Response to National Initial Assessment and Referral for Mental Healthcare Guidance for Children and Adolescents

A submission to the:
Australian Government, Department of Health

Prepared by:
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Authorised by:
Tracy Adams, CEO, **yourtown**

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Email: research@yourtown.com.au Tel: 07 3867 1324

yourtown is a national organisation and registered charity that aims to tackle the issues affecting the lives of children and young people. Established in 1961, **yourtown's** mission is to enable young people, especially those who are marginalised and without voice to improve their quality of life. **yourtown** provides a range of face-to-face and virtual services to children, young people and families, these include:

- **Kids Helpline**, a national free 24/7 telephone and on-line counselling and support service for 5- to 25-year-olds, with special capacity for young people with mental health issues;
- Mental health service/s for children aged 0-11 years old, and their families, with moderate mental health needs;
- **Parentline**, a telephone and online counselling and support service for parents and carers;
- Accommodation and therapeutic responses to young parents with children who are at risk, and to women and children seeking refuge from domestic and family violence, including post-refuge support;
- Expressive Therapy interventions for young children and infants who have experienced trauma and abuse, or been exposed to violence;
- Young Parent Programs offering case work, individual and group work support and child development programs for young parents and their children; and,
- Employment, educational programs and social enterprises, which support young people to re-engage with education and/or employment, including programs specifically developed for those experiencing long-term unemployment.

Kids Helpline

Kids Helpline is unique within Australia as the only national 24/7, confidential support and counselling service, specifically designed to meet the needs of children and young people, aged 5 to 25 years. It offers counselling support via telephone, email and real time webchat and is staffed by a paid professional workforce, with all counsellors holding a tertiary qualification.

Since its establishment in March 1991, children and young people have been contacting Kids Helpline about a diverse group of issues ranging from everyday topics such as family, friends, and school to more serious issues of child abuse, bullying, mental health issues, drug and alcohol use, self-injury, and suicide.

Mental health has been a number one concern for many years for children and young people contacting Kids Helpline. In 2020, Kids Helpline counsellors responded to 176,012 contacts from children and young people aged between 5 and 25 years. The top concerns were about mental health, emotional wellbeing, family relationships, suicide, and friend and peer relationships. Specifically, Kids Helpline responded to 45,035 counselling contacts about mental health and wellbeing. This equates to 861 contacts per week or 123 contacts per day. In addition, in 2020, the Kids Helpline website had more than 2.1 million unique visitors.

yourtown supports the work of the Australian Government's Department of Health (the Department) to develop the National Initial Assessment and Referral (IAR) for Mental Healthcare Guidance, and Decision Support Tool (the Tool) to assist general practitioners (GPs) and clinicians to recommend the most appropriate level of care for a child (aged 5-11) or adolescent (aged 12-17) seeking mental health support. **yourtown** welcomes the opportunity to provide feedback through the Department's consultation survey on the proposed Tool to enhance assessment and delivery of mental health services to children and young people.

yourtown recognises the benefit of the Tool in face-to-face services; however, there are significant limitations upon applicability of such tools in the virtual service delivery context. **yourtown** delivers Kids Helpline, Australia's only national, free, private, and confidential 24/7 phone and online counselling service for 5- to 25-year-olds. Ensuring that conversations that children or young people have with Kids Helpline remain private is central to the Kids Helpline service delivery model, with all calls/webchats received considered anonymous and confidential. Given this, the Tool is primarily a tool designed for face-to-face clinical or GP services and is not an appropriate tool for a virtual (and primarily anonymous) context, regardless of any modifications that might be proposed.

While **yourtown** supports the application of such a tool in face-to-face services, given the limitations of applicability in the virtual service delivery context, funding of mental health services should not come with an expectation that the Tool will be used. Further, given Kids Helpline plays a unique and critical role in Australia's mental health support system for children and young people, **yourtown** also proposes that Kids Helpline should be expressly included within the IAR as a service that clinicians could refer children and young people to for support.

The following provides **yourtown**'s responses to the consultation survey questions.

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

The general instructions for rating the domains and overarching rules for rating are straightforward. Furthermore, the terminology of clinical severity and service needs are clear, jargon free and user friendly. **yourtown** supports reference to the Emerging Minds resources for clinicians wanting to refresh their competencies.

The instructions could take into account that children may be accompanied by a parent or caregiver, which may influence the ratings. Children aged 5-11 years old are unlikely to be presenting themselves to a GP or clinician and are likely to be accompanied by a parent or carer. Also, a parent may not present their child and will talk about their child with the GP or clinician. We suggest including concise guidance about who is to be present for the assessment and how information should be weighted regarding comments from parents and comments from children.

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?

Domain 2 – Risk of Harm converges two distinct assessments: 1) harm to self or others related to mental health symptomology, and 2) harm from others. In the context of assessing a child, harm from others becomes a child protection matter, or a matter of engaging the child's legal guardian to address the issue. This could be covered by the 'harm from others' assessment' in Domain 6 –

Social and Environmental Stressors, specifically, the section about, "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)". Rather than combining two discrete assessments in Domain 2 that arguably should be kept separate, the harm from others assessment could be part of Domain 6. This Domain could be restructured and renamed to, 'Domain 6 – Safety, Social and Environmental Stressors'. Domain 2 would then centre on harm to self or others.

Other suggestions to ensure the domains and elements are comprehensive or appropriate are as follows:

- In Domain 2, the reference to 'complete suicide' could be replaced by 'die by suicide' which is preferred safe language to use when talking about suicide[1].
- Play (both structured and unstructured) could be added to Domain 3 – Functioning, due to its vital role in children's development and wellbeing.
- In Domain 3, discussion of a child's ability to fulfil usual roles/responsibilities could be expanded to include school/educational engagement and attendance.
- In Domain 4 – Impact of Co-Existing Conditions, assessment could consider the presence and impact of co-existing conditions, not only with the child or adolescent, but also within the family unit.
- In the Practice Point in Domain 6, references to 'trauma' could be replaced by 'adversity' because trauma is a response to a situation, which in this case, is adversity.
- Domain 7 – Family and Other Supports could include explicit discussions about the relationship between the child and the parent or caregiver.
- In Domain 7, the section on the supports available for the child could be expanded to include supports available for the family unit.
- Domain 8 – Engagement and Motivation, could focus not only on the parent's or caregiver's motivation to engage in, or accept assistance, but also the child's understanding and willingness to accept assistance.

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?

The role of clinical judgement is clear.

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?

Recommendation: The Levels of Care should include telephone and online counselling services, such as Kids Helpline, in their support services for children and young people.

[1] See everymind for preferred language guidelines https://everymind.org.au/suicide-prevention/understanding-suicide/role-of-language-and-stigma

There are known gaps in services available for children and adolescents. A child or young person may have been assessed as having a mental disorder but may not utilise or be able to access mental health services (due to long wait lists or availability). This issue is more pronounced for children and adolescent living in lower socio-economic areas.[2] Personal reasons for not accessing services may include lack of awareness regarding how to access services, fear of being judged, and services not being child friendly. Online and tele-health resources can address barriers such as accessibility and stigma related to using mental health services. Indeed, children and young people are more likely to engage with mental health information and services via digital technologies, especially if the technologies are interactive, user-friendly, supportive, and provide a level of privacy control for them.[3] We recommend including telephone and online counselling services, such as Kids Helpline, in the Levels of Care support services.

While Kids Helpline would fit in Level 1 – Self Management, the service also currently plays an important support role in the other Levels of Care. Kids Helpline receives referrals from a range of Federal and State government departments, and other mental health providers. Counselling and support are delivered by tertiary qualified, youth specialist counsellors. Children and young people call, use webchat or email Kids Helpline counsellors, and access digital resources. Kids Helpline plays an important role in Australia's mental health infrastructure through:

- Prevention services for children and young people regarding any issue that could lead to mental ill-health, and inviting children and young people to talk about anything, including issues that intersect with mental health, by:
    - Encouraging help seeking;
    - Promoting wellbeing;
    - Facilitating early referral to support; and,
    - Referring to Kids Helpline digital health resources.

- Providing a front door to the mental health system for children and young people with any mental health concern or need by:
    - Helping children and young people navigate the mental health system;
    - Providing different modes of access and is free, making it easy for children and young people to access;
    - Signposting and referring children and young people to community services; and,
    - Referring to Kids Helpline digital health resources.

[2] Meadows, G. M., Enticott, J. C., Inder, B., Russell, G. M., & Gurr, R. (2015). Better access to mental health care and the failure of the Medicare principle of universality. Medical Journal of Australia, 202(4).
[3] Campbell, A., & Robards, F. (2013). Using technologies safely and effectively to promote young people's wellbeing: A better practice guide for services. Victoria, Australia: Young and Well Cooperative Research Centre.

- Providing a soft entry for children and young people with emerging or undiagnosed mental health needs by:
    - Supporting anonymous access and is a non-confronting service that children and young people feel comfortable accessing;
    - Inviting children and young people to call about any reason so that can 'test' the service and disclose issues when they feel comfortable;
    - Preparing children and young people to access formal services;
    - Providing psychoeducation; and,
    - Referring to Kids Helpline digital health resources.

- Providing a safety net for children and young people with diagnosed mental health needs by:
    - Providing 24/7 access to Kids Helpline where there are service delivery gaps in the mental health system by:
        - Providing access to help when no other service is available, either due to long waiting lists or after hours;
        - Ensuring services can be easily accessed by children and young people in rural and remote communities, and who identify as First Nations, culturally and linguistically diverse, or LGBTQIA+;
        - Working directly with clients in crisis and links in with their external supports (e.g., psychologist) and other services (e.g., Police);
        - Referring to **yourtown's** My Circle, a free, private, safe and confidential social platform for young people aged 13-25 years old, with mental health issues, from early stage to crisis; and,
        - Referring to Kids Helpline digital health resources.

- Providing case management for children and young people with complex diagnosed mental health needs including:
    - Undertaking assessments;
    - Case planning, setting goals and case reviews;
    - Developing safety plans;
    - Coordinating support services;
    - Referring clients to other services;
    - Organising and/or participating in case teleconferences with other support services (e.g., GPs, psychiatrists or psychologists);
    - Facilitating self-management; and,
    - Referring to **yourtown's** My Circle, a free, private, safe, and confidential social platform for young people, aged 13-25 years old, with mental health issues, from early stage to crisis.

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 standardised

assessment tools (Strengths and Difficulties Questionnaire, Work and Social Adjustment Scale – Youth Version) 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?

The Standard Assessment Tools included in the IAR Guidance are sufficient and appropriate.

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?

Recommendation: Given all calls/webchats received from children and young people by Kids Helpline are considered anonymous and confidential, the Australian Government should:

- Recognise the applicability of the Tool in face-to-face services only;
- Recognise the Tool lacks applicability in virtual service settings; and,
- Ensure funding of services is not conditional on the use of the Tool.

While the Tool could be applied in face-to-face services, the Tool is not applicable to Kids Helpline that delivers anonymous and confidential tele-health and online counselling and support for children and young people across Australia. When initially seeking help, children and young people often feel more comfortable making contact anonymously via online support services. This can include accessing websites with age-appropriate information such as the Kids Helpline website and making contact anonymously via online counselling modes such as Kids Helpline's email and webchat counselling services. The anonymity enables children and young people to test the reliability of the service and overcome their fears of being judged when seeking help for issues that have attached stigma (e.g., mental health and suicidal ideation). Once trust is built, children and young people may then feel more comfortable and confident talking to counsellors via phone counselling. Application of the Tool is therefore significantly limited in the virtual context.

The Tool also appears to require parents to converse with clinicians and assist children and adolescents with navigating referrals pathways. This does not fit with the anonymous nature of help seeking from children and young people, many of whom may be struggling with issues in their families, homes, and schools. In addition, the paucity of on-the-ground mental health services for children and young people means referrals may not be available or accessible, particularly in rural and remote areas.

Given the applicability of the Tool only in a face-to-face context, funding should not be tied to an expectation that the Tool would be used, and expectations for implementation should exclude digital tele-health and online counselling services for children and young people.

There is also a risk that the Tool may not be used because the clinical and support services in the Levels of Care and referral pathways are not described in tangible terms, and there may be no existing service for a referral due to the scarcity of mental health services for children and young people, particularly in regional and remote areas.

In order for the Tool to work effectively:

- Clinical and support services identified in the Levels of Care should be expanded to link directly to face-to-face and digital services;
- Referrals need to be suitable and available;
- Pathways to the referral need to be easy to navigate for children, adolescents and their families or guardians; and,
- Referrals need to be successful, that is, taken up by children, adolescents, and their families.

Recommendation: The Department should ensure the IAR and Tool are culturally appropriate and culturally safe, and consult and co-design the IAR and Tool with children, young people, and their families, particularly those who identify as being from First Nations, or culturally and linguistically diverse communities.

yourtown appreciates that the IAR Guidance, and Decision Support Tool aim to assist mental health services to deliver a consistent and culturally appropriate to clinical assessment and referral. However, western conceptualisations of mental health and illness in the Tool may not be culturally appropriate with other cultures, such as First Nations cultures, that are built around collectivist kinship systems.[4] We recommend consultation and co-design with children and families from First Nations, and culturally and linguistically diverse communities should be undertaken to ensure the tool is culturally sensitive and safe to use.[5]

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

Training and upskilling are key supports **yourtown** envisages would be required by our staff working in face-to-face services. In particular, the training would need to focus not only on the implementation, but also the context of the Tools to better inform discussion and assessment. If the Tool was required to be applied in the virtual context, significant resources and supports would be required to adjust the service delivery model.

The Levels of Care are discussed in high level terms in the IAR Guidance, and Tool. This means professionals implementing the Guidance and Tool do not have specific referral pathways to recommend to children, adolescents, and their families. The confidence of professionals using the Tool would be enhanced if the Levels of Care had links to services which were assessed in terms of quality, availability, and accessibility. For example, Primary Health Tasmania has commissioned primary mental health services for: people with a mild or moderate mental illness, adults with a complex or severe mental illness, First Nations peoples, young people, and people living in aged care facilities. Their services portal provides details about these commissioned mental health services. The Tool could link directly with directories such as this for a more seamless referral approach. In addition to this, additional work is required to address the lack of available mental health services for children and young people, and the long waitlists for services.

[4] Lohoar, S., Butera, N., & Kennedy, E. (2014). Strengths of Australian Aboriginal cultural practices in family life and child rearing. CFCA Paper No. 25

[5] For culturally appropriate ways of working with First Nations peoples in a mental health context, see Dudgeon, P., Milroy, H., & Walker, R. (eds). (2014). **The 2nd Edition of Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice** https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/expired-projects/working-together-second-edition/

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 Department of Health may want to link with the Queensland Department of Children, Youth Justice and Multicultural Affairs regarding their work on improving care and post-care for children and young people. Specifically, the Strengthening Health Assessment Pathways for Children and Young People in Care project seeks to bring together the Child Safety and Health sectors and promotes the use of its health assessment tool (that includes a mental health and wellbeing component) to align with the National Clinical Assessment Framework.

Conclusion

We would welcome the opportunity to explore these ideas with you further in more detail. Should you require any further information, please do not hesitate to contact Kathryn Mandla, Head of Advocacy and Research at **yourtown** via email at kmandla@yourtown.com.au.