In between looking and seeing: recognition, referral and assessment of children and adolescents' mental health problems at the interface of primary care and secondary mental healthcare

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"Knowing when to say 'I don't know' is half of knowledge."

Malik ibn Anas

Chapter 5

General discussion

In this dissertation we aimed to contribute to gaps in the evidence on timely recognition, referral and assessment of children and adolescents with mental health disorders by addressing three main questions. The first main question was: to what extent do professionals recognize typical symptoms of mental health problems. As a major example of a prevalent but overlooked mental health problem, we experimentally focused on the early recognition of anxiety disorders. As a first in literature, this study focused on professionals' very first diagnostic considerations (chapter 2). We presented both general practitioners and mental health professionals with examples of how problems could be expressed by minors with anxiety disorders and their families during a typical consult and asked for professionals first diagnostic interpretation. The second main objective was to quantify the predictive value of reasons for referral once the need for mental health treatment is recognized in minors. To this end we retrospectively extracted and coded referral letters from general practice to child and adolescent psychiatry. A coding scheme was developed and suggestions for meaningful use of referral letters are presented (chapter 3). Thirdly, we investigated whether an integrated use of various assessment forms can potentially improve the prediction of the type of mental health disorder. Many studies on evidence-based assessment instruments exist, yet in practice the question remained how we could increase their meaningful use. To add to this end, we investigated the incremental value of structured screening and elaborated assessment together with referral letters and clinicians remote evaluation of available information (chapter 4). In the current chapter, the findings of these studies are summarized and discussed. Subsequently general implications for future studies and clinical practice are elaborated on.

Summary of findings

Recognition

Studies on the prevalence and underrecognition of mental health disorders are common. In most of these studies recognition is quantified as a diagnostic outcome. Such studies examine whether professionals recognize the presence of a demarcated mental health disorder. In clinical practice, however, it is rather the rule than exception that early mental health problems are not defined clearly. This is of major importance when considering timely recognition. In the face of undefined problems, professionals' familiarity with the frequent

occurrence of anxiety disorders is critical. Therefore, we questioned whether professionals sufficiently consider the likelihood of the presence of an anxiety disorder in their early decision-making. As anxiety disorders are a relatively silent problem associated with a broad range of symptoms, we hypothesized that the underrecognition of anxiety disorders could be related to professionals' unfamiliarity with the wide variety of symptoms and how widespread these problems are –and not only related to for example patients avoidance of disclosure during consult situations. Nonetheless, to the best of our knowledge, there were no empirical studies on the early diagnostic interpretation of professionals as a factor of influence on early recognition. To contribute to this question, we presented general practitioners and mental health professionals with hypothetical cases, so called vignettes, in which mixed anxiety symptoms were described (chapter 2). The professionals were asked what their first interpretation of the type of problem was. Both general practitioners and mental health professionals selected anxiety related problems less than what could be expected based on the content of the vignettes and compared to their selection rate of the other type of mental health problems. General practitioners recognized anxiety related problems also less than what could be expected based on the prevalence of anxiety disorders in community and primary care samples. Notably, general practitioners and mental health professionals did not differ significantly with regard to their recognition rate of the other disorder groups in these mixed anxiety vignettes. The study results (chapter 2) suggest that already at the very beginning of the diagnostic process professionals overlook anxiety disorders. In view of early recognition and prevention, the question remains what the recognition rates would be if they were not made aware of the focus of the study on psychosocial problems during the informed consent.

Referral

Anxiety disorders tend to be evaluated as a relatively mild problem.[1] In line therewith, in the vignette study (chapter 2) we hypothesized that general practitioners would report that it is usually suitable and sufficient to treat anxiety disorders in primary care.[1] This would partly explain why most anxiety disorders are less often referred for specialised mental health treatment.[2] Contrary to expectation, general practitioners reported preferring a treatment in mental healthcare for anxiety disorders when asked explicitly. This finding suggests that general practitioners do not per se underprioritise anxiety disorders, and that the low

referral rates in clinical practice might be more of an issue of underrecognition rather than underprioritisation and trivializing of anxiety disorders. Also, in line with this conclusion, the referral letters investigated in the second study (chapter 3) showed the lowest agreement rate for anxiety disorders when inspecting the agreement between the reason for referral and the classifications of disorders that were made in child and adolescent psychiatry. Even in referred samples, the recognition of anxiety disorders by general practitioners, falls behind when compared to other common mental health disorders.[3]

Although there are several studies on the substantial value of reasons for referral as indicated on referral letters for the adult mental health process, only two earlier studies presented the predictive value of referral letters to child and adolescent mental healthcare.[4] [5] One of these studies is on autism spectrum disorders and one on non-obsessive compulsive anxiety disorders. In chapter 3, we presented agreement metrics between the reason for referral mentioned in referral letters and the clinical classification made in child and adolescent mental healthcare for all commonly treated mental health disorders obtained from a large sample referred by general practitioners. To this end we coded the reasons for referral by including both tentative diagnoses and symptoms and problems mentioned in referral letters. Over half of the referral letters indicated one or more of the core symptoms or the tentative diagnoses of the clinically established classifications. When indications of internalizing and developmental/ externalizing problems were grouped, we found that respectively half and two-thirds of the outcomes were in line with the suggested reason for referral. Variations between specific disorder groups were observed with the lowest sensitivity for anxiety disorders and the highest for eating disorders. Referrers often indicated the child's context, such as problems between parents, difficulties studying or being bullied. We found no effects of gender, age, the severity of the problems as estimated by the specialist or whether the child has a mental healthcare history or not, except for age and attention-deficit hyperactivity disorders (ADHD). Referral letters better predicted ADHD with increasing age. An indication of urgency or a severe status in the referral letters was significantly associated with a lower functional impairment score (CGAS-score, as estimated in child and adolescent mental healthcare). All in all, the study results imply that there is more opportunity to draw from the contents of referral letters than expected based on anecdotal evidence and clinicians' stances, as well as room to improve the value and use of

referral letters, particularly on the level of the specific disorders (e.g., anxiety disorders versus depressive disorder).

Assessment

Adequate information is critical to facilitate diagnosis making and allocating the needed care.[6] This holds both for decision-making in primary care and secondary care. However, as the advised assessment methods differ at various stages of care (e.g., primary care versus specialised mental healthcare) yet also overlap, insight is needed in the incremental value of various nodes of information. This is what we examined in chapter 4 of this dissertation. Here we linked the I) referral letters that form a proxy for the tentative diagnosis made by referring clinicians, II) to results of the broadband screening questionnaire with potential for use in primary care, III) to results of elaborate structured assessment with potential for use at registration and diagnosis-making at secondary mental healthcare, and IV) to the tentative remote diagnosis made by a clinician with online access to the results of the previous instruments. The value of these four nodes of assessment in predicting the best estimate clinical consensus diagnoses was investigated (also called LEAD diagnoses; longitudinal, expert, and all data[7]). Nearly all instruments showed statistically significant independent predictive value in predicting the classification of commonly treated mental health disorders (chapter 4). This suggests that structured acquisition and integrated use of information obtained at various stages of the care landscape might add to the diagnostic procedure. Although each instrument certainly contributed additional information in our study, there was no indication that the most extensive assessment method (the remote evaluation of a clinician of the DAWBA open and close ended questions) holds the highest value and should have been used first and only.[8] More specifically, we found that the different instruments showed different strengths and weaknesses. In general, whereas the referral letters were conservative about indicating specific mental health disorders (high specificity, lower sensitivity), the screening questionnaire was over-inclusive (high sensitivity, low specificity). This exemplifies the importance of integrated use of clinicians judgement with a screening instrument (the SDQ) in primary care. The more extensive method (i.e. the automatised DAWBA score and the remote clinical rating within the DAWBA environment) showed a more balanced profile considering sensitivity and specificity. The study results illustrate that these nodes of information all have a unique value.

Clinical implications and practical value

The studies in this dissertation highlight potential to improve the diagnostic process for minors with mental health problems. The first study implicates the necessity to focus on professionals' awareness of the likelihood of a mental health problem (chapter 2). To ameliorate the likelihood of recognition and adequate management, professionals' familiarity with characteristic features, prevalence, and impact of mental health problems needs to be improved. Although precise diagnosis-making is not the task of a general practitioner, the finding that they recognized anxiety even less than the prevalence of anxiety disorders in the population highlights the importance of increasing knowledge to improve their ability to identify or exclude problems. As portrayed in the case described in Box 1, awareness is a step towards enquiring further, and without further enquiring recognition is unlikely or delayed.[9 10] Knowledge of the epidemiology of a disorder could increase awareness on the presence of caseness during consultations. Especially in practices where structured assessment is not implemented, readily available knowledge by the person of the clinician is crucial.[11]

Results of the second study imply that information transferred from general practice holds substantial value for specialised mental healthcare (chapter 3). When viewed as more than a bureaucratic piece of paper by both primary and secondary care professionals, referral letters cosuld be incorporated explicitly in the referral-intake process in mental healthcare and elaborated on during the interview with patients. Then, next to improving communication between primary and specialised care,[6] referral letters might contribute to diminishing families experience of fragmented care. This potential of referral letters is not a capacity to depreciate as many families experience a referral as being in limbo which in turn negatively impacts their reach for support and clinical outcomes.[12-14] To reach this potential however, a clear division of the responsibilities is needed at the referring and receiving end of healthcare as well as a mutual understanding of what referral letters stand for.[6] For the latter, an important consideration is what the reason for referral reveals: do the reasons for referral reflect referrers' true diagnostic opinion or is it what they believe needs to be written to access mental healthcare? Nonetheless, there is ground to assume that referral letters mirror the most outstanding symptoms and complaints as captured by its writer.[15]

Box 1

Imagine again a consultation in general practice. This time, Ann, an-eleven-year-old girl, visits for her recurring earache. The GP, Dr. Hartveld, knows Ann as a shy child who cooperates well with no other particularities. While she is examining the child's ears, the mother mentions that although Ann looks timid, she can certainly be temperamental. Usually, this occurs when they are in a hurry.

The GP considers whether it would be wise to ask anything about what is told here, in between the lines. Even though there is no explicit request for help considering these problems, she decides to enquire further. It turns out that the mother means that although Ann can sit so quietly, she can also get pretty upset. About three times a week. But "Luckily Ann also has many strong points". She goes to school as usual even when she has not slept well because of the earaches. Ann doesn't want to miss any school and wants to finish all her homework properly. Her study skills are good. The teacher thinks Ann is a smart child. She does say, however, that "Ann can respond rather impatiently if she can not handle certain situations". The initial interpretation of the GP is that this might be an example of typical development in a child with a strong will or might point towards characteristics on the autism spectrum. She also remembers that recently she had learned about how common anxiety disorders are and that they might manifest as temper tantrums.

The GP concludes that it is likely that Ann shows subclinical levels of anxiety symptoms as her earaches happen to strike before spelling tests. She has a tendency to worry a lot which might be why she shows temperamental outbursts when they are in a hurry or doing something new. Ann is also able to develop an adequate relation with the GP and mother does not report other typicalities pointing towards autism. Dr. Hartveld decides to hand parents a screening questionnaire which they later discuss with the general practice-based mental health nurse. The mental health nurse shares some tips regarding coping with her worries and temper tantrums. They decide to monitor her anxious behaviour; especially as she will go to secondary school next year and these transition periods often mark whether a child will adapt or experience more challenges.

A few months later mother revisits and explains that they have read more about emotional and behavioural problems in families. She explains that she recognized several other challenges related to the anxious attitude of Ann and also experienced difficulties in how they, as parents, should respond to her needs. The GP searches in the medical record for the notes of the general practice-based mental health nurse. He had reported that the family could consult the local youth teams for parenting support or be referred to mental healthcare if Ann is particularly hindered by her fears. Parents agree with a referral and the GP writes out a referral letter in which she shares the consult notes and the results of the screening questionnaire. Once the family registers with Ann at mental healthcare an intake is planned. Since they have no other request and the screening results that were shared pointed towards emotional problems only, the professional starts with a more elaborate assessment and clinical interview to gain and create a more in depth understanding of the context of their challenges, strengths and possibilities.

The transferred information is what the referrer recognized or acknowledged as a possible need and substantiated its likeliness to reach mental health treatment.[16] From this view, referral letters could be seen as a product of the referrer's decision-making and form an approximation of their repertoire, beliefs and preferences for diagnosis and treatment. In this perspective, referral letters are no more to be viewed as the result of a simple discretionary activity but to be acknowledged as valuable for clinical and educational purposes. When viewed as such, referral letters could also inform policy-making and curricula development for general practitioners. In some countries, referral letters are already included in postgraduate training.[17 18] As concluded by a review study on communication in healthcare, further efforts are required to feature communication between professionals as an essential skill of caregivers.[15]

The third study is a first infer on the potential of a sequential approach to assessment investigated in a clinical dataset (chapter 4). Within data obtained from a best practice, we explored the incremental value of four structured assessment instruments applicable for different purposes in and between primary and secondary mental healthcare. The results suggest that they all add, but none are sufficient to determine the diagnostic classifications. This implies that it is worthwhile to do further research on the integrated use of these instruments across the board of primary and secondary care and how they impact the decision-making. Studies on integrated care found that professionals do report a need for sound methods to evaluate and monitor patients' needs, however, the selection and interpretation of such methods forms an initial barrier and constraints in time and resources form further barriers.[19 20] The evidence-based assessment implementation is called "the thorniest challenge faced in the mental health field".[21] An explicit sequential procedure that efficiently brings together purposes as initial detection and later prioritisation of registration (i.e., from screening, up to elaborate assessment and evaluation by clinicians), and helps to combine all information from various informants, might be a method to bridge needs in terms of assessment at the interface of primary and secondary care and add to implementing stepped-care and matched-care approaches. A recent systematic review concluded that there is a need for readily available systems and methods that target primary care physicians as they work in an environment with fewer resources.[22] Unfortunately, there are not much well disseminated lists of psychometrically sound instruments that suffice to

feasibility criteria and are adaptable to the needs in and between primary and secondary care are scarce.[23] The instruments presented in chapter four form an example to this end.

Although there are proven benefits of using sound assessment methods in the clinical process,[24-27] we do not aim to suggest their dogmatic use for the sake of evidence-based assessment in itself. Evidence-based assessment captures both the process and the methods of assessment (chapter 1), and aiming to increase the use of structured assessment methods should not oppose the process - or vice versa. The aim of evidence-based assessment is to improve the delivery of high quality care through "integrating individual clinical expertise with the best available external clinical evidence from systematic research" (chapter 1[28]). Thus, clinicians should be able to freely move between procedures and omit components when for the benefit of the individual patient. In our view, this is a practically self-evident side note, as is implicitly portrayed in the methods section of chapter four by the many missing data points due to circumstances that are the reality of day-to-day clinical practice (such as emergency referrals). However, an unsubstanstiated aversion towards structured assessment in the name of flexibility and patient satisfaction will not benefit the quality of care. When asked to clinicians in the field, the focus is yet too often placed on the perceived difficulties of structured assessment (such as that it might impede patient satisfaction or time constraints), whereas patient surveys do not subscribe to this concerns.[29] From a policy point of view, the inclusion of assessment instruments in primary care might also be economically beneficial. A prospective pilot study on the effects of the SDQ[30] and the DAWBA[27] at the interface of primary care found that it improved the detection of internalizing problems and decreased unnecessary referral for externalizing problems. The latter type of problems often forms pressure on referrals whereas young people with internalizing problems are not detected sufficiently without elaborate diagnosis making.[10 11 31]

In a recent evaluation of the changes since the youth health act, a shared element in the problematic cases was found to be the absence of a timely assessment and qualitative diagnostics.[32 33] Considering the research agenda on evidence-based assessment, three consecutive steps are described:[24] evaluating the evidence on the accuracy of methods and for the population at hand, evaluating feasibility in terms of costs for institutions, clinicians and patients, and implementation. The many efforts and reports on the first two steps now

give passage to the last but not easiest step concerning implementation. Since we now do have a massive list of structured assessment instruments,[34] it is time to focus on the how and when of assessment in daily practice.[24] One practical port of implementation for these methods in the Netherlands, might be the mental health nurses that are commonly appointed in general practices since 2008. The number of practices with a mental health nurse increased from 27% in 2010 to 87% in 2016 and their workflow is crystallized increasingly considering help for adults.[35 36] Nevertheless, there are major variations between practices and mental health nurses and no guidelines for most child and adolescent mental health problems. Compared to general practitioners, most mental health nurses see fewer children and adolescents as most mental health nurses are educated in adult psychiatry.[36] This further emphasizes the importance of clear guidelines and integrated approaches for detection and diagnosis in primary care.

Methodological considerations and suggestions for future studies

The studies in this dissertation fill gaps in the evidence base on recognition, referral, and assessment of child and adolescent mental health problems. However, future studies extending the study-methods are needed to better inform daily practice and policy-making. In the following section, starting points for such future studies are introduced and elaborated on. Specific limitations of each empirical study have already been mentioned in the previous chapters. Here we will reflect on more general overarching methodological issues and starting points for future studies.

A limitation of the study results, in general, is the focus on symptoms and signs as defined in the diagnostic and statistical manual of mental disorders (DSM[37 38]), sometimes at the expense of inclusion of the role of personal and social stressors.[39] Patients surrounding and contextual factors are critical as they affect mental health and the decision-making.[40-42] In the vignette study described in chapter 2 for instance, even though the vignettes were created with some context, the influence of factors such as family and school context on decision-making were not examined in specific.[43] This vignette study was the first to use descriptions specifically developed to mimic real-life consultations and early presentation of

yet undefined symptoms. This was sufficient to investigate average recognition. However, it was not sufficient to explore the specific effects of the described symptoms and expressions on the professionals' decision-making. Future studies using a factorial vignette design[44] could systematically vary potential determinants of decision-making such as the level of impairment or the described content of the symptoms and signs.[40 45 46] Also, to enhance our understanding of moderators of recognition, factors related to the person of the professional might be added. Studies implementing a qualitative approach might help us gain further understanding of the professionals' internal recognition process.[45]

Considering the study described in chapter 3, we examined the frequency of contextual factors mentioned in the referral letters. An improvement would be to include the interaction between context, symptoms and level of impairment in future studies. Also, for generalisable conclusions on the value of referral letters for the diagnostic process, a multi-center study is necessary as diagnostic metrics are dependent on the prevalence of the type of mental health disorder, which could differ between institutions.[47] Another methodological consideration for the studies on referral letters is the question of "value". As a first infer, we mainly focused on value as being an agreement between referral letters and the final classifications made. This reflects a top-down approach starting from the perspective of mental healthcare. Such a top-down approach is not likely to result in lasting improvements, especially when viewed in light of previous studies in various areas of medicine that found that there are discrepancies in how primary care physicians perceive their referral letters and how specialised care specialists evaluate them.[6 12 16] These studies reveal that both parties evaluate their own communication and referral letters as qualitatively better, and luckily, that they both wish to receive more feedback from each other.[6] To stimulate sincere communication and collaboration between primary and secondary healthcare, future studies could take a bottom-up approach by, for example, starting with a qualitative approach to the topic of referral letters and aim to understand the end-product of a referral letter by focusing on professionals wordings, associations, internal working schemes and implicit algorithms. Also, other elements that make a referral letter valuable should be explored and investigated to facilitate efficacy in patients' care journey. Such elements are for instance, how the referral came into being or the patient's own help request.[6 48]

A related limitation applies to the third study described in chapter 4. In that study, we had included referral letters from all referrers including for instance, local youth teams and paediatricians. A pattern seemed to emerge when we analyzed the possible effects of the pathway to care. In general the associations between what the referrer mentioned and the outcome were higher for specialist referrals than for general practitioner referrals, which were higher than that of local youth teams. Nonetheless, we found very wide confidence intervals and no significant effects. This might be a result of the categories we had created by combining various types of specialists (for example: psychiatrists and paediatricians) and the major variations between local youth teams as they were still developing as a newly created function group. Future studies in diverse samples could implement a multilevel analysis to account for potential effects of the pathway to care. With such a study, the strengths and weaknesses of each type of referrer could be found and build upon.

In chapter 4, we aimed to shed light on the issue of incremental value of evidence-based assessment instruments. The results of this study should be viewed with the realization that we inspected incremental value in the chronological order in which the data was obtained. As described in the introduction of chapter 4, ideally, the decision to refer should result from both clinical judgement and screening. Thus the screening should be followed by the decision to refer, rather than being obtained after referral (Figure 3). Future studies could inspect incremental value in this order. Also, rather than investigating a selected sample that reached secondary care, future studies could investigate the value of a sequential approach in a prospective design by starting with a sample that is just visiting primary care professionals. This will enable better quantification of the false negatives and true negatives. Furthermore, studies that quantify the broad impact and societal benefits of an integrated sequential approach are needed, as cost-utility is a major topic in today's healthcare landscape and we have a sufficient base to move from descriptive studies to comparative and validation studies.[22 49] An earlier randomized controlled trial in specialised care found that disclosure of the results of the DAWBA had a statistically significant effect on the classifications made for some anxiety disorders, but not other disorders.[50] The authors conclude that the DAWBA should be examined as a referral tool rather than an assessment instrument. No comparative studies, however, measured effects at the interface of primary and secondary care. Last but not least, the study measures could be enriched with readily

available data such as consult notes of clinicians from various stages of healthcare (Figure 3). This could facilitate analysis of different stages of signaling and triage from the build-up to the initial inquiry to the initiation of treatment. By definition, medical records and consult notes capture broad and longitudinal health information with the potential to enable highly generalisable study results, the exploration of changes over time and integration of environmental (i.e., family) data. If proven as a sufficient prediction or classification tool, studies on the automatised use of readily available data might provide an efficient decision support system and contribute to timely detection and reducing the workload of professionals.

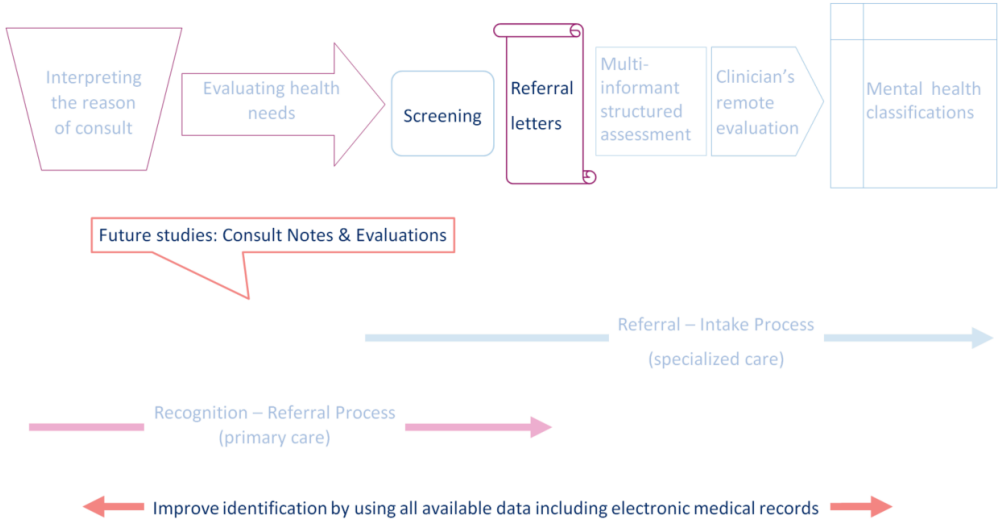

Figure 3. Future studies

In future prospective studies, the order of the instruments could better resemble the reality at the interface of primary and secondary care, by completing the screening in primary care, before initiating a management plan or referral. Future studies could also investigate identification, referral and treatment by integrating other readily available data.

To note on the methodological paradigm of the studies, the starting point for this dissertation is the idea that drawing up specific symptoms is beneficial. This relies on several assumptions. To begin with, it relies on the assumption that some sort of diagnosis-making and assessment is necessary to guide towards focused and effective treatment. Supporting this premise, several studies suggest that disorder-specific treatment methods are more effective than general interventions.[51-54] Used as a label to communicate a cluster of problems that often occur together, classifications influence health outcomes by facilitating

the selection of appropriate treatment techniques.[26 55 56] However, in practice, with scarcity and efficiency as bottlenecks, a relevant question is: “eliciting symptoms, then what?”,[57] or, assessing, then what? Especially given the status quo considering waiting lists for mental healthcare, we would like to note that recognition is insufficient as long as referring professionals have to decide when and how one can reach support or treatment.[1 16 58 59] Efforts to improve access and efficacy of treatment should continue, while increasing efforts to improve timely recognition, and prevention.[60]

Moreover, and relatedly, is the concept of diagnosis and gold standard in psychiatry. In each of the studies, we used the best estimate-all data classifications that were made by drawing from both structured assessment and clinical judgment.[61] Nonetheless, in the pure sense of the word, first the outcome should be operationalised perfectly to quantify predictive value. This means that a gold standard should have perfect diagnostic metrics (100% sensitivity and 100% specificity).[62] Given that this is not the reality in medicine and even less in psychiatry, future studies on prediction and assessment could account for and calculate the uncertainty in the outcome measure.[63]

Irrespective of the reliability of study methods and statistics used, the topical question of the validity of diagnosis-making in psychiatry remains. An in-depth review and discussion of this topic is beyond the scope of the empirical studies presented here. However, independent from the question of what we should measure, we hold the stance that a form of diagnosis - and thus assessment- is needed to guide the mental health treatment. To inform on the focus of the treatment, it is necessary to understand where a patient and his or her system is standing in terms of strengths and challenges in various fronts such as cognitions, interpersonal characteristics, coping and social support. Thus regardless of what the reference standard concerns (the well-known and often used DSM classifications,[37] or alternatives such as the general psychopathology factor,[64] transdiagnostic factors,[65] the context of the challenges as in the power threat meaning framework,[66 67] or syndemics[41]), a method to bridge gaps in assessment in and between primary and secondary mental healthcare is needed. The methods described in this study might act as such examples in designing and testing acceptable methods that meet the needs of primary care (meeting the needs of detection, management and referral) and secondary care (facilitating prioritisation

of registrations, implementation of reliable assessment and monitoring of treatment effects).[68]

Conclusion

The societal toll and human misery associated with mental health disorders is well established. Nonetheless, only about one in five minors with mental health difficulties access adequate professional support. Care pathways and procedures have to facilitate timely recognition and adequate evaluation of patients' needs to navigate those who can benefit towards the frequently cited and meaningful goal of the right service in the right place, at the right time, and delivered by the right person. In the ideal situation, as in the example described above (Box 1), professionals can 'look' at a patient and 'see' patients' needs by relying on their sufficient knowledge to recognize a probable mental health need, their skills to enquire further, known methods to reliably assess strengths and weaknesses, and readily available resources to translate what they see into an adequate support or management plan.

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