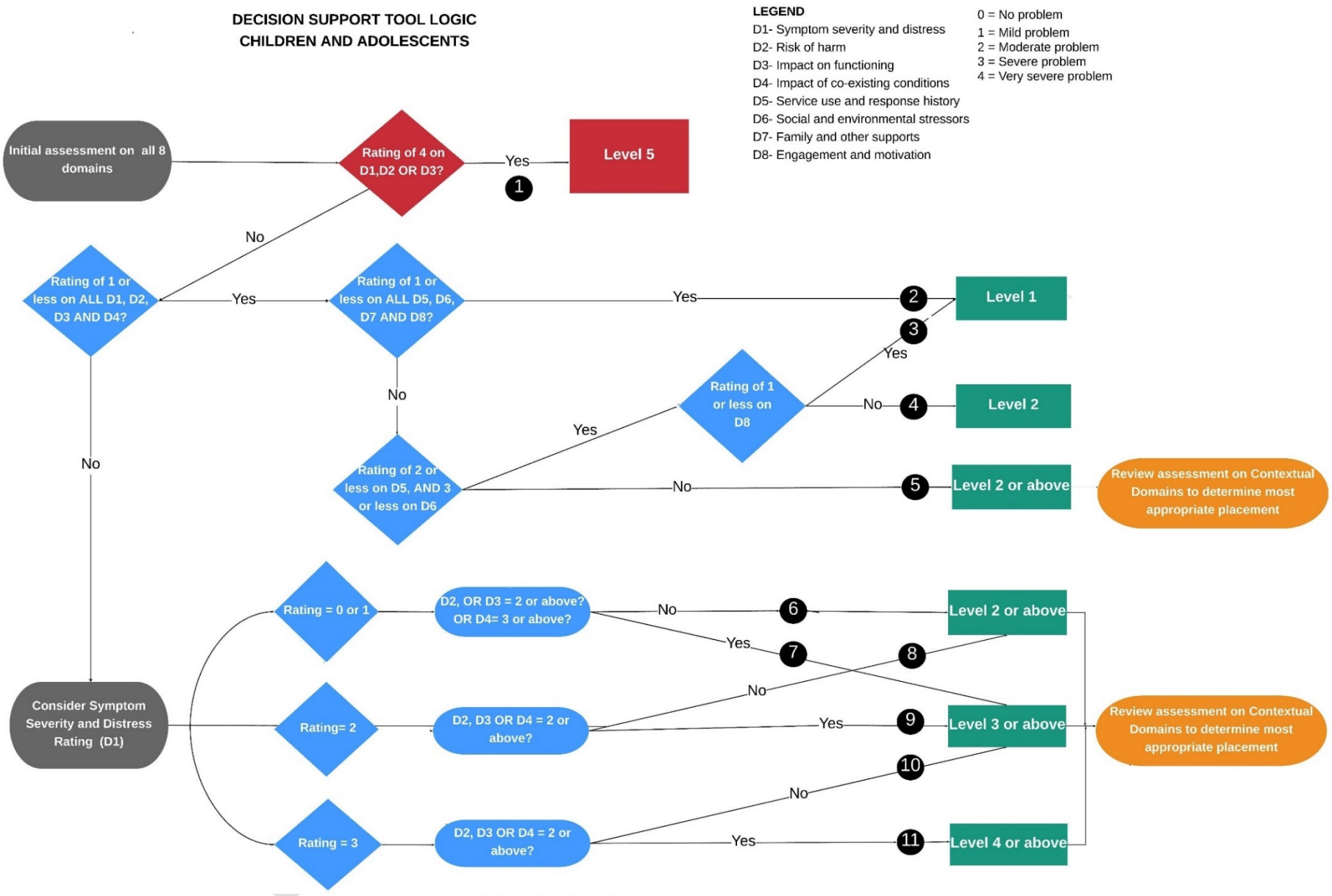
There are 5 levels of care and 11 possible pathways into the 5 levels of care. The 11 pathways are referenced using the black numbered circle.

Pathway 1: 'red flag' items are identified that would usually warrant referral to Level 5 care which includes acute and specialist community mental health services (largely state and territory services). These include very severe ratings on symptoms, risk, and functioning domains. 'Red flag' items act as independent criteria that automatically place an individual in a specific level of care, regardless of what their assessment is on other domains.

Pathways 2 – 5: targets people with relatively minor problems on primary domains. Decisions about this group are guided using treatment history (D5) and other contextual domains, into (mostly) Level 1 or 2 care.

Pathways 6 – 11: There is considerable complexity in this potentially large group. Presentations in this group are classified initially based on symptom/distress severity, then on the presence of other complexity in the other primary domains. This group are then allocated to levels based on contextual domains which are unmapped. Most of this group are expected to be referred to Level 2 or above.

Figure 3 – Decision Support Logic


DECISION SUPPORT TOOL LOGIC
CHILDREN AND ADOLESCENTS
LEGEND
D1- Symptom severity and distress
D2- Risk of harm
D3- Impact on functioning
D4- Impact of co-existing conditions
D5- Service use and response history
D6- Social and environmental stressors
D7- Family and other supports
D8- Engagement and motivation
0 = No problem
1 = Mild problem
2 = Moderate problem
3 = Severe problem
4 = Very severe problem
Initial assessment on all 8 domains
Rating of 4 on D1,D2 OR D3?
Yes
1
Level 5
No
Rating of 1 or less on ALL D1, D2, D3 AND D4?
Yes
Rating of 1 or less on ALL D5, D6, D7 AND D8?
Yes
2
Level 1
3
Yes
No
Rating of 1 or less on D8
No
4
Level 2
Yes
No
Rating of 2 or less on D5, AND 3 or less on D6
No
5
Level 2 or above
Review assessment on Contextual Domains to determine most appropriate placement
No
Consider Symptom Severity and Distress Rating (D1)
Rating = 0 or 1
D2, OR D3 = 2 or above? OR D4= 3 or above?
No
6
Level 2 or above
Yes
7
8
Rating= 2
D2, D3 OR D4 = 2 or above?
No
Yes
9
Level 3 or above
Review assessment on Contextual Domains to determine most appropriate placement
10
Rating = 3
D2, D3 OR D4 = 2 or above?
No
Yes
11
Level 4 or above

Interpreting Standard Assessment Tools to Guide Initial Assessments

Standardised assessment tools such as the Strengths and Difficulties Questionnaire (SDQ) and the Work and Social Adjustment Scale (WSAS) can be a useful tool for guiding ratings across the Domains. Indicative thresholds for these instruments are summarised below. The thresholds below should not be used in isolation to determine a rating on any domain but may be useful in building certainty.

PRACTICE POINT

The standard assessment tools described in this Guidance are a potentially useful way of gathering information about current clinical need and may provide a useful baseline from which to measure the benefit of any intervention. However, the findings from standard assessment tools are, on their own, not enough to inform assessment and referral decisions. Furthermore, assessment tools should only be used if clinically appropriate, by an appropriately trained professional, and with consent. The scores and indicative thresholds from standard assessment tools are not indicative of a diagnosis, but representative of distress, functional impairment, or likelihood of a diagnosis at the time the measure was scored and is not a diagnostic assessment.

Users should note that the standard assessment tools referenced in this section have not been developed with culturally appropriateness and safety in mind and may not be appropriate for Aboriginal and/or Torres Strait Islander People, and adolescents with migrant or refugee backgrounds.

Where there is significant discordance between clinician assessment and scores on standard assessment measures- this is an indicator that a comprehensive assessment is required.

Strengths and Difficulties Questionnaire – Domains 1, 2, 3 and 6

The Strengths and Difficulties Questionnaire (SDQ) is a brief questionnaire measuring internalising, externalising, and prosocial behaviour and is widely used throughout Australia. The questionnaire contains five subscales:

1. Emotional symptoms
2. Conduct problems
3. Hyperactivity/inattention
4. Peer relationship problems
5. Prosocial behaviour

The SDQ is a mandated assessment tool for monitoring outcomes in the Primary Mental Health Care Minimum Data Set (PMHC MDS). Thresholds for categorising scores are provided in the table below.

PARENT VERSION	'This score is close to average - clinically significant problems in this æare unlikely'	'This score is slightly raised, which may reflect clinically significant problems'	'This score is high - there is a substantial risk of clinically significant problems in this area'
Total Difficulties Score	0-13	14-16	17-40
Emotional Symptoms Score	0-3	4	5-10
Conduct Problem Score	0-2	3	4-10
Hyperactivity Score	0-5	6	7-10
Peer Problem Score	0-2	3	4-10

	'This score is close to average – clinically significant problems in this area are unlikely.	'This score is slightly low – which may reflect clinically significant problems.	'This score is low - there is a substantial risk of
Prosocial Behaviour Score	6-10	5	0-4

SELF COMPLETED VERSIONS	'This score is close to average - clinically significant problems in this area are unlikely'	'This score is slightly raised, which may reflect clinically significant problems'	'This score is high - there is a substantial risk of clinically significant problems in this area'
Total Difficulties Score	0-15	16-19	20-40
Emotional Symptoms Score	0-5	6	7-10
Conduct Problem Score	0-3	4	5-10
Hyperactivity Score	0-5	6	7-10
Peer Problem Score	0-3	4-5	6-10
	'This score is close to average - clinically significant problems in this area is unlikely'	'This score is slightly low – which may reflect clinically significant problems'	'This score is low - there is a substantial risk of clinically significant problems in this area. a substantial risk of clinically significant problems in this area'
Prosocial Behaviour Score	6-10	5	0-4

Work and Social Adjustment Scale - Youth (WSAS-Y) – Domain 3

The WSAS-Youth version (WSAS-Y) and WSAS-Parent version (WSAS-P) are brief measures of functional impairment. The items of WSAS-Youth version (WSAS-Y) are similar to the original WSAS but have been adapted to be age-appropriate and to capture areas likely to be functionally affected in young people. Like the WSAS, the WSAS-Y consists of five items that are rated on a nine-point Likert scale, generating a global score ranging from 0 to 40. The WSAS-Y is accompanied by a parallel parent/guardian version (WSAS-P). The questionnaires contain five subscales:

1. School studies and work
2. Daily skills
3. Social activities
4. Hobbies
5. Family and relationships

Total score	Interpretation
0-10	Nil to mild impairment

11-20	Significant impairment
21+	Moderately severe to very severe impairment

Source for thresholds: https://psyarxiv.com/f8zev/

End