



Australian Government

phn

An Australian Government Initiative

# NATIONAL PHN GUIDANCE

Initial assessment and referral  
for mental healthcare



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Version History		
Number	Date	Notes
0.1	2 Nov 2018	Released for consultation with PHNs.
1.0	11 Mar 2019	Release Version.
1.01	12 Apr 2019	Minor correction to Decision Support Tool Logic graphics on pages 70-74, to indicate a rating of 2 on D1 (Symptom Severity and Distress) where D2, D3 or D4 = 2 or above are assigned to Level 3 or above care (previously suggested Level 4 or above).
1.02	30 Aug 2019	Revisions to Guidance and Glossary to: <ul style="list-style-type: none"> <li>• Provide additional clarity about non-suicidal self-injurious behaviour (Domain 2 – Risk of harm).</li> <li>• Include thresholds for the Edinburgh Postnatal Depression Scale (EPDS) (Domain 1 – Symptom severity and distress).</li> <li>• Make minor adjustments to wording to improve clarity.</li> <li>• Accessibility improvements.</li> </ul>
1.03	6 January 2020	Revisions to Glossary to remove thresholds on standard assessment tools from rating points within Domain 1 and Domain 3. Thresholds for standard assessment tools are now included in Appendix 3. Threshold scores used for each standard assessment tool have been reviewed to reflect best available evidence.  Prevalence estimates in Background chapter updated to 2018 population.
1.04	2 October 2020	Adjustments to rating descriptors to improve consistency.  Adjustments to improve web-accessibility.  Addition of copyright statement and disclaimer.  Update of Expert Advisory Group members.
1.05	15 July 2021	Addition of Foreword to document.  Correction of an anomaly within the decision support logic for individuals assessed with no or mild problems on all Primary Domains, resulting in a higher level of care recommended than required by the combination of ratings. Programmers are encouraged to review the changes to the logic by comparing the logic within v1.04 and v1.05. Programmers coding the logic into information management systems are required to contact Logicly for an updated version of the code library and test data set: <a href="mailto:support@logicly.com.au">support@logicly.com.au</a>  Updates to Section 1 to capture <ul style="list-style-type: none"> <li>• project progress (development of the guidance)</li> <li>• an update of the primary mental healthcare landscape</li> <li>• an update of digital mental health service utilisation data</li> <li>• inclusion of National Mental Health Service Planning Framework estimates by level of care.</li> </ul> Introduction of a new over-arching rule relating to not rating up in instances of uncertainty.  Distress in Domain 1, at rating point 1b and 2b corrected to incorporate distress associated with mental health issues consistent with wording of 3b.  Relocation of <i>Glossary for Rating the Assessment Domains</i> from an Appendix to new Section 6 in main body of document.  Addition of new Appendix 2 <i>Guide to Digital Decision Support Tools</i> .

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## Foreword

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This Guidance has been developed by the Australian Department of Health to provide advice to Primary Health Networks (PHNs) on establishing effective systems for the initial assessment and referral of individuals presenting with mental health conditions in primary health care settings. The Guidance brings together information from a range of sources including Australian and international evidence and advice from a range of leading experts.

As demonstrated by the Literature Review undertaken to inform this project, there is a lack of established evidence regarding initial assessment and decision making in stepped care systems. Furthermore, the transferability of the evidence to the Australian context is limited. Recognising that this Guidance has been developed using the available evidence and expert advice, the Department of Health will undertake activities that will support ongoing development of the Guidance and tools, based on examining their utility in the field. This work is expected to guide broader implementation of nationally consistent approaches to the initial assessment and referral of people referred to PHN-commissioned services for mental health assistance.

### Stage 1

In stage 1 of the project, the Department of Health formed an Expert Advisory Group and Project Steering Committee. The Department of Health commissioned a literature review and completed a PHN survey to understand the current stepped care implementation progress, and initial assessment and referral activity.

### Stage 2

During stage 2 of the project, the Department of Health developed and released a draft of the National IAR Guidance, for consultation with PHNs and other key stakeholders. In March 2019, the Department of Health officially released the first version of the National IAR Guidance.

### Stage 3

During this stage of the project, the Department of Health developed and disseminated an Initial Assessment and Referral in Stepped Care Systems Resource Toolkit. The Toolkit includes:

- A brief implementation guide for PHNs.
- Clinical governance resources.
- Learning resources (including vignettes and workshop slides).
- Additional decision support flowcharts to guide specific components of the initial assessment.

### Stage 4

The Department of Health facilitated an Implementation Review to examine the validity and utility of the National Guidance. The Implementation Review was undertaken by the University of Melbourne and involved 9 PHNs, each of whom had been selected to complete a small-scale implementation test of the Guidance. The University of Melbourne authored a report on the findings and supplied the report to the Department of Health for consideration and dissemination.

### Stage 5

This stage of the project will run from February 2021 to February 2022. During this stage of the project the Department of Health will facilitate adaptations to the National Guidance for children (5-11) and adolescents (12-17).

# Table of Contents

<b>Section 1 – Introduction</b> .....	<b>7</b>
Overview .....	7
Scope.....	9
Background.....	11
Prevalence of Mental Illness and Community Need .....	11
The Primary Mental Health Care Landscape .....	12
Medicare and the MBS Better Access Initiative .....	12
Primary Health Network Commissioned Services.....	13
Digital Mental Health Interventions .....	14
The Role of the Specialist Acute and Community Mental Health System.....	15
High Level View of how Current Demand is met by The Primary Mental Health Care System .....	16
Development of the Guidance .....	17
Literature Review .....	17
PHN Summary Report .....	17
Guiding Principles.....	18
<b>Section 2 – Initial Assessment Domains</b> .....	<b>20</b>
Overview of Assessment Domains and Relationship to levels of care .....	22
Domain 1 – Symptom Severity and Distress (Primary Domain) .....	23
Domain 2 – Risk of Harm (Primary Domain).....	23
Domain 3 – Functioning (Primary Domain) .....	23
Domain 4 – Impact of Co-Existing Conditions (Primary Domain) .....	24
Domain 5 – Treatment and Recovery History (Contextual Domain).....	24
Domain 6 – Social and Environmental Stressors (Contextual Domain).....	24
Domain 7 - Family and Other Supports (Contextual Domain).....	25
Domain 8 - Engagement and Motivation (Contextual Domain).....	25
Using the Decision Support Tool to rate the Initial Assessment Domains.....	26
<b>Section 3 – Levels of Care</b> .....	<b>28</b>
Mapping Population Need to the Levels .....	29
Referral Criteria to Levels of Care.....	30
Level 1 (Self-Management).....	31
Level 2 (Low Intensity Services) .....	32
Level 3 (Moderate Intensity Services).....	33
Level 4 (High Intensity Services).....	34
Level 5 (Acute and Specialist Community Mental Health Services) .....	35
<b>Section 4 – Progress Monitoring</b> .....	<b>36</b>
<b>Section 5 – Clinical Governance</b> .....	<b>38</b>
<b>Section 6 – Glossary for Rating the Assessment Domains</b> .....	<b>47</b>
General Instructions for Rating the Domains .....	47
Overarching Rules and Guides to Ratings.....	47

Primary Assessment vs. Contextual Domains .....	48
Domain 1 – Symptom Severity and Distress (Primary Domain) .....	50
Domain 2 – Risk of Harm (Primary Domain).....	51
Domain 3 – Functioning (Primary Domain) .....	52
Domain 4 – Impact of Co-Existing Conditions (Primary Domain) .....	53
Domain 5 – Treatment and Recovery History (Contextual Domain).....	54
Domain 6 – Social and Environmental Stressors (Contextual Domain).....	54
Domain 7 – Family and Other Supports (Contextual Domain).....	55
Domain 8 - Engagement and Motivation (Contextual Domain).....	56
<b>Appendix 1 – Decision Support Tool.....</b>	<b>57</b>
Decision Support Tool Logic .....	57
A Step Through of the Logic .....	58
<b>Appendix 2 – Guide to the Digital Decision Support Tools.....</b>	<b>60</b>
Attachment A: Terms of Use for the Online Decision Support Tool .....	63
Attachment B: Integrator Agreement – Application Programming Interface .....	65
<b>Appendix 3 – Interpreting Standard Assessment Tools to Guide Assessments on Domain 1 and Domain 3 .....</b>	<b>68</b>
<b>Appendix 4 – PHN Summary Report .....</b>	<b>71</b>
<b>Acknowledgements.....</b>	<b>75</b>
Figure 1: Overview of Guidance.....	8
Figure 2: Estimated prevalence of mental health conditions and stepped care levels of need based on severity.....	12
Figure 3: Summary of the role of primary mental healthcare in responding to community demand for mental health services .....	16
Figure 4: Summary rating form for assessing domains (see Section 6 – Glossary for Rating the Assessment Domains).....	27
Figure 5: Schematic representation of levels of care .....	29
Figure 6: Treatment need estimating using the NMHSPF mapped to the five levels of care.....	30
Figure 7: Mapping assessments on 8 interactive domains to 5 levels of care .....	57
Figure 8: Decision support tool logic for mapping assessment on domains to levels of care .....	58
Table 1: Clinical Governance .....	40

# Section 1 – Introduction

## Overview

Primary Health Networks (PHNs) were established with the key objectives of increasing the efficiency and effectiveness of health services for consumers, particularly those at risk of poor health outcomes, and improving coordination of care to ensure consumers receive the right care in the right place at the right time.

In 2015 the Australian Government released its Response to the Review of Mental Health Programmes and Services. The Response set a new and broad ranging role for PHNs in the mental health reform process through the planning and commissioning of primary mental health services at a regional level, supported by a flexible funding pool for mental health and suicide prevention services.

PHNs are responsible for planning and commissioning across six key objectives and service delivery priority areas:

1. Improve targeting of psychological interventions to appropriately support people with mild mental illness at the local level through the development and/or commissioning of **low intensity mental health services**.
2. Support region-specific, cross sectoral approaches to **early intervention for children and young people with, or at risk of mental illness** (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group.
3. Address service gaps in the provision of **psychological therapies for people in under-serviced and/or hard to reach populations**, including rural and remote populations, making optimal use of the available service infrastructure and workforce.
4. Support **clinical care coordination for people with severe and complex mental illness** who are being managed in primary care including through the phased implementation of primary mental health care packages and the use of mental health nurses.
5. Encourage and promote a regional approach to **suicide prevention** including community-based activities and liaising with Local Hospital Networks (LHNs) and other providers to ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide.
6. Enhance and better integrate **Aboriginal and Torres Strait Islander mental health services** at a local level facilitating a joined-up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services.

PHN regional mental health planning and commissioning of services is founded upon a stepped care approach.

In a stepped care approach, a person presenting to the health system is **matched** to the least intensive level of care that most suits their current treatment need, considering the balance between intended benefits and potential risks. A secondary and key feature of stepped care is ongoing outcome and experience measurement to provide close to real-time feedback on outcomes allowing treatment intensity to be adjusted (stepping up or stepping down) as necessary. To achieve this, an initial assessment is required. This is undertaken in partnership with the individual to determine **suitable and appropriate treatment** choices/options.

This Guidance is focussed on **the initial response to requests for mental health assistance in primary care settings** and is designed to assist the various parties involved in the initial assessment and referral process. Without a consistent national approach, PHNs (and their commissioned providers and referrers) will inevitably assess and assign levels of care inconsistently, resulting in discrepancies in the type of care provided across PHN regions, for similar clinical presentations. This Guidance has been developed to

support nationally consistent evidence-informed initial assessment and referral processes and will be refined as new evidence emerges.

It is acknowledged that PHNs are at different stages in the implementation of stepped care and this Guidance has been developed with that in mind. It is expected that PHNs will use the Guidance to:

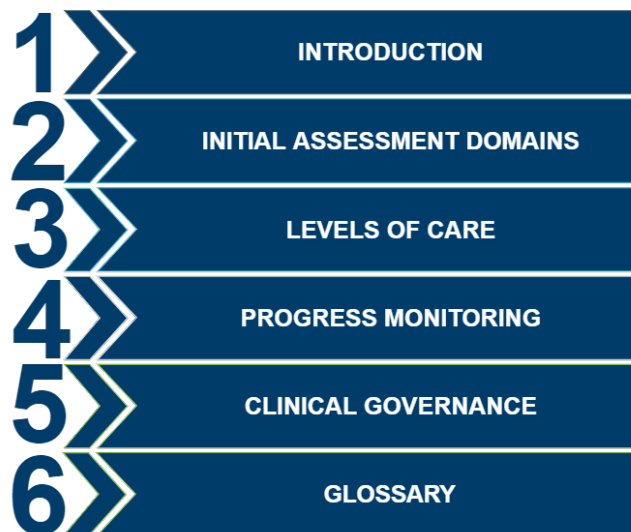
- Design initial assessment and referral processes for referrers and commissioned primary mental health care services.
- Review existing initial assessment and referral processes for commissioned primary mental health care services.
- Guide the development of referral pathways (e.g., Health Pathways).
- Provide clear and consistent information to referrers, consumers, carers, and communities.

Instigate clinical governance policies and protocols to monitor the safety and quality of assessment and referral systems.

## Overview of Initial Assessment Guidance

The Guidance includes relevant background information (Section 1 – Introduction), information about the initial assessment domains (Section 2 – Initial Assessment Domains), a consistent description of the levels of care (Section 3 – Levels of Care), advice about progress monitoring (Section 4 – Progress Monitoring), information about clinical governance expectations (Section 5 – Clinical Governance) and the glossary for rating the assessment domains (Section 6 – Glossary).

Figure 1: Overview of Guidance





## Scope

This Guidance is focussed on the **initial response to requests for mental health assistance in primary care settings**, and is designed to assist the various parties involved in the initial assessment and referral process including:

- General Practitioners (GP) and other clinicians seeking to make referrals into an agreed care pathway.
- Intake teams responsible for undertaking initial assessments which may involve making recommendations on the level of care required.
- Commissioned providers responsible for undertaking initial assessments and/or recommending the level of care required.
- PHNs or commissioned providers implementing systems for the initial assessment and referral of individuals seeking help.

### *Issues this Guidance seeks to address*

This Guidance has been developed to provide:

- A description of the different levels of care for consistent use by PHNs.
- Criteria to assist with the initial assessment and assignment of an initial level of care.
- A description of the evidence-based services likely to meet the clinical and recovery needs of the consumer based on the level of care identified.
- Guidance relating to clinical governance within initial assessment and referral systems.

### *Issues that are not covered*

The Guidance does not provide:

- Information about treatment guidelines.
- Information or advice about medication.
- Information about more detailed and comprehensive psychological or diagnostic assessment.

Whilst this Guidance refers to the critical interface between primary mental health care and acute, tertiary and specialist secondary settings, this Guidance is not intended to be applied within acute or specialist mental health care settings. The Guidance has the potential to be used in private psychology and psychiatry services.

### *Target population*

This Guidance includes information and advice about initial assessment and referral that is common across most population groups. However, the processes necessary for ensuring the Guidance is appropriate for some population groups has not yet been undertaken. These groups include:

- Children and young people (work is currently underway and scheduled for completion in 2022).
- Aboriginal and Torres Strait Islander Peoples.
- People from culturally and linguistically diverse backgrounds.
- Older Australians.

- And people with multi-morbidities (including development disorders and intellectual disability).

PHNs will need to consider the additional requirements for high quality initial assessment and referral processes for these population groups. The Department of Health is considering additional future work in this regard.

### *Expectations of PHNs*

The Guidance does not endorse or recommend a specific mechanism for intake (e.g., centralised, or de-centralised intake systems). The mechanism for referral systems is a local and individual PHN decision. The Guidance can be applied irrespective of intake mechanism.

The Guidance represents the Department of Health's expectations regarding the standards PHNs will uphold and the requirements considered necessary to undertake initial assessment. PHNs have scope to build in additional requirements to suit local circumstances.

Section 3 – Levels of Care of this Guidance outlines a list of core services recommended for each level of care. Availability of the recommended core services will vary from region to region depending on a variety of factors (e.g., funding, workforce availability). The intervention recommendations contained within this Guidance are not limited to PHN commissioned services. The intervention recommendations that are included in the guidance may be delivered by community managed organisations, state and territory mental health services, private providers, general practice and so on.

The Clinical Governance section includes some mandatory expectations of PHNs. This includes the expectation of compliance with the National Standards for Mental Health Services and the National Safety and Quality Digital Mental Health Standards.

### *Clinical Judgement and Consumer Choice*

This Guidance is not a substitute for professional knowledge and clinical judgement. Systems and processes for initial assessment and referral should consider the unique and personal circumstances of the individual, including other health or social issues, their preferences and choices, and any risk or safety issues.

## Background

Primary mental health care in Australia is delivered through a variety of programs and provides services to about eight out of every ten people who present to health services for assistance. This section summarises the Australian primary mental health care landscape and the role of the 31 PHNs, set against the backdrop of what is known about prevalence and need for mental health care.

## Prevalence of Mental Illness and Community Need

An understanding of the prevalence of mental illness across the spectrum of severity sets the context for understanding the different service responsibilities in the sector.

One in five Australian adults (aged 16 to 85 years) will experience a mental illness each year and almost half will experience a mental disorder in their lifetime.<sup>1</sup> Anxiety disorders and affective (mood) disorders are the most common, affecting approximately 14% and 6%, respectively, of the adult population each year, with these conditions often co-occurring. In addition, almost one in seven (14%) young people (aged 4 to 17 years) are estimated to have experienced a mental illness in the previous year.<sup>2</sup>

The experience of mental health conditions ranges across a wide spectrum. The most common experience is of approximately 5.8 million people 'at risk' who do not meet criteria for a diagnosis but who have some mental health need. This includes people who have had a previous illness and are at risk of relapse without ongoing care, as well as those who have early symptoms and are at risk of developing a diagnosable illness. For these people, prevention, and early intervention through primary health care (mainly general practitioners), digital mental health and self-help services are most relevant. These services are predominantly the responsibility of the Commonwealth.

People with mild mental illnesses, estimated at 2.3 million people, as well as those with moderately severe mental illness, with around 1.1 million people, represent the next largest groups. People with mild to moderately severe illnesses are also predominantly managed in the primary mental health care system, with the bulk of services currently being provided through general practice and the Medicare Better Access initiative. Again, this layer of service responsibility rests with the Commonwealth.

At the highest end of the spectrum of need, there are approximately 775,000 people with severe mental illness. For this group, the responsibility for clinical services is shared between the Commonwealth and states as well as private hospitals. The National Disability Insurance Scheme provides support to eligible individuals experiencing the most significant disability associated with severe mental illness.

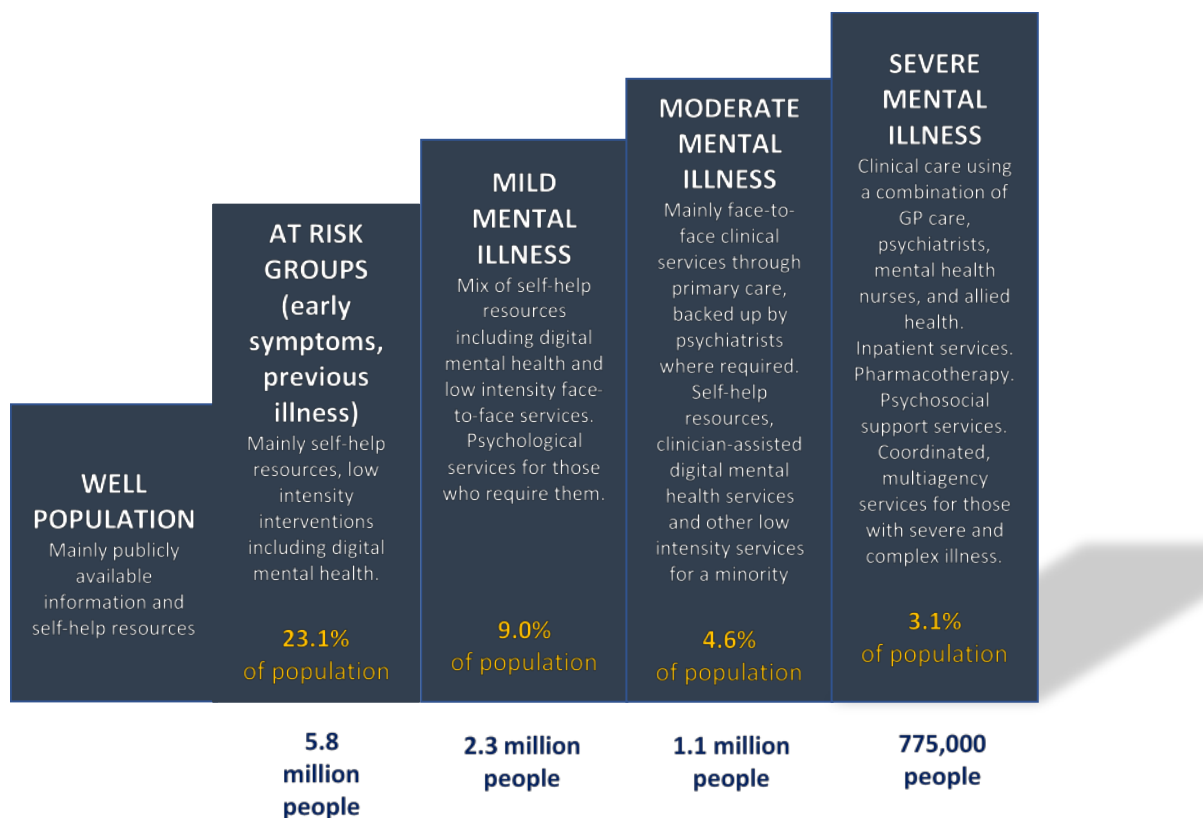
Figure 2 summarises the estimated prevalence, graded according to levels of need.

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<sup>1</sup> Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing 2007: Summary of Results, ABS cat. no. 4326.0, Canberra, ABS.

<sup>2</sup> Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015), The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra, Department of Health.

Figure 2: Estimated prevalence of mental health conditions and stepped care levels of need based on severity.



Source: Adapted from Figure 8, COAG Health Council (2017), *The Fifth National Mental Health and Suicide Prevention Plan*, Commonwealth of Australia, updated to 2018 population

In total, 10 million people, or around 38 percent of the Australian community, have some level of mental health need. Not all require health care or professional treatment, nor will they seek formal assistance. The 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB) found that most people identified as meeting criteria for a diagnosis of mental illness did not perceive a need for care, of any kind. Evidence also shows that many people with milder and sub-diagnostic symptoms recover without formal health care intervention. The challenge in implementing a stepped care model, and developing initial assessment and referral processes, is to ensure that people are guided to the option that best meets their needs and has the least burden on them and the health system. From the perspective of managing the potential demand, PHNs also need to ensure that best use is made of the full range of options to assist people in need in a way that targets scarce resources to where they are needed most.

## The Primary Mental Health Care Landscape

Primary mental health care services are delivered across a range of platforms. This section summarises the main elements of primary mental health care arrangements in Australia.

### Medicare and the MBS Better Access Initiative<sup>3</sup>

The MBS system is a universal system that provides Commonwealth-subsidised treatment for selected mental health services provided by GPs, psychiatrists, psychologists and eligible social workers and

<sup>3</sup> The Better Access initiative commenced in November 2006. Its formal title is *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS*

occupational therapists. The Better Access Initiative, introduced in November 2006, substantially expanded the role of Medicare in mental health service provision, and aims to increase access for people with a clinically diagnosable mental disorder to evidence-based treatment.

10.7% of Australians (2.7 million people) accessed 12.4 million Medicare-subsidised mental health-specific services in 2019–20. 45.3% of Medicare-subsidised mental health-specific services were provided by psychologists (including clinical psychologists), 30.6% were provided by GPs and 20.3% were provided by psychiatrists in 2019–20. Many individuals consulted more than one of these professionals.

Medicare is the predominant provider of services to those Australians who seek professional assistance for a mental health problem, with its coverage and role increasing annually.

## Primary Health Network Commissioned Services

PHNs are responsible for commissioning a range of services across the stepped care spectrum. PHN commissioned mental health services were provided to approximately 236,257 clients in 2019-20 (including 97,257 young people supported through headspace centres).

### Low Intensity Services

Low intensity mental health services are generally targeted at people with, or at risk of, mild mental health conditions. PHNs are limited to commissioning only low intensity mental health services that have an established evidence base. Low intensity mental health services are designed to be accessed quickly (without the need for a formal referral from a third-party service or provider), easily (through a range of modalities including face-to-face, group work, telephone and digital) and typically involve fewer or shorter sessions that reduce the treatment burden experienced by the consumer.

Commissioning activity is intended to increase the number of people who can access care, reserving more intensive interventions for those whose clinical and recovery needs cannot be met without more intensive health professional assistance.

### Psychological therapies

PHNs are responsible for funding psychological treatment services for people in underserved groups, including those in rural and remote areas, where there are barriers to accessing MBS-subsidised services. This service stream replaced the former *Access to Allied Psychological Services (ATAPS)* and *Mental Health Services to Rural and Remote Areas (MHSRRA)* programs.

### Coordinated care for people with severe mental health conditions

PHNs are responsible for commissioning services for people with severe mental illness who are being supported in primary care, including clinical care coordination for people with severe and complex mental illness through the phased implementation of primary mental health care packages and the use of mental health nurses. This incorporates the former *Mental Health Nurse Incentive Program (MHNIP)*.

### Commissioned services for children and young people, including headspace

PHNs are required to commission primary mental health care services for children and young people with, or at risk of, mental illness being managed in primary care, including commissioning of headspace centres nationally. headspace centres provide early intervention mental health services to young people aged 12-25 years. The services are designed to simplify access for a young person and their family seeking support for mental health or related issues. A variety of practitioners (including GPs, allied mental health clinicians and youth access workers) are onsite across a growing network of centres located in rural, regional, and metropolitan communities. In 2019-20, an estimated 97,257 young people accessed a headspace centre.

## Services for young people with severe mental illness

PHNs are required to develop and commission new early intervention services to meet the needs of young people with, or at risk of, severe mental illness who can be appropriately supported in the primary care setting.

PHNs commission a range of flexible, responsive, and evidence-based services designed to address gaps in local service environments for young people with, or at risk of, severe mental illness. This includes specialised and targeted mental health services provided by multi-disciplinary teams, clinical care coordination combined with psychological interventions and early psychosis programs. This activity is also expected to target young people who have comorbid mental health and alcohol or other drug issues.

## Aboriginal and Torres Strait Islander Mental Health Services

PHNs are also tasked with commissioning culturally appropriate, evidence-based mental health services for Aboriginal and Torres Strait Islander people to improve access, complement and link to existing activities such as drug and alcohol services, suicide prevention and/or broader social and emotional wellbeing services as well as mainstream services.

PHNs have commissioned services to address local gaps and community identified needs across a continuum of primary mental health services for Aboriginal and Torres Strait Islander people - including priority access to culturally appropriate low intensity mental health services, psychological services and suicide prevention services among others.

Aboriginal Controlled Health Organisations and Medical Services, headspace centres, state and territory mental health services and mainstream primary care providers are also major providers of mental health services for Aboriginal and Torres Strait Islander people.

## Suicide Prevention

Research indicates there are a number of groups in the population that are at higher risk of suicide who are targeted by PHN commissioned mental health services. PHNs are required to undertake planning and commissioning of community-based suicide prevention activity, through a more integrated and systems-based approach in partnership with Local Hospital Networks (LHNs) and other local organisations.

## Digital Mental Health Interventions

Increasingly, Australians are turning to telephone and online mental health services, and an ever-growing range of solutions are emerging. These solutions deliver psychoeducation, prevention and early intervention, crisis intervention, treatment and/or peer support. Many digital interventions have demonstrated effectiveness and strong levels of acceptance, having been designed to be affordable, accessible and customisable (e-mental health in Australia). In 2017, the Australian Government invested in a digital mental health gateway- Head to Health. Head to Health connects people to online and phone mental health services appropriate for their individual clinical needs.

Given the number of providers, it is difficult to quantify the number of people accessing digital mental health interventions in Australia, however data for some of the biggest providers indicates a growing reach and uptake.

- **beyondblue:** beyondblue's telephone support service engages a team of mental health professionals to provide free, immediate, short-term counselling, advice, and referrals to anyone in Australia via telephone and email and web chat. In 2019-20 there were **273,845 people** who contacted the telephone support service, and **1.35 million people** accessed the online peer support forum.
- **MindSpot:** the MindSpot clinic is a telephone and online service for Australian adults experiencing symptoms of anxiety or depression. The service provides screening, assessment, and treatment. In

2019-20 MindSpot provided clinical services to **22,647 individuals** and saw **503,241 unique visitors** to the webpage.

- **eheadspace:** the eheadspace service provides online and telephone support to young people, parents, families, and peers. In 2019-20 eheadspace serviced over 31,000 young people, providing **78,187 sessions of service**.
- **ReachOut:** ReachOut is an online platform providing information, advice and services to young people and their families. In 2019-20, ReachOut's online forums for peer support were accessed by **303,838 unique visitors** and the ReachOut website was accessed by **2.82 million unique visitors**.
- **MoodGYM and eCouch:** MoodGYM is a cognitive behavioural therapy (CBT) based intervention designed to prevent or reduce symptoms of anxiety and depression. In 2019-20 MoodGYM had **25,329 new registrations** for their training program from within Australia and **115,172 unique visitors** to their website. In 2019-20 eCouch had **4,452 Australians register** for the self-help program and **44,103 unique Australian visitors** to the website.
- **Lifeline:** Lifeline provides 24-hour crisis support and suicide prevention services. In 2019-20 Lifeline received **989,192 calls** in the 13 11 14 service and **36,163 calls** to 13 HELP, the dedicated bushfire support service.

## The Role of the Specialist Acute and Community Mental Health System

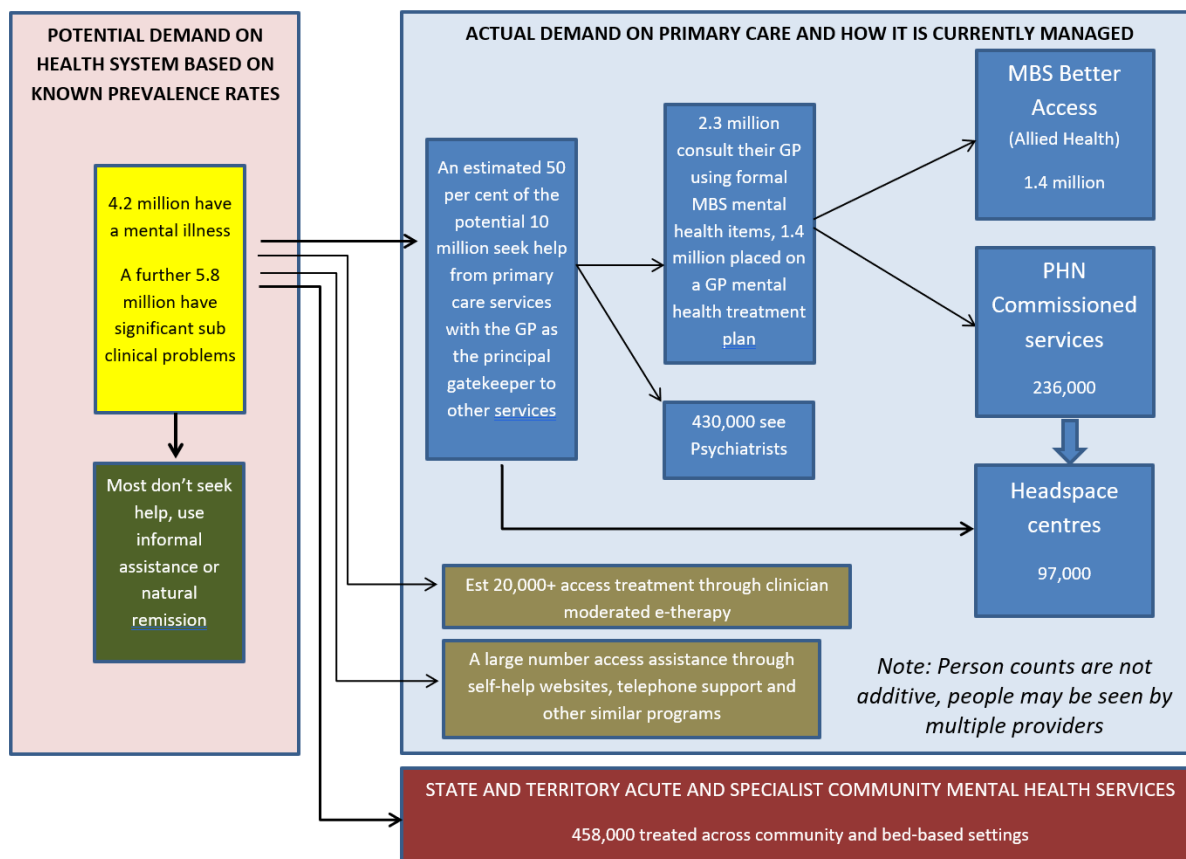
Specialist acute and community mental health services delivered primarily through state and territory funding, together with private hospitals, provide the most intensive mental healthcare. These services usually include intensive team-based specialist assessment and intervention with involvement from a range of different types of mental health professionals, including case managers, psychiatrists, social workers, mental health nurses, occupational therapists, psychologists, and other workers. Specialist mental health services include treatment and care provided in bed-based settings, including acute psychiatric units, step-up/down facilities, and rehabilitation units.

Nationally, specialised state and territory mental health services see approximately 1.9 percent of the population annually. Their predominant focus is on those with severe and more complex mental health conditions. Around 9.7 million community mental health care service contacts were provided to approximately 453,000 people in 2018–19 (Australian Institute of Health and Welfare, community mental health care services 2018–19).

# High Level View of how Current Demand is met by The Primary Mental Health Care System

Figure 3 provides a summary view of the current role of primary mental health care in responding to community need for mental health care.

Figure 3: Summary of the role of primary mental healthcare in responding to community demand for mental health services





## Development of the Guidance

In developing this Guidance, the Department of Health commissioned two formative pieces of work including:

- A targeted literature review examining key features of international approaches to initial assessment and referral in primary mental health care.
- A Summary Report on the current state of play across PHN regions in the approach to initial assessment and referral.

### Literature Review

The Australian Psychological Society (APS) was funded to undertake a review of the literature to identify key features of international and national approaches to initial assessment and referral within a stepped care framework. The review included both grey literature and a scoping review of the peer reviewed literature. A total of 21 documents were identified, which included the results of randomised controlled trials, as well as guidelines about stepped care approaches. Results were obtained from a total of 13 countries.

It was evident from the literature review that internationally there are a wide range of approaches to initial assessment and referral within stepped care frameworks in mental health care settings. Each approach has its own focus and processes to suit local circumstances.

### PHN Summary Report

A national PHN survey (Survey 1) was undertaken throughout November and December 2017 to inform the development of the National IAR Guidance. The PHN Summary Report, was made available to PHNs via SharePoint. The survey took the form of a structured interview with pre-determined questions designed to elicit consistent information from across the PHN network. The national survey was conducted via telephone.

The questions sought to explore existing initial assessment and referral processes and where possible, secure access to copies of policies, procedures, tools, and other resources in use by each PHN. Finally, the survey examined PHN identified needs associated with National Guidance material and resources.

The PHN Summary Report confirmed that there are 4 typical intake and referral mechanisms in place across PHNs. These include:

1. Centralised intake process coordinated by the PHN.
2. Centralised intake process coordinated by a commissioned provider.
3. Direct to provider referral pathways.
4. A combination of the above (including where intake is facilitated for PHN commissioned and non-PHN commissioned services).

Additional surveys conducted since this initial survey, have confirmed that these continue as the 4 typical intake and referral mechanisms in place across PHNs. More information about the PHN Summary Report is in Appendix 4 – PHN Summary Report.

## Guiding Principles

The following principles underpin this Guidance and help to inform high quality initial assessment and referral systems.

### 1. Supported decision-making to support consumer choice

Supported decision-making is enhanced when a clinician offers knowledge and information about what evidence-based interventions are likely to be of benefit, communicates the risks associated with each treatment option (including the risks associated with no treatment) and the outcome probabilities. The consumer in turn contributes expertise in their clinical and social experiences, values, preferences, circumstances, and barriers. Carers and/or significant others may also have insights and can add significant value when they are actively engaged and encouraged to participate as part of the decision-making process. Within supported decision-making frameworks, there is an inherent respect and appreciation for the perspectives of consumers, carers, and clinicians alike.

Intake processes should also allow for the individuals' communication needs and ensure that information provided uses plain language and is culturally appropriate. Clinicians should be particularly sensitive to the communication needs of people experiencing a disability, and people who do not speak or read English.

### 2. Least treatment burden, but most likely to result in the best outcome

This Guidance aims to minimise the intrusiveness and intensity of the initial assessment process wherever possible, by limiting the number and length of initial assessments and minimising re-assessment where it is clinically appropriate to do so.

Intervention recommendations for each needs level are based on the least intensive and least intrusive evidence-based intervention that is most likely to lead to the most significant possible gain. Observing this principle is likely to increase consumer participation in treatment.

### 3. Accessible care options

An individual is more likely to engage in an intervention that is simple to access, flexible and affordable. The advice in this Guidance is dependent on initial assessment and referral that are sensitive to the participation needs of the consumer. For example, if an individual works full time and is unable to commit to appointments within business hours, after-hours, online or telephone interventions may be warranted if clinically appropriate. It is also important to understand (through respectful and discreet enquiries) the persons' capacity to fund the intervention.

### 4. Responsive and flexible

People's clinical needs change over time and in well-functioning stepped care systems, services use routine outcome monitoring and consumer feedback to make changes to the intervention as needed. Subsequently, services respond by increasing or decreasing service intensity, or varying the type or number of services provided. This should happen seamlessly and without requiring re-referral and re-entry to the system (including where a consumer has been discharged). Importantly, as changes are made to the intervention, there should be timely communication with the GP and referrer.

### 5. Effective clinical governance

A high performing initial assessment and referral system is under-pinned by robust clinical governance. This Guidance is underpinned by the National Safety and Quality Health Services Standards and the National Standards for Mental Health Services. PHNs have responsibility for ensuring effective mechanisms are in place for monitoring and managing the quality of care in a way that meets or exceeds the national standards.

## 6. Safe services

In accordance with the National Standards for Mental Health Services, safety is defined as the avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered. Entities responsible for initial assessment and referral have an important role in supporting the safety of consumers, carers, and the community. PHNs have responsibility for ensuring effective mechanisms are in place to support the safety of consumers, carers, families, communities, and staff.

## Section 2 – Initial Assessment Domains

An initial assessment is used to gather information from the referrer and consumer to guide decisions about the most appropriate next steps (e.g., intervention, further assessment). PHNs must be confident that an effective initial assessment is undertaken to match the consumer with the most appropriate level of care. For this context, the initial assessment is focussed on information gathering to assign a level of care and is not seeking to make a diagnosis or replace a comprehensive mental health assessment.<sup>4</sup>

The information used to inform the initial assessment can be collected using a variety of methods:

- Review of the information supplied in the referral form or GP mental health treatment plan if information is sufficiently detailed. If information is not sufficiently detailed, further liaison with the GP is important.
- Interview with the consumer (and if appropriate carer or family members) undertaken by the referrer, central intake team or commissioned provider.
- A combination of both - review of information supplied in the referral form/mental health treatment plan, and further discussion with the referrer and/or consumer to seek further information not already available.

Initial assessment should be undertaken by a clinician who is suitably qualified and experienced to perform a mental health assessment. This group includes:

- GPs,
- Psychologists,
- Credentialed mental health social workers or social workers who have completed additional training in mental health assessment and referral skills and have access to mental health focussed supervision,
- Psychiatrists,
- Credentialed mental health nurses or registered nurses who have completed additional training in mental health assessment and referral skills and have access to mental health focussed supervision, and
- Occupational Therapists who are endorsed to provide the Better Access initiative.

In well-supervised environments, it may be appropriate to engage non-clinical staff (e.g., peer workers, youth workers, workers trained in the delivery of low intensity services) in undertaking components of the initial assessment. Where non-clinical staff are involved in the initial assessment process, PHNs should ensure that:

- Non-clinical staff are adequately trained in mental health assessment and referral skills.
- Suitably qualified and experienced mental health clinicians oversee decision-making by non-clinical staff. Key decision-making points during the IAR process include:
  - decisions about the rating on each of the domains, and
  - the decision about an assignment of a level of care.

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<sup>4</sup> **Note-** the information collected through this initial assessment is not intended to meet all the requirements of the National Primary Mental Health Care Minimum Data Set (PMHCMDS). PHNs and their commissioned providers should be aware of data requirements associated with the PMHCMDS.

- Non-clinical staff have immediate access to supervision from a suitably qualified and experienced clinician (e.g., when-ever it is needed, via telephone or onsite supervision).

### **PRACTICE POINT**

PHNs must be confident that intake and referral systems are operated by professionals who have an ability to build rapport and trust. The outcome of the initial assessment will lose validity if the consumer is reluctant to provide or disclose information.

## Overview of Assessment Domains and Relationship to levels of care

The initial assessment process recommended in this Guidance identifies eight domains that should be assessed when determining the next steps in the referral and treatment process for a person referred to a PHN commissioned 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 5-8):* These cover Treatment and Recovery 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 for individuals presenting for assistance should consider the consumer'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 person's care 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 individual referred for care.

### PRACTICE POINT

If there is uncertainty in the ratings during the initial assessment, the individual should be supported to access an appropriate clinician for a comprehensive assessment.

Clinicians using the Decision Support Tool should never "rate up" when uncertain. The clinician should build certainty to rate with confidence (e.g., through additional questions or administering a standard assessment tool), seeking additional clinical input, or referring for a comprehensive assessment.

"Rating up" may erroneously signal an issue that is not present for the individual and result in an inaccurate representation of that person's treatment needs.

Underpinning the concept of domains is the concept of relative importance and severity – some factors within each domain are more important than others, and some domains are more critical in the overall assessment of an individual's need for a given level of care. While the relative importance of each domain may vary for each consumer, an overall judgement is needed that requires decisions to be made about the severity of presenting problems within each domain.

An individual's presenting problems on each domain can interact in different ways. For example, a person presenting with mild to moderate symptoms but no significant problems on any of the contextual domains may require a different level of care from one with mild to moderate symptoms but extensive social and environmental stressors or a poor response to previous treatment.

The Guidance includes a Decision Support Tool. The Decision Support Tool:

- Provides a guide to assessing severity of problems on each of the eight domains. This is presented as a rating glossary at Section 6, including a hierarchical ranking of factors relevant to each domain to guide judgements about problem severity.
- Detailing the logic and steps in a decision support tool format of how assessment on each of the domains, and interaction between them, can be used by clinicians to inform decisions about selecting an appropriate level of care. This is provided at Appendix 1.

## Domain 1 – Symptom Severity and Distress (Primary Domain)

An initial assessment should examine severity of symptoms, distress, and previous history of mental illness. Severity of current symptoms and associated levels of distress are important factors in assigning a level of care and making a referral decision. Assessing changes in symptom severity and distress also forms an important part of outcome monitoring.

Assessment of an individual on this domain should consider:

- current symptoms and duration,
- level of distress,
- experience of mental illness, and
- are symptoms improving/worsening, is distress improving/worsening, are new symptoms emerging?

Validated measures such as the Kessler Psychological Distress Scale (K10), Kessler Psychological Distress Scale for Aboriginal People (K5), Patient Health Questionnaire 9 (PHQ-9), Generalised Anxiety Disorder 7 Item Scale (GAD-7), and the Edinburgh Postnatal Depression Scale (EPDS) are potentially useful for understanding symptom severity and distress. Appendix 3 defines threshold points for each of these instruments for guiding judgements about problem severity when used in the general population but are not directly translatable to clinical populations presenting for care. The thresholds should therefore not be used in isolation to determine a rating on Domain 1 but may be useful in understanding symptom severity and distress.

## Domain 2 – Risk of Harm (Primary Domain)

An initial assessment should include an evaluation of risk to determine a person's potential for harm to self or others. Results from this assessment are of fundamental importance in deciding the appropriate level of care required.

Recent Australian and international evidence indicates that risk prediction is a flawed, imprecise, and misleading activity in mental healthcare and can contribute to both over and under prediction of risk. This domain is not about predicting the individuals that are likely to attempt or complete suicide or other forms of harm, rather this domain guides evaluation of risk and is focussed on examining:

- suicidality – current and past suicidal ideation, attempts,
- self-harm (non-suicidal self-injurious behaviour) – current and past,
- severe symptoms that pose a danger to self or others, and
- risk arising from severe self-neglect.

### **PRACTICE POINT**

Risk of harm must be considered in the context of information gathered on the other 7 domains- information gathered across the other 7 domains (e.g., if the person is experiencing loneliness, hopelessness, worthlessness, significant environmental stressors etc) is very important in evaluating harm.

## Domain 3 – Functioning (Primary Domain)

An initial assessment should consider functional impairment caused by or exacerbated by the mental health condition. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining mental health intervention intensity within a stepped care continuum. Assessment of an individual on this domain should consider:

- a person's ability to fulfil usual roles/responsibilities,
- impact on or disruption to areas of life (e.g., employment, parenting, education, activities of daily living), and
- the person's capacity for self-care.

## Domain 4 – Impact of Co-Existing Conditions (Primary Domain)

Increasingly, individuals are experiencing and managing multi-morbidity (coexistence of multiple conditions including chronic disease). An initial assessment should specifically examine morbidity that contributes to (or has the potential to contribute to) increased severity of mental health problems and/or compromises the person's ability to participate in the recommended treatment.

Assessment of an individual on this domain should consider:

- substance use/misuse and the associated impact on the individual,
- physical health condition and the associated impact on the individual where they have a concurrent mental health condition, and
- intellectual disability or cognitive impairment.

## Domain 5 – Treatment and Recovery History (Contextual Domain)

This initial assessment domain should explore the individual's relevant treatment history and their response to previous treatment. Response to previous treatment is a reasonable predictor of future treatment need and is particularly important when determining appropriateness of lower intensity services.

Assessment of an individual on this domain should consider:

- whether there has been previous treatment (including specialist or mental health inpatient treatment),
- if the person is currently engaged in treatment, and
- their response to past or current treatment.

When considering this domain relevant treatment refers to treatment by a qualified mental health provider rather than informal care provided by friends, family, or social networks.

## Domain 6 – Social and Environmental Stressors (Contextual Domain)

This initial assessment domain should consider how the person's environment might contribute to the onset, maintenance, or exacerbation of a mental health condition. Significant situational or social complexities can lead to increased condition severity and/or compromise ability to participate in the recommended treatment.

Unresolved situational or social complexities can influence the outcome of treatment. Furthermore, understanding the complexities experienced by the individual (with carer/support person perspectives if available), may alter the type of service offered, or indicate that additional service referrals may be required (e.g., a referral to an emergency housing provider).

Assessment of an individual on this domain should consider life circumstances that may be associated with distress such as:

- significant transitions (e.g., job loss, relationship breakdown, sudden or unexpected death of loved one),



- trauma (e.g., physical, psychological, or sexual abuse, witnessing or being a victim of an extremely violent incident, natural disaster),
- experiencing harm from others (including violence, vulnerability, exploitation),
- interpersonal or social difficulties (e.g., conflict with friend or colleague, loneliness, social isolation, bullying, relationship difficulties),
- performance related pressure (e.g., work, school, exam stress),
- ability to or difficulty having basic physical, emotional, environmental, or material needs met (such as homelessness, unsafe living environment, poverty),
- illness, and
- legal issues.

## Domain 7 - Family and Other Supports (Contextual Domain)

This initial assessment domain should consider whether informal supports are present and their potential to contribute to recovery. A lack of supports might contribute to the onset or maintenance of the mental health condition and/or compromise ability to participate in the recommended treatment.

## Domain 8 - Engagement and Motivation (Contextual Domain)

This initial assessment domain should explore the person's understanding of the mental health condition and their willingness to engage in or accept treatment.

Assessment of an individual on this domain should include the individual's:

- understanding of the symptoms, condition, and impact,
- ability and capacity to manage the condition, and
- motivation to access necessary supports (particularly important if considering self-management options).

## Using the Decision Support Tool to rate the Initial Assessment Domains

Section 6 includes the Decision Support Tool- which shows how the domains are rated, using a scoring system that grades each domain on a 5-point scale, 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. The rating scale and glossary has been prepared as an example of how the domains can be rated for future trial in the field. A snapshot of the summary rating scale is shown in Figure 4 below.

Figure 4: Summary rating form for assessing domains (see Section 6 – Glossary for Rating the Assessment Domains)

## INITIAL ASSESSMENT SUMMARY SHEET

PRIMARY ASSESSMENT DOMAINS	
<p><b>DOMAIN 1: Symptom severity and distress</b></p> <ul style="list-style-type: none"> <li>0. No problem</li> <li>1. Mild or sub-diagnostic</li> <li>2. Moderate</li> <li>3. Severe</li> <li>4. Very severe</li> </ul> <p style="text-align: right;"><i>Initial Assessment Rating</i> <input style="width: 50px;" type="text"/></p>	<p><b>DOMAIN 2: Risk of harm</b></p> <ul style="list-style-type: none"> <li>0. No identified risk</li> <li>1. Low risk of harm</li> <li>2. Moderate risk of harm</li> <li>3. High risk of harm</li> <li>4. Very high risk of harm</li> </ul> <p style="text-align: right;"><i>Initial Assessment Rating</i> <input style="width: 50px;" type="text"/></p>
<p><b>DOMAIN 3: Functioning</b></p> <ul style="list-style-type: none"> <li>0. No problems</li> <li>1. Mild impact</li> <li>2. Moderate impact</li> <li>3. Severe impact</li> <li>4. Very severe to extreme impact</li> </ul> <p style="text-align: right;"><i>Initial Assessment Rating</i> <input style="width: 50px;" type="text"/></p>	<p><b>DOMAIN 4: Impact of co-existing conditions</b></p> <ul style="list-style-type: none"> <li>0. No problems</li> <li>1. Minor impact</li> <li>2. Moderate impact</li> <li>3. Severe impact</li> <li>4. Very severe impact</li> </ul> <p style="text-align: right;"><i>Initial Assessment Rating</i> <input style="width: 50px;" type="text"/></p>
CONTEXTUAL DOMAINS	
<p><b>DOMAIN 5: Treatment and recovery history</b></p> <ul style="list-style-type: none"> <li>0. No prior treatment history</li> <li>1. Full recovery with previous treatment</li> <li>2. Moderate recovery with previous treatment</li> <li>3. Minor recovery with previous treatment</li> <li>4. Negligible recovery with previous treatment</li> </ul> <p style="text-align: right;"><i>Initial Assessment Rating</i> <input style="width: 50px;" type="text"/></p>	<p><b>DOMAIN 6: Social and environmental stressors</b></p> <ul style="list-style-type: none"> <li>0. No problem</li> <li>1. Mildly stressful</li> <li>2. Moderately stressful</li> <li>3. Highly stressful</li> <li>4. Extremely stressful</li> </ul> <p style="text-align: right;"><i>Initial Assessment Rating</i> <input style="width: 50px;" type="text"/></p>
<p><b>DOMAIN 7: Family and other supports</b></p> <ul style="list-style-type: none"> <li>0. Highly supported</li> <li>1. Well supported</li> <li>2. Limited supports</li> <li>3. Minimal supports</li> <li>4. No supports</li> </ul> <p style="text-align: right;"><i>Initial Assessment Rating</i> <input style="width: 50px;" type="text"/></p>	<p><b>DOMAIN 8: Engagement and motivation</b></p> <ul style="list-style-type: none"> <li>0. Optimal</li> <li>1. Positive</li> <li>2. Limited</li> <li>3. Minimal</li> <li>4. Disengaged</li> </ul> <p style="text-align: right;"><i>Initial Assessment Rating</i> <input style="width: 50px;" type="text"/></p>

## Section 3 – Levels of Care

This section provides a description of the different levels of care. The information gathered through the initial assessment (Section 2 – Initial Assessment Domains) is used to assign 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.

### PRACTICE POINT- A NOTE ABOUT CONSUMER CHOICE AND PREFERENCE

There is strong evidence to indicate that when a consumer works in partnership with a trusted health care professional and is involved in making decisions about their care and selection of the service of 'best fit', they are less likely to drop-out of care, and more likely to experience positive outcomes ([reference](#)). World class health care considers the choices and preferences of the individual. In a stepped care model, the individual should be given a choice within "steps" or within a level of care (e.g., the consumer may have a strong preference for telephone-based psychological interventions rather than face-to-face). A choice across "steps" or levels of care is not always practical or necessary (e.g., if the consumer does not require higher intensity supports) and this can often be resolved using supported decision-making strategies.

Supported decision-making strategies for initial assessment and referral:

- Make sure the consumer is provided with information using their preferred way of receiving information (e.g., written/verbal/visual, English/other language, with/without a support person).
- Make sure the consumer is provided with a list of recommended intervention options (including the option of no intervention) and encourage the consumer to contribute their own options, ideas, solutions, and expectations. This might include interventions such as culturally relevant activities, or self-care strategies.
- Ensure the consumer 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, intervention length and commitment required, waiting periods, potential impact on symptoms).
- Check in, to ensure the consumer has understood the information provided and ensure enough time for any questions from the consumer (or carer/family member).
- Support the decision of the consumer, acknowledging that other options can be explored in the future if this decision does not work out.

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

<https://healthtalkaustralia.org/supported-decision-making/overview/>

Mental health services in Australia represent a complex array of service types, ranging from population-level services available to all on the internet through to highly specialised services that include short and long-term hospital care.

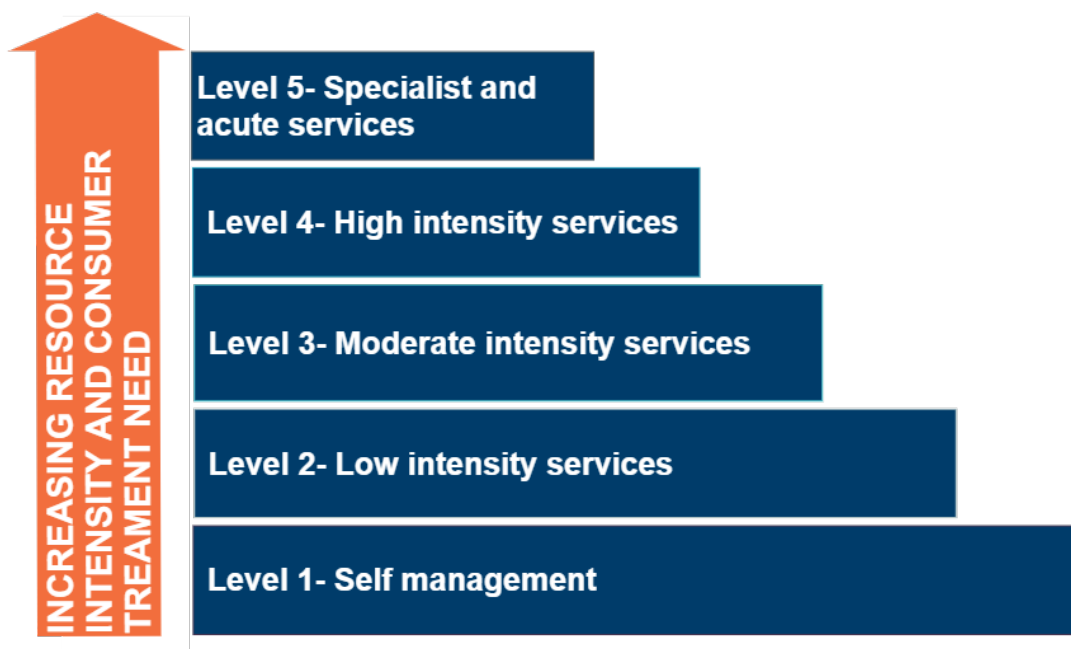
Grouping these into 'levels' is aimed at describing a continuum of services based **on levels of resource intensity**. This is not intended to imply that there is natural division of service types into tiered categories. While some services are associated with a single level of care, most will appear in multiple categories. For example, GP mental health care can be associated with lower levels of care when it is provided in isolation, or higher levels when delivered in combination with other services or interventions (e.g., psychiatrist or involvement of a multidisciplinary team).

The levels therefore are best thought of as combinations of interventions that form potential 'packages' for people requiring that level of care. The levels are differentiated by the amount and scope of resources available. A given individual may use some or all interventions described at that level and move between levels of care as required.

The core services and additional supports listed within each level of care include intervention options generally available within the mental health sector more broadly. The core services and additional supports do not represent PHN-only commissioned services. In any region, the core services and additional supports may be available through a variety of funding sources and providers.

Five levels of care are summarised in Figure 5 below.

Figure 5: Schematic representation of levels of care



Primary mental health care falls into Levels 1 to 4

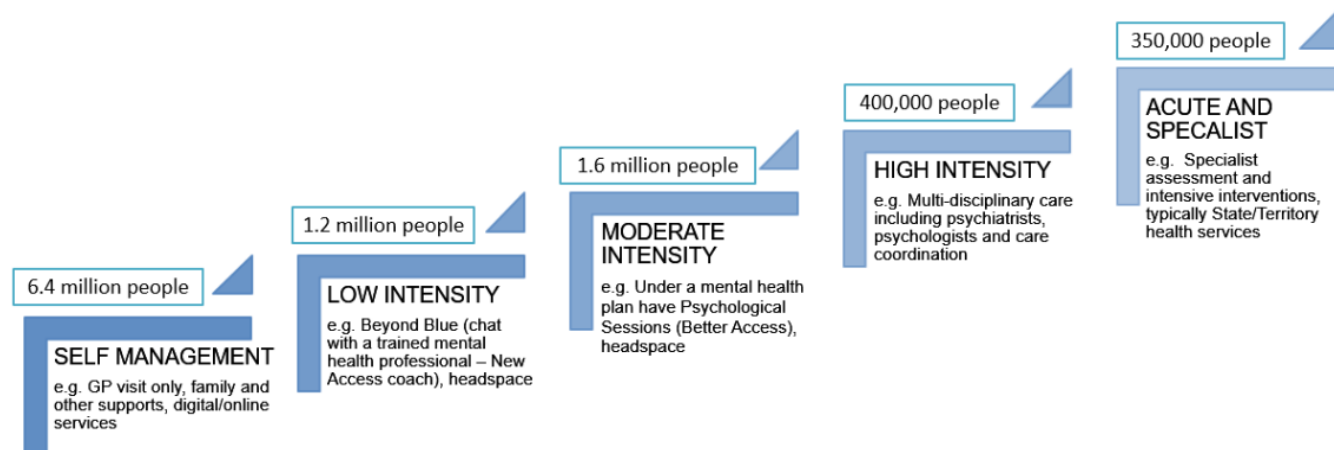
- Level 1 (self-management) is suggested for people with relatively minor problems on the Primary Domains. Contraindications to Level 1 care include problems with engagement/motivation (because these will work against any referral to self-management strategies) and severe problems in treatment/recovery history or very severe environmental stressors.
- Level 2 (low intensity interventions) is targeted at people with mild problems in the primary domains, where these do not present in the context of significant problems on the contextual domains. Level 2 may also be suitable for people with moderate symptoms, but this is dependent on the extent of presenting problems on other primary and contextual domains.
- Level 3 (moderate intensity interventions) is targeted at people with mild to moderate symptoms/distress where these present in the context of significant problems on other domains. Level 3 is also proposed as suitable for management of severe symptoms where no significant problems are present on other primary domains.
- Level 4 (high intensity interventions) is targeted to individuals with severe symptoms/distress, where these occur in the context of significant other problems (up to severe levels). Level 4 is not suitable for people with severe symptoms who present with very severe problems on either risk or functioning. Individuals referred with this array of presenting problems are suggested as best referred to Level 5 care.

## Mapping Population Need to the Levels

The Department of Health drew from information contained within the National Mental Health Services Planning Framework (NMHSPF) to estimate, in an optimal stepped care approach to service delivery, how

many people could benefit from treatment at each level of care. The modelling examined the total population with a potential need, including both those with diagnosable mental illness, and those with sub-threshold or at-risk problems. This equates to a total of 10 million people or roughly 40% of the population, as described earlier in this Guidance (see Figure 2: Estimated prevalence of mental health conditions and stepped care levels of need based on severity.) The results are summarised below.

Figure 6: Treatment need estimating using the NMHSPF mapped to the five levels of care



Source: Department of Health, 2019. Initial Submission to the Productivity Commission Inquiry into Mental Health, <https://www.pc.gov.au/inquiries/completed/mental-health/submissions#initial>

The outcome of the modelling provides indicative estimates of the how mental health needs in the population are spread across the five defined levels of care:

- The majority of people (6.4 million of the total 10 million) are modelled as not seeking (or requiring) formal mental health service assistance and are able to achieve better health through self-management (Level 1). Most people in this group experience mental health problems at a mild or sub clinical threshold level.
- Of those people who present to the health system for assistance (the remaining 4.6 of the total 10 million), most can be assisted through Level 2 and Level 3 care (1.2 million and 1.6 million respectively).
- Around 750,000 will require Level 4 or Level 5 assistance (400,000 and 350,000 respectively).

## Referral Criteria to Levels of Care

Suggested referral criteria for each of the Levels are outlined in descriptions of levels of care that follow. These are based on the initial assessment of each of the domains. As the domains are interactive (in that each of the assessment factors can interact with judgements on other domains) there is considerable complexity in the possible combinations. The suggested referral criteria aim to simplify the approach by focusing only on the main patterns of presenting problems likely to be found in primary mental health care.

It is important to emphasise that the proposed referral criteria are offered only to guide judgements about the likely best treatment option. Each presenting individual will have unique requirements that must always take precedence in decision making.

## Level 1 (Self-Management)

**Definition:** services at this level of care are designed to prevent the onset of illness and are mostly focused on supporting the person to self-manage any distress or symptoms. This level of care generally involves evidence-based digital therapies and other forms of self-help. A summary of the evidence-based digital mental health therapies 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, workplaces, and general practice).

### Core clinical services:

This level of care is focussed on self-help activities. Clinical services are generally not required, however where they are involved, they should:

- Be focussed on monitoring, with capability to step up into other interventions as required.
- Include psychoeducation and information via a GP. The GP may also consider developing a MHTP (if consistent with Medicare Benefits Schedule).

### Other clinical interventions that may be required:

- lifestyle interventions (e.g., nutrition, sleep, exercise, meaningful social connections), and
- group work.

**Support services:** additional services, if needed, are focussed on actively linking the person with services that can help to practically address any situational stressors (e.g., finances).

### Referral criteria:

A person suitable for this level of care typically has no risk of harm, is usually experiencing mild symptoms and/or no distress/low levels of distress- which may be in response to recent social and environmental stressors. Symptoms have typically been present for a short period of time. The individual is generally functioning well and should be motivated to pursue self-management options. People 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. Additionally, Level 1 care is unlikely to be suitable for those with severe problems in their treatment/recovery history or very severe environmental stressors – each of these would usually trigger a referral to Level 3 care.

### Using the Initial Assessment Rating Glossary to support decision making:

Individuals suited to this level of care may have been rated during the initial assessment as having:

Mild or no problems on all Primary Domains (Symptom Severity and Distress, Risk of Harm, Functioning and Impact of Co-existing Conditions, all scores  $\leq 1$ ) **AND**

- No significant problems on Treatment and Recovery History, Social and Environmental Stressors and Engagement and Motivation (all scores  $\leq 1$ ), **OR**
- Moderate problems on Treatment and Recovery History (score  $\leq 2$ ) but with good Engagement and Motivation (score  $\leq 1$ ), **OR**
- High Social and Environmental Stressors (score  $\leq 3$ ) but with good Engagement and Motivation (score  $\leq 1$ ).

## 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 digital interventions) and typically involve few or short sessions.

**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, workplaces, and general practice).

### Core clinical services:

- Psychoeducation and information via a GP. The GP may also consider developing a MHTP (if consistent with Medicare Benefits Schedule).
- Evidence-based low intensity interventions (including online, telephone and face-to-face low intensity structured psychological services, or brief interventions delivered by mental health professionals).

### Other clinical interventions that may be required:

- lifestyle interventions (e.g., nutrition, sleep, exercise, meaningful social connections).
- group work.

**Support services:** additional services, if needed, are focussed on actively linking the person with services that can help to practically address any situational stressors (e.g., finances).

### Referral criteria:

A person 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 6 months but this may vary). The individual is generally functioning well but may have problems with motivation or engagement that contraindicate a referral to Level 1 care. Where the person has experienced previous treatment for a previous episode, they are likely to have had a moderate or better recovery.

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.

### Using the Initial Assessment Rating Glossary to support decision making:

Individuals suited to this level of care may have been rated during the initial assessment as having:

- Mild or no problems on all Primary Domains (Symptom Severity and Distress, Risk of Harm, Functioning and Impact of Co-existing Conditions, all scores  $\leq 1$ ) AND
  - moderate problems on Treatment and Recovery History (score  $\leq 2$ ) and limited Engagement and Motivation (score  $\geq 2$ ), **OR**
  - high Social and Environmental Stressors (score  $\leq 3$ ) and limited Engagement and Motivation (score  $\geq 2$ )

### OR

- Mild Symptom Severity and Distress (score = 1) in the context of moderate Impact of Co-existing Conditions (score =2)

### OR

- Moderate Symptom Severity and Distress (score = 2) but no significant problems indicated by Risk of Harm, Functioning or Impact of Co-existing Conditions (all scores  $\leq 1$ ).



## Level 3 (Moderate Intensity Services)

**Definition:** moderate intensity services generally provide structured, reasonably frequent, and intensive interventions (e.g., a defined number of psychological sessions delivered regularly).

**Care environment:** typically, community locations (e.g., consulting rooms), outreach into residential environments (e.g., aged care facilities, schools) or if appropriate, via telephone or videoconference (e.g., for people in remote communities), and clinician assisted e-therapies.

### **Core clinical services:**

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

- Evidence-based psychological interventions provided by a mental health clinician.
- Active GP management, mental health assessment (and development of a MHTP).

### **Other clinical interventions that may be required:**

- community based psychiatry.
- clinical care coordination services within primary care (if more than 2 services are involved in providing care).

**Support services:** additional services, if needed, are focussed on:

- community supports (including peer support and social participation support).
- assistance to access support and advice relating to known environmental stressors.
- lifestyle interventions (e.g., nutrition, sleep, exercise, meaningful social connections).

### **Referral criteria:**

A person requiring this level of care is likely to be experiencing mild to moderate symptoms/distress (that would meet criteria for a diagnosis). Symptoms have typically been present for 6 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 5. People 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.

### **Using the Initial Assessment Rating Glossary to support decision making:**

Individuals suited to this level of care may have been rated during the initial assessment as having:

- Mild or lesser Symptom Severity and Distress (score  $\leq 1$ ) but with complexity indicated by significant problems on Risk of Harm or Functioning (scores  $\geq 2$ ) or Impact of Co-existing Conditions (score  $\geq 2$ ) OR
- Moderate Symptom Severity and Distress (score = 2) with associated moderate or higher problems on any other Primary Domain (Risk of Harm, Functioning, Impact of Co-existing Conditions, scores  $\geq 2$ ) OR
- Severe Symptom Severity and Distress (score = 3) but problems on all other Primary Domain (Risk of Harm, Functioning, Impact of Co-existing Conditions) are mild or less (all scores  $\leq 1$ ).

## Level 4 (High Intensity Services)

**Definition:** high intensity services including periods of intensive intervention that may involve multi-disciplinary support. Usually supporting people experiencing severe mental illness, significant functional impairment and/or risk factors.

**Care environment:** typically, face-to-face interventions in community locations (e.g., consulting rooms) or outreach to the person within their home or other environment.

**Core clinical services:**

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

- Evidence-based psychological interventions provided by a mental health clinician.
- Clinical care coordination services within primary care (if more than 2 services are involved in providing care).
- Involvement of a mental health nurse.
- Community-based psychiatric care.
- Active GP management, mental health assessment, integrated physical health care (and development of a MHTP).

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

- psycho-social disability support services (including peer support, daily living support, social skills training, and social participation support).
- community supports (including peer support and social participation support).
- assistance to access support and advice relating to known environmental stressors.
- lifestyle interventions (e.g., nutrition, sleep, exercise, meaningful social connections).

**Referral criteria:**

A person requiring this level of care usually has a diagnosed mental health condition with significant symptoms and/or significant problems with functioning. A person 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.

**Using the Initial Assessment Rating Glossary to support decision making:**

Individuals suited to this level of care may have been rated:

- Severe Symptom Severity and Distress (score = 3) with significant associated problems on one or more other Primary Domains (Risk of Harm, Functioning, score of 2 or 3, or Impact of Co-existing Conditions score of 2-4)
- Severe Symptom Severity and Distress in the context of very severe problems (score = 4) on either Risk of Harm or Functioning are not suited to this level but should be referred for Level 5 care.

## Level 5 (Acute and Specialist Community Mental Health Services)

**Definition:** specialist mental healthcare usually includes intensive team-based specialist assessment and intervention (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.

**Care environment:** typically, community locations with outreach to the person 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 person is likely to benefit from psychiatric assessment and care, crisis management, and therapeutic interventions using assertive 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:

- psycho-social disability support services (including peer support, daily living support, social skills training, and social participation support).
- community supports (including peer support and social participation support).
- assistance to access support and advice relating to known environmental stressors.
- lifestyle interventions (e.g., nutrition, sleep, exercise, meaningful social connections).

### **Referral criteria:**

A person requiring this level of care usually has significant symptoms (e.g., hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions) and problems in functioning independently across multiple or most everyday roles (work, education, parenting, volunteering) and/or is experiencing:

- Significant risk of suicide, self-harm, self-neglect, or vulnerability.
- Significant risk of harm to others.
- A high level of distress with potential for debilitating consequence.

### **Using the Initial Assessment Rating Glossary to support decision making:**

Individuals suited to this level of care may have:

- Very severe problems (score = 4) on one or more of Symptom Severity and Distress, Risk of Harm and Functioning domains.
- Severe Symptoms/Distress (score = 3) in the context of moderate to severe problems in one or more other Primary Domains (Risk of Harm, Functioning, score 2 or 3, Impact of Co-existing Conditions score of 2-4) are assigned by the decision logic to 'Level 4 or above'. Level 5 care should be considered where there are associated severe or higher problems multiple Contextual Domains (Treatment and Recovery History, Social and Environmental Stressors, Family and Other Supports, Engagement and Motivation).

## Section 4 – Progress Monitoring

Across all levels of care, progress monitoring is essential. Research indicates that progress monitoring improves outcomes by detecting when an individual is not improving or is deteriorating under the intervention and shares this information with the individual. This process lends itself to changes to the care plan or approach used- leading to a more flexible and responsive intervention.

Progress monitoring also helps to ensure that the intervention commenced/continued as planned and is an objective way of ascertaining if the intervention is successfully reducing symptoms and/or improving functioning.

### Who should monitor progress?

Progress monitoring should be undertaken by a clinician who is familiar with the consumer and consistently involved in their care (e.g., GP or mental health service provider) and in consultation with others where appropriate (e.g., other clinicians involved in providing support, family and informal supports). A clinician who is familiar with the consumer and consistently involved in their care, is more likely to confidently assess progress and identify deterioration. The clinician should initiate pro-active and regular follow up with the individual to monitor progress and identify early signs of deterioration (see below practice point about deterioration) or disengagement.

### How should progress monitoring occur?

Progress monitoring should be formalised, systematic, and regular. Importantly, this information should be shared with the consumer to derive the clinical benefits of outcome monitoring and be incorporated into a care plan in consultation with the consumer (as per Practice Point regarding Consumer Choice and Preference). Where appropriate, carers and/or family members should also be encouraged to identify changes or concerns.

### PRACTICE POINT

Regular review of a consumer's progress should be built into the intervention to capture new information that becomes available, so that individuals requiring a higher level of care, are stepped up speedily and efficiently. To facilitate this process health and social outcomes should be routinely and regularly recorded and shared with the consumer. There is emerging evidence that routine outcome measures, collected on a session-by-session basis, provides the level of information necessary to guide timely 'step up' or 'step down' decisions and can improve the effectiveness of the intervention.

### How often should progress monitoring occur?

Generally, people within Level 4 or 5 care will require more frequent and assertive follow up and monitoring. Follow up should also be provided whenever instigated by the consumer, carer, or family member.

### When should a step-up be considered?

A step-up should be considered when:

- The consumer has not experienced reduced symptoms within a reasonable timeframe.
- The consumer has not experienced recovered functioning within a reasonable timeframe.
- There is evidence of deterioration or a changing risk of suicide or harm to self, to others, or from others.
- Consumer identified recovery goals are not being or are unlikely to be met.
- The consumer is experiencing new social and environmental stressors.

## PRACTICE POINT

The [Australian Commission of Quality and Safety in Health Care](#) lists 5 indicators of deterioration, including (1) clinician, consumer or carer reported change; (2) distress; (3) loss of touch with reality or consequences of behaviours; (4) loss of function; (5) elevated risk to self, others or property.

### When should a step-down be considered?

Step-down refers to a decrease in service intensity and does not necessarily mean a transfer of care to a new provider. A step-down also includes where an intervention is ceasing. A step-down should be considered when the consumer has completed the recommended intervention in accordance with their care plan and now fits the description of a lower level of care. Other indicators that a step-down is appropriate include:

- Reduced symptoms, over a consistent period.
- Improved or recovered functioning observed through improved productivity, performance, and/or reduced days out of role.
- Not at risk of deterioration, is able to independently identify signs of deterioration and take appropriate action (e.g., initiate re-engagement with the GP or mental health service).
- The consumer indicates they are ready to step-down or exit.

## PRACTICE POINT

Standard assessment tools, consumer reported outcome and experience measures, when taken at the commencement of treatment (baseline), can help to inform a decision about progress or deterioration.

If a change in service type and/or intensity is required, the initial assessment should not be repeated. Changes to the intervention should be **fast-tracked** and wherever possible:

- Waiting periods are avoided or eliminated.
- Involve a facilitated and “warm” referral. A warm referral typically involves a supported introduction to the new service (e.g., supporting the individual to make the initial contact with the new service or provider) and (with the consent of the individual) providing relevant written reports or notes.
- Include a clear and documented hand over of duty of care.

## Section 5 – Clinical Governance

This section includes advice that aims to support the clinical governance responsibilities of PHNs and their commissioned providers. PHNs have a responsibility for ensuring that initial assessment and referral systems are consistent with the [National Standards for Mental Health Services \(NSMHS\)](#) and the [National Safety and Quality Health Service \(NSQHS\) Standards](#) and the Department of Health guidance which states:

*Your Organisation must establish and maintain appropriate clinical governance and quality assurance arrangements for all components of the Activity and with a particular focus on the services commissioned. Building on the requirements of the PHN Grant Programme Guidelines (1.3 PHN Governance Arrangements) this must include:*

- i. Ensuring a high-quality standard of services which is supported by appropriate quality assurance processes.*
- ii. Ensuring the workforce is practicing within their area of qualification and competence.*
- iii. Ensuring appropriate clinical supervision arrangements are in place.*
- iv. Ensuring appropriate risk assessment and management procedures are in place.*
- v. Establishing and maintaining appropriate consumer feedback procedures, including complaint handling procedures.*
- vi. Ensuring appropriate crisis support mechanisms are in place to provide information to patients on how to access other services in a crisis situation, noting it is not the role of the PHN to provide or commission this type of service.*
- vii. Ensuring transition pathways are in place that allow consumers to seamlessly move to an appropriate alternate service should their circumstances change.*

*Your Organisation is required to ensure that services are consistent with the National Standards for Mental Health Services 2010 and any other relevant standards, such as the National Practice Standards for the Mental Health Workforce 2013*

In addition, Guidance provided by the Department of Health to PHNs states:

### *PHN Mental Health Guidance*

*PHNs need to ensure minimum standards are met and that clinical governance arrangements are in place. Clinical supervision channels should also be ensured in all commissioned services as a quality assurance mechanism.*

*Duty of care provisions need to be established to ensure consumers accessing commissioned services are provided with information about how to access other services in a crisis situation or when the level of service offered by the commissioned service no longer matches their presenting need. Service providers must appropriately screen for risk, routinely monitor and track a consumer's progress and support consumers to move to more appropriate services if required.*

With reference to initial assessment and referral within primary mental health care, the table below outlines the necessary clinical governance responsibilities for PHNs and commissioned providers. These considerations include responsibilities assigned to:

1. PHNs- associated with their role as **commissioners** of services.
2. Organisation or provider responsible for operating and undertaking initial assessment and referral - **This may include the PHN, if the PHN is directly providing intake services (e.g., central intake delivered by a PHN team).**

This section is not intended to provide advice on clinical governance requirements associated with all components of primary mental health care commissioning and service delivery. Only those requirements that are associated with initial assessment and referral are included.

Table 1: Clinical Governance

	PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
<p>Requirement 1: Initial assessment and referral practices are resulting in optimal alignment of clinical need and treatment need (NSMHS-10.3.3)</p>	<p>The PHN should establish system-level and contract-level monitoring processes that provide an indication of whether initial assessment and referral practices are resulting in an effective alignment of clinical need with treatment need. The PHN must define performance measures relating to alignment of clinical need with treatment need. PHNs should consider undertaking an analysis of effectiveness including:</p> <ul style="list-style-type: none"> <li>• Proportion of consumers seeking access to higher intensity interventions after initial match to a lower intensity service or seeking access to lower intensity.</li> <li>• Service after initial match to a higher intensity intervention.</li> <li>• Local data indicating consumer flow between providers/service types.</li> <li>• Proportion of consumers who experience positive recovery outcomes (e.g., reduction in distress, improved functioning).</li> <li>• Proportion of consumers who have a positive experience of initial assessment and referral.</li> </ul>	<p>The provider must establish initial assessment and referral practices which effectively match clinical need with treatment need and ensure referral decisions result in the consumer gaining access to evidence-based and recommended interventions that are matched to their presenting clinical need.</p> <p>Clinical decision making must be documented and auditable.</p>	<p>The Provider should regularly audit compliance with the National Guidance and decision support tools and undertake remedial action in instances of non-compliance.</p>
<p>Requirement 2: The consumer has a choice of the services available, and their preferences are</p>	<p>The PHN provides current and up to date information about available services mapped against the levels of</p>	<p>Providers must be informed about the range of interventions available at each level and offer a choice of interventions available within the</p>	<p>Providers should adopt a supported decision-making</p>



	PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
understood and supported (NSMHS 10.4)	care and makes this information available for initial assessment and referral purposes. In doing so, PHNs should aim to be clear about the scope of the services available.	broader community to consumers during the initial assessment and referral process.  Providers must seek to understand and accommodate the economic, practical, cultural, and personal circumstances that may limit a consumer's willingness or ability to participate in some interventions.	approach to initial assessment and referral.
Requirement 3: Initial assessment and referral processes minimise burden on the consumer (NSMHS- 10.3.5)	The PHN should work with commissioned providers and other stakeholders to examine opportunities for integrated initial assessment and referral processes aiming to minimise the likelihood of the consumer needing to undergo duplicate and/or unnecessary assessments.	The provider, with the consent of the consumer, must ensure all information collected during the initial assessment is made available to the service provider securely.	Where possible, information sourced through previous initial assessments and other relevant treatment information should be made available to streamline the process and support the consumer to share information that is new or has changed.  PHN has a process to conduct audits on referrals to examine quality of referrals coming in and information sent on to service providers.
Requirement 4: Identification and management of risk of suicide, harm to self, to others and from others during initial assessment and referral	The PHN must ensure that contract specifications clearly define requirements for managing risk in initial assessment and referral decision making and processes to mitigate those risks.  The PHN must define performance measures relating to safety. These	The provider must ensure that appropriate processes for assessing and managing consumer risk are in place and monitored (NSMHS 2.3).  The provider must have in place a process for facilitating rapid identification of risk (including suicide risk, risk of self-harm, risk of harm to others and risk of harm from others) and processes that maintain consumer safety during referral to specialist and/or emergency	The provider should monitor the appropriate use of escalation processes, including failure to act (National Standards for MHS- Standards 9.4.1, 9.4.2).

	PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
	<p>measures should be included in provider contracts and/or service models.</p> <p>Service models and related contract specifications must clearly articulate the reporting and auditing responsibilities of providers.</p>	<p>services. This includes ensuring the timeliness of any recommended intervention matches the risks associated with suicide, harm to self, harm to others and harm from others.</p> <p>Where a consumer who is at risk of suicide or self-harm, or who has a changing risk profile, is required to wait for a service, the provider must work with the consumer and significant others (including carers and family) to develop a safety plan and facilitate a supported referral for additional services and supports.</p> <p>The provider must ensure consumers (and significant others) have information about 24-hour services available in the event of a crisis (National Standards for MHS- Standard 10.2.3).</p> <p>The provider must have in place a documented policy and/or established process and an appropriate mechanism to escalate care and arrange emergency assistance.</p>	
Requirement 5- Identification and management of adverse events, complaints, and incidents (NSMHS 1.16)	<p>Contracts with commissioned providers must clearly outline the expectations and processes for reporting adverse events, critical incidents and serious complaints associated with initial assessment and referral.</p> <p>The PHN must have in place a documented process for reviewing all</p>	<p>The provider must have in place a process for recording and reporting adverse events, incidents and complaints arising from initial assessment and referral practices.</p> <p>The provider must make clear and promote the process for reviewing and reporting adverse events, incidents, and complaints.</p>	<p>Serious or critical incidents and complaints associated with initial assessment and referral should be subject to a root cause analysis (RCA) with the process being overseen by the CEO, board and/or clinical governance committee- the results should be reported to the PHN.</p>

	PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
	<p>adverse events, critical incidents and serious complaints arising from initial assessment, referral, and all other relevant intake processes.</p> <p>The PHN should undertake an analysis of incident trends associated with initial assessment and referral to determine system-level and process-level flaws and work with providers and stakeholders (e.g., referrers) to undertake quality improvement activities.</p>		
<p>Requirement 6- Staff undertaking initial assessment and referral must have the requisite skills and experience (NSMHS- 10.4.2)</p>	<p>Service models and related contract specifications must clearly articulate workforce requirements, training and orientation expectations and intended scope of practice for staff undertaking initial assessment and referral (PHNs need to be confident that there is sufficient coverage within initial assessment and referral systems to ensure that demand for initial assessment is met and that waiting times are minimised).</p> <p>The PHN must define a process through which compliance with these specifications are monitored (e.g., through provider activity reports, audits etc.) and how non-compliance will be managed by the PHN.</p>	<p>The provider must employ or contract appropriately qualified and experienced staff and have systems in place for verifying and maintaining qualifications and registrations. At a minimum initial assessment must be undertaken by a clinician who is competent to perform a mental health assessment. This may include:</p> <ul style="list-style-type: none"> <li>• GPs.</li> <li>• Psychologists and other mental health professionals.</li> <li>• Psychiatrists.</li> <li>• Credentialed mental health nurses or registered nurses who have completed additional training in mental health assessment and referral skills and have access to mental health focussed supervision.</li> </ul> <p>There may be instances where non-clinical staff may be required to undertake the initial assessment. This is suitable only where:</p>	

	PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
		<ul style="list-style-type: none"> <li>• Non-clinical staff have immediate access to supervision from a suitably qualified mental health professional.</li> <li>• Non-clinical staff are provided with formal and evidence-based training in mental health assessment and referral skills.</li> <li>• Decision-making by non-clinical staff is overseen by a suitably qualified mental health professional.</li> </ul> <p>The provider must be confident that there is sufficient coverage within initial assessment and referral systems to ensure that demand for initial assessment is met and that waiting times are minimised.</p> <p>The provider must define a scope of practice for employed or contracted staff involved in initial assessment and referral. The scope of practice must outline the extent and limits of practice permitted across differing roles (e.g., clinical versus non-clinical roles). The provider must have in place a system to regularly review the scope of practice (National Safety and Quality Health Service Standards 1.23).</p> <p>The provider must define a process through which compliance with scope of practice will be monitored and how non-compliance will be managed.</p>	
Requirement 7- Staff responsible for initial	The PHN must ensure that contract specifications clearly define training and	The provider must have in place a professional development policy and procedure outlining	

	PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
assessment and referral must have access to training and supervision	<p>supervision requirements and expectations of staff employed or contracted by providers.</p> <p>Funding models should make available an appropriate proportion of the overall budget to ensure providers are able to fund the necessary training and supervision requirements.</p> <p>If permitting employment/contracting of non-clinical staff, funding models should factor in the time required and cost involved in ensuring initial training and skill development has been undertaken.</p>	<p>the professional development activity and supervision requirements of staff involved in initial assessment and referral. This includes competency-based training in:</p> <ul style="list-style-type: none"> <li>• Mental health assessment.</li> <li>• Undertaking a risk assessment (including risk of suicide, self-harm, harm to others and harm from others).</li> <li>• Supporting consumers in crisis.</li> </ul> <p>This also includes orientation in:</p> <ul style="list-style-type: none"> <li>• Mental health services within the region and an understanding of where each service is positioned across the stepped care continuum.</li> <li>• Local health and social care pathways and referral processes.</li> <li>• Evidence-based digital interventions.</li> <li>• Local crisis or emergency services when referring individuals for immediate support.</li> </ul>	
Requirement 8- Initial assessment and referral systems result in efficient use of available resources	<p>PHNs should establish mechanisms for monitoring the use of services to detect patterns indicating under-use (e.g., low intensity) and overuse of other interventions (e.g., psychological therapies). The PHN must be prepared to work with providers to take corrective action if this is occurring. This should be closely monitored during implementation</p>	<p>The provider must operate the initial assessment and referral system in a way that delivers fidelity with the stepped care concepts and therefore a person presenting to the mental health system is matched to the level of care that most suits their current need.</p>	

	PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES - PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
	<p>and/or introduction of new service models.</p> <p>The PHN may need to consider redesigning components of the initial assessment and referral system if service use is not consistent with estimated service demand.</p> <p>PHNs should establish requirements for communication and promotion of new models of service delivery- particularly those services which are poorly understood or have low levels of acceptability.</p>	<p>The provider must regularly review and analyse service utilisation data, this may involve:</p> <ul style="list-style-type: none"> <li>• Regular review of the MDS against established KPIs.</li> <li>• An audit including a review of initial assessment results and subsequent referral decisions.</li> </ul> <p>The provider must undertake corrective action if there is an indication that service use is not consistent with estimated service demand. Corrective action may include:</p> <ul style="list-style-type: none"> <li>• Additional training and/or supervision for staff undertaking initial assessment and referral.</li> <li>• Information and education for referrers.</li> <li>• Providing feedback to clinicians on variation in practice and health outcomes.</li> <li>• Support clinicians to engage in a review of their practice and referral decisions.</li> </ul>	

# Section 6 – Glossary for Rating the Assessment Domains

This section provides a guide to assessing the severity of problems on each of the eight domains (the Glossary). 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 person.

## Overarching Rules and Guides to Ratings

- Within each domain, if more than one descriptor applies to the consumer, 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 person'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 person'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 person'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 individual should be supported to access an appropriate clinician for a comprehensive assessment.
- This tool should not be used without clinical oversight.
- It should not be used as a screening tool because it cannot be used without some form of personalised assessment.

## Primary Assessment vs. Contextual Domains

The eight domains fall into two categories:

- *Primary Assessment Domains (Domains 1 to 4)*: These cover Symptom 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 Treatment and Recovery 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 SUMMARY SHEET

## PRIMARY ASSESSMENT DOMAINS

### DOMAIN 1: Symptom severity and distress

- 0. No problem
- 1. Mild or sub-diagnostic
- 2. Moderate
- 3. Severe
- 4. Very severe

Initial Assessment Rating

### DOMAIN 2: Risk of harm

- 0. No identified risk
- 1. Low risk of harm
- 2. Moderate risk of harm
- 3. High risk of harm
- 4. Very high risk of harm

Initial Assessment Rating

### DOMAIN 3: Functioning

- 0. No problems
- 1. Mild impact
- 2. Moderate impact
- 3. Severe impact
- 4. Very severe to extreme impact

Initial Assessment Rating

### DOMAIN 4: Impact of co-existing conditions

- 0. No problems
- 1. Minor impact
- 2. Moderate impact
- 3. Severe impact
- 4. Very severe impact

Initial Assessment Rating

## CONTEXTUAL DOMAINS

### DOMAIN 5: Treatment and recovery history

- 0. No prior treatment history
- 1. Full recovery with previous treatment
- 2. Moderate recovery with previous treatment
- 3. Minor recovery with previous treatment
- 4. Negligible recovery with previous treatment

Initial Assessment Rating

### DOMAIN 6: Social and environmental stressors

- 0. No problem
- 1. Mildly stressful
- 2. Moderately stressful
- 3. Highly stressful
- 4. Extremely stressful

Initial Assessment Rating

### DOMAIN 7: Family and other supports

- 0. Highly supported
- 1. Well supported
- 2. Limited supports
- 3. Minimal supports
- 4. No supports

Initial Assessment Rating

### DOMAIN 8: Engagement and motivation

- 0. Optimal
- 1. Positive
- 2. Limited
- 3. Minimal
- 4. Disengaged

Initial Assessment Rating

## Domain 1 – Symptom Severity and Distress (Primary Domain)

An initial assessment should examine severity of symptoms, distress, and previous history of mental illness. Severity of current symptoms and associated levels of distress are important factors in assigning a level of care and making a referral decision. Assessing changes in symptom severity and distress also forms an important part of outcome monitoring.

Assessment of an individual on this domain should consider:

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

### **0= No problem in this domain – no descriptors apply**

#### **1= Mild or sub diagnostic**

- a) Currently experiencing some, but not all, of the symptoms associated with an anxiety disorder (e.g., symptoms like excessive worry, difficulty concentrating) or depressive disorder (e.g., symptoms like sadness, irritability, exhaustion, disrupted sleep, anger) that have typically been present for less than 6 months (but this may vary). Current symptoms at a level that would likely result in a diagnosis or associated with a mild level of distress.
- b) Other mental health condition that is associated with mild distress.
- c) Currently experiencing symptoms (described above) at sub diagnostic level but risk of escalating.

#### **2= Moderate**

- a) Currently experiencing symptoms indicative of an anxiety disorder (e.g., excessive worry, panic, racing mind, difficulty concentrating) or depressive disorder (e.g., excessive sadness, irritability, exhaustion, disrupted sleep, loss of interest and pleasure) that have typically been present for more than 6 months (but this may vary) but symptoms may be of more recent origin. Symptoms are at a level that would likely meet diagnostic criteria, and/or are associated with a moderate to high level of distress.
- b) Other mental health condition that is associated with moderate to high levels of distress.
- c) History of a diagnosed mental health condition that has not responded to treatment, with continuing symptoms and moderate to high levels of distress.

#### **3= Severe**

- a) A history of significant and ongoing symptoms indicative of a severe mental illness (e.g., hallucinations, paranoia, disordered thinking, extreme mood variation, delusions, extreme avoidant behaviour) but the symptoms are mostly well managed or are re-appearing and at risk of escalation without ongoing assistance.
- b) Other mental health condition that is associated with very high levels of distress.
- c) Recent onset of symptoms indicative of a severe mental illness and the person is experiencing high to very high levels of distress.
- d) Has been admitted to hospital for a mental health condition in previous 12 months.

#### **4= Very severe**

- a) A history of significant and persistent symptoms that are indicative of a severe mental illness (e.g., hallucinations, paranoia, disordered thinking, extreme mood variation, delusions, severe avoidant behaviour) and symptoms are mostly poorly managed.

- b) Recent onset of symptoms that are indicative of a severe mental illness (e.g., hallucinations, paranoia, disordered thinking, extreme mood variation, delusions, or severe avoidant behaviours) presenting in the context of significant complexity requiring multiple agency involvement.
- c) Other long-term mental health condition presenting in the context of significant complexity that requires multiple agency involvement.

## Domain 2 – Risk of Harm (Primary Domain)

An initial assessment should include an evaluation of risk to determine a person’s potential for harm to self or others. Results from this assessment are of fundamental importance in deciding the appropriate level of care required.

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

- suicidality – current and past suicidal ideation, attempts,
- self-harm (non-suicidal self-injurious behaviour) – current and past,
- severe symptoms that pose a danger to self or others, and
- self-neglect that poses a risk to the person’s safety.

The PHQ-9 (item 9) and the EPDS (item 10) include specific items relating to suicide or self-harm risk. If these tools are used, revisit the scores for these items to assist rating this domain.

### **PRACTICE POINT**

Risk of harm must be considered in the context of information gathered on the other 7 domains- information gathered across the other 7 domains (e.g., if the person is experiencing loneliness, or significant environmental stressors) is very important in evaluating harm.

#### **0= No identified risk – no descriptors apply**

#### **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) May have engaged in behaviours in the past that posed a risk to others but no current or recent instances.
- c) Occasional non-suicidal self-injurious acts in the recent past and not requiring surgical treatment.

#### **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) Current or recent behaviours that pose a non-life-threatening risk to self or others.
- c) Frequent non-suicidal self-injurious acts in the recent past and not requiring surgical treatment.

#### **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) Current or recent life-threatening self-harm or dangerous behaviours to self or others.
- c) Clearly compromised self-care ability 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.
- d) Frequent non-suicidal self-injurious acts in the recent past and requiring surgical treatment.

#### **4= Very high risk of harm**

- a) Current suicidal intention with plan and means to carry out. Few or no protective factors.
- b) Long term history of repeated and life-threatening self-harm or dangerous behaviour to self or others that is prominent in the person's current presentation.
- c) Evidence of current severe symptoms (e.g., hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions) with behaviour that poses an imminent danger to self or others.
- d) Extremely compromised self-care ability to the extent that the person is in real and present danger and experiencing harm related to these deficits.

## Domain 3 – Functioning (Primary Domain)

An initial assessment should consider functional impairment caused by or exacerbated by the mental health condition. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining mental health intervention intensity within a stepped care continuum.

Assessment of an individual on this domain should consider:

- a person's ability to fulfil usual roles/ responsibilities,
- impact on or disruption to areas of life (e.g., employment, parenting, education, or other social roles), and
- impact on the person's basic activities of daily living (e.g., self-care, mobility, toileting, feeding, and personal hygiene).

#### **0= No problems in this domain – no descriptors apply**

#### **1= Mild impact**

- a) Diminished ability to function in one or more of their usual roles, including work, social, parenting/care of dependents, education but without significant or adverse consequences.
- b) The person experiences brief and transient disruptions in functioning.

#### **2= Moderate impact**

- a) Functioning is impaired in more than one of their usual roles including work, social, parenting and family, education, to the extent that they are unable to meet the requirements of those roles on average 1 to 2 days per month.
- b) The person experiences 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 person's life (e.g., work, education, interpersonal relationships, or self-care) but the person can function independently with adequate treatment and community support.
- b) The person experiences difficulties with basic self-care (e.g., hygiene, eating, or appearance) on a frequent, consistent basis 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 person's life (e.g., unable to work or participate in education, withdrawal from interpersonal relationships).
- b) Mental health condition contributes to severe and persistent self-neglect that poses a threat to health.

## **Domain 4 – Impact of Co-Existing Conditions (Primary Domain)**

Increasingly, individuals are experiencing and managing multi-morbidity (coexistence of multiple conditions including chronic disease). An initial assessment should specifically examine the presence of other concurrent health conditions that contribute to (or have the potential to contribute to) increased severity of mental health problems and/or compromises the person's ability to participate in the recommended treatment.

Assessment of an individual on this domain should consider:

- substance use/misuse and the associated impact on the individual,
- physical health condition and the associated impact on the individual's concurrent mental health condition, and
- intellectual disability or cognitive impairment.

#### **0= No problem in this domain – no descriptors apply**

#### **1= Minor impact**

- a) 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 person.
- b) Physical health condition(s) present but are stable and do not have an impact on the concurrent mental health condition of the person.

#### **2= Moderate impact**

- a) Ongoing or episodic substance abuse impacting on, or with the potential to impact on, the concurrent mental health condition of the person or ability to participate in treatment.
- b) Physical health condition present and impacting significantly on the mental health condition of the person or their ability to participate in treatment.

#### **3= Severe impact**

- a) Substance use occurs at a level that poses a threat to health or represents a barrier to mental health related recovery.
- b) Physical health condition present and requires intensive medical monitoring and is seriously affecting the mental health of the person (e.g., worsened symptoms, heightened distress).
- c) Intellectual disability or cognitive impairment that impacts significantly on the mental health condition and impedes the person's ability to participate in treatment.

#### **4= Very severe impact**

- a) Severe substance use disorder with inability to limit use without specialist AOD intervention, in the context of a concurrent mental health condition.
- b) Significant physical health conditions exist which are poorly managed or life threatening, and in the context of a concurrent mental health condition.
- c) Severe intellectual disability or severe cognitive impairment that impacts significantly on the mental health condition and impedes the person's ability to participate in treatment.

## Domain 5 – Treatment and Recovery History (Contextual Domain)

This initial assessment domain should explore the individual's relevant treatment history and their response to previous treatment. Response to previous treatment is a reasonable predictor of future treatment need and is particularly important when determining appropriateness of lower intensity services.

Assessment of an individual on this domain should consider:

- whether there has been previous treatment (including specialist or mental health inpatient treatment),
- if the person is currently engaged in treatment, and
- their response to past or current treatment.

When considering this domain relevant treatment refers to treatment by a qualified mental health provider rather than informal care provided by friends, family, or social networks.

### **0= No prior treatment history**

- a) No history of previous treatment for a mental health condition.
- b) In a current treatment arrangement that is appropriate and meets person's needs.

### **1= Full recovery with previous treatment**

- a) Previously sought help for earlier episode(s) and generally able to achieve full recovery with no need for ongoing intervention.

### **2= Moderate recovery with previous treatment**

- a) Previously received treatment for earlier episode(s) and generally able to achieve and maintain partial recovery with limited support.

### **3= Minor recovery with previous treatment**

- a) Recently received treatment for an episode(s) with only minor improvement.
- b) Previously accessed intermittent specialist supports (e.g., psychiatry services, state, and territory specialist mental health services) for current or previous episode but limited response.
- c) Currently receiving treatment but is not making the expected level of progress despite intensive, structured, and medical supports delivered over an extended period.

### **4= Negligible recovery with previous treatment**

- a) Recently received treatment for an episode with negligible or no improvement despite intensive, structured, and specialist medical supports delivered over an extended period.
- b) Ongoing need for or use of specialist supports (e.g., psychiatry services, state and territory services).
- c) Currently receiving treatment but is deteriorating despite intensive, structured, and specialist medical supports delivered over an extended period.

## Domain 6 – Social and Environmental Stressors (Contextual Domain)

This initial assessment domain should consider how the person's environment might contribute to the onset or maintenance of a mental health condition. Significant situational or social complexities can lead to increased condition severity and/or compromise ability to participate in the recommended treatment. Unresolved situational or social complexities can limit the likely benefit of treatment. Furthermore,

understanding the complexities experienced by the individual (with carer/support person perspectives if available), may alter the type of service offered, or indicate that additional service referrals may be required (e.g., a referral to an emergency housing provider).

Assessment of an individual on this domain should consider life circumstances that may be associated with distress such as:

- significant transitions (e.g., job loss, relationship breakdown, sudden or unexpected death of loved one),
- trauma (e.g., physical, psychological, or sexual abuse, witnessing or being a victim of an extremely violent incident, natural disaster),
- experiencing harm from others (including violence, vulnerability, exploitation),
- interpersonal or social difficulties (e.g., conflict with friend or colleague, loneliness, social isolation, bullying, relationship difficulties),
- performance related pressure (e.g., work, school, exam stress),
- ability to or difficulty having basic physical, emotional, environmental, or material needs met (such as homelessness, unsafe living environment, poverty), and
- legal issues.

**0= No problem in this domain – no descriptors apply**

**1= Mildly stressful environment**

- a) Person experiences their environment as mildly stressful.

**2= Moderately stressful environment**

- a) Person experiences their environment as moderately stressful.

**3= Highly stressful environment**

- a) Person experiences their environment as highly stressful.

**4= Extremely stressful environment**

- a) Person experiences their environment as extremely stressful.

## Domain 7 – Family and Other Supports (Contextual Domain)

This initial assessment domain should consider whether informal supports are present and their potential to contribute to recovery. A lack of supports might contribute to the onset or maintenance of the mental health condition and/or compromise ability to participate in the recommended treatment.

**0= Highly supported**

- a) Substantial and useful supports willing to and capable of providing ample emotional support.

**1= Well supported**

- a) A few useful supports are available and willing to and capable of providing support in times of need.

**2= Limited supports**

- a) Usual sources of useful support may be reluctant to provide support, difficult to access, or have insufficient resources to provide support whenever it is needed.

**3= Minimal supports**

- a) Very few actual or potential useful sources of support are available.

#### **4= No supports**

- a) No useful sources of support are available.

## **Domain 8 - Engagement and Motivation (Contextual Domain)**

This initial assessment domain should explore the person's understanding of the mental health condition and their willingness to engage in or accept treatment.

Assessment of an individual on this domain should include the individual's:

- understanding of the symptoms, condition, and impact,
- ability and capacity to manage the condition, and
- motivation to access necessary supports (particularly important if considering self-management options).

#### **0= Optimal**

- a) Complete understanding of condition and impacts.
- b) Takes an active role in managing condition.
- c) Motivated about recovery and competently accesses support as needed.

#### **1= Positive**

- a) Good understanding of condition and impacts.
- b) Capable of taking an active role in managing condition.
- c) Mostly willing to accept supports as needed.

#### **2= Limited**

- a) Limited understanding or confusion about condition and impacts.
- b) Unlikely to access supports without prompting and encouragement.
- c) Limited interest in taking an active role in managing condition.

#### **3= Minimal**

- a) Rarely accepts reality of condition but may acknowledge associated situational difficulties.
- b) No ability or interest in managing the condition.
- c) Some reluctance to accept supports, does not use resources available.

#### **4= Disengaged**

- a) No awareness or understanding of the condition and impacts.
- b) Actively avoids managing the condition.
- c) Deliberately avoids potentially useful and available supports.



# Appendix 1 – Decision Support Tool

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 person’s 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.

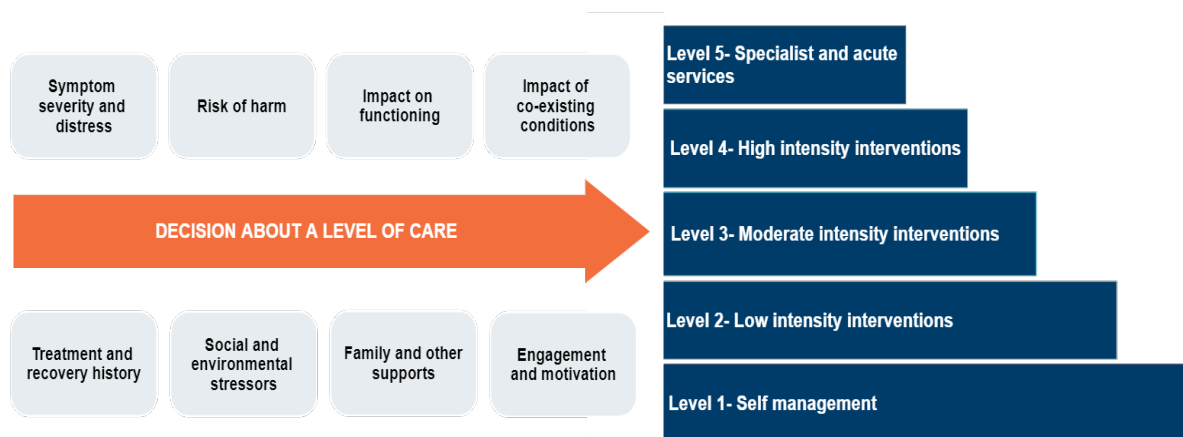
The approach described in this Guidance aims to unpack the referral decision process into its component parts and describe a logic for determining the recommended level of care for a person presenting for assistance with a mental health problem.

Assessment on the eight domains detailed in Section 6 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. Any given individual 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 person’s intensity of needs and referral to a level of care needs to consider all assessed domains and their component factors in combination.

An individual’s presenting problems on each domain can interact in different ways. As an example, a person 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 a person 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 7

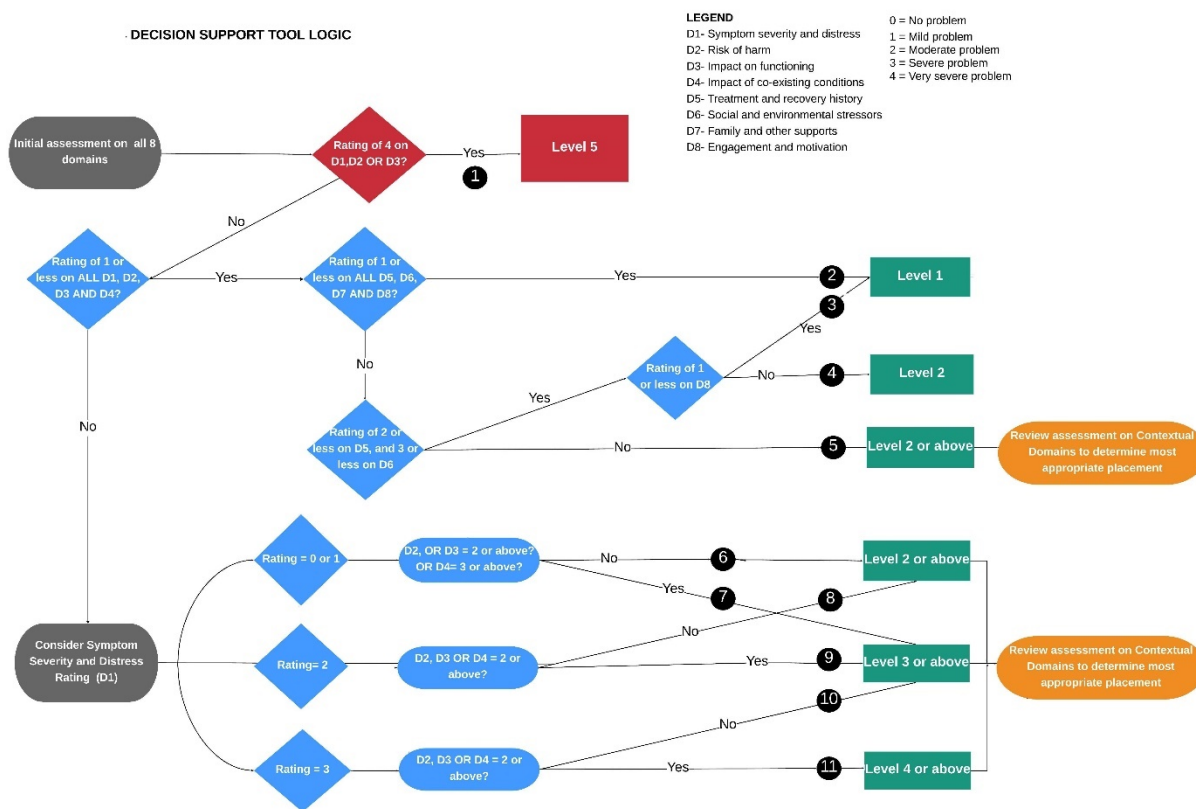
Figure 7: Mapping assessments on 8 interactive domains to 5 levels of care



## Decision Support Tool Logic

Figure 8 summarises the proposed logic that underpins the decision support tool. It shows how ratings of the domains using the glossary scoring guide provided in Section 6, and interactions between the domains, can be applied to guide referral decisions.

Figure 8: Decision support tool logic for mapping assessment on domains to levels of care



## 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 by the use of 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.

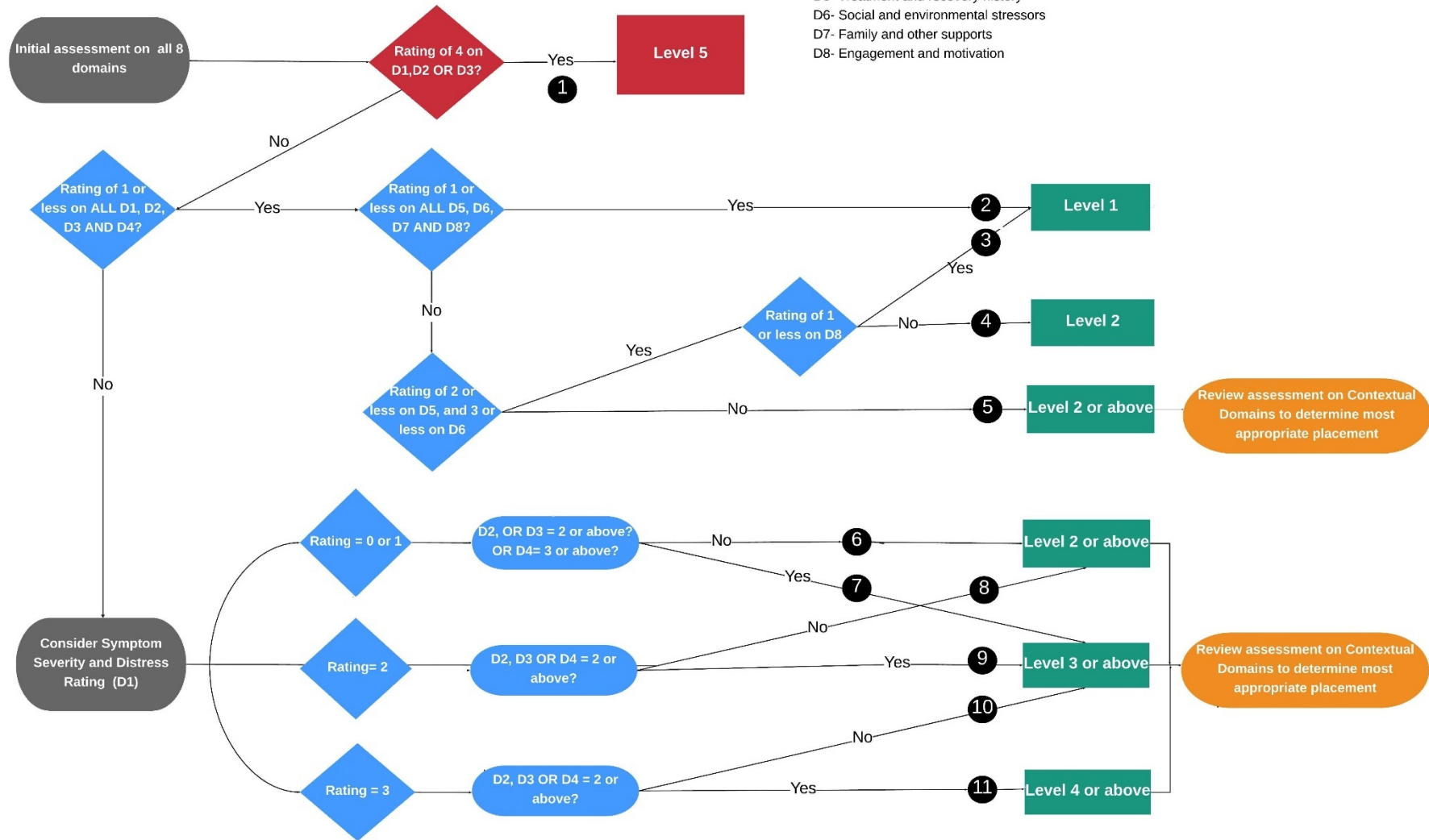
**Pathways 2 – 5:** targets people with relatively minor problems on primary domains. Decisions about this group are guided using treatment history (D5) and other contextual domains, into (mostly) Level 1 or 2 care.

**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 (as yet) unmapped. Most of this group are expected to be referred to Level 2 or above.

**DECISION SUPPORT TOOL LOGIC**

**LEGEND**

- D1- Symptom severity and distress
  - D2- Risk of harm
  - D3- Impact on functioning
  - D4- Impact of co-existing conditions
  - D5- Treatment and recovery 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



# Appendix 2 – Guide to the Digital Decision Support Tools

## Overview of the Digital Decision Support Tools (DSTs)

The Australian Government Department of Health has funded the development of automated digital options to assist in the translation of assessment ratings on the eight domains to a recommended level of care. These options remove the requirement for users of the IAR guidance to manually convert assessment ratings using the decision logic outlined in the guidance document.

Recognising the many different environments in which the IAR guidance materials are being implemented, two options have been developed to provide for maximum flexibility:

### Online Decision Support Tool

This simple tool allows individual practitioners to enter the eight domain ratings and view the derived level of care outcome online. The tool:

- Does not require the capture of any identifying information.
- Does not require authentication.
- Provides access to context sensitive help regarding the eight domains.
- Processes the entered scores and presents the recommended level of care.
- Provides access to context sensitive help regarding the recommended level of care.
- Provides a responsive experience across devices from phones through to desktop computers.
- Allows the user to copy a CSV row of the domain scores to facilitate data collection into an existing spreadsheet.
- Allows the user to download a CSV file of the domain scores to facilitate data collection in a new spreadsheet.
- Meets Australian Government accessibility requirements.
- Meets Australian Government security requirements.

### Application Programming Interface (API)

This service may be utilised by organisations wanting to easily integrate into their own local systems the capture of the eight domain scores and the computations of the recommended level of care that are generated by the Online Decision Support Tool. The mechanism for doing this is via a request over the internet to the API service from the organisation's local system. The Online API:

- Does not require the capture of any identifying information other than the organisation making the request.
- Requires the integrator to use an API key linked to their organisation (an API key creates a linkage to the origin of the request).
- Allows submission of the eight domain scores.
- Processes the entered scores and return the recommended level of care.
- Meets Australian Government security requirements.

## Reference Implementation and Test Data Set

The reference implementation has been developed as a software library. The library consumes the eight domain scores and returns the derived recommended level of care via an implementation of the scoring algorithm.

The reference implementation can be used by third party developers to understand how to best create a local implementation of the scoring algorithm. This might be desirable where a different programming language to the one used in the reference implementation is a local requirement. It may also be integrated into local systems. This method of integration does not require the integrator to send data to an external system over the internet. The reference implementation:

- Implements the scoring algorithm required to consume the 8 domain scores and return the resulting recommended level of care.
- Includes documentation for developers.
- Includes examples of use; and
- Includes a test suite to ensure accuracy.

A test data set has been developed covering a large number of possible combinations of domain ratings and the associated derived level of care. The test data set may be used by third party developers who wish to implement the scoring algorithm themselves.

## Digital Decision Support Tools- Conditions of use

The following conditions apply to use of digital decision support tools:

1. Both digital options are being made available to PHNs for use only by commissioned service provider organisations, associated referrers and other stakeholders.
2. Use of the digital tools by PHNs, commissioned provider organisations, referrers and other stakeholders should be on the understanding that the logic underpinning the DST may change.

Additionally:

- Specific Terms of Use have been defined for users of the Online Decision Support Tool. These require the user to indicate their acknowledgement that use of the tool is not a substitute for independent professional knowledge and clinical judgement and agree to the defined Terms of Use. These are set out in Attachment A: Terms of Use for the Online Decision Support Tool.
- Users of the API are required to agree to an 'Integrator Agreement' that sets out Terms of Use appropriate to their role. These are provided at Attachment B: Integrator Agreement – Application Programming Interface.

For the reference implementation and test data set only:

- Organisations seeking to embed the DST logic into their own local software must test the accuracy of their coding by validating results using the supporting test data.

## How to access the Digital Decision Support Tools

### Online Decision Support Tool

The online Decision Support Tool is available at <https://iar-dst.online/#/>. Users are required to indicate acknowledgment and acceptance of the Terms of Use as a pre-requisite to accessing the tool. This will occur via a simple 'click wrap' agreement process. Documentation on use of the online decision support tool is available at <https://docs.iar-dst.online/en/latest/>. The documentation includes extracts from the IAR Guidance and a user guide.

## Online API

The digital decision support tool has been integrated into the existing Online Measures Self Service System (OMSSS) API, which PHNs are already integrating into their systems. While the stand-alone online interface may be used separately, OMSSS provides an automatable mechanism for capturing decision support tool scores and the recommended level of care for use in local systems.

Documentation regarding use of the OMSSS REST API is available at <https://api.omsss.online/>

To obtain an account to access the OMSSS REST API, please contact [support@logicly.com.au](mailto:support@logicly.com.au). Access to an account requires the user (referred to as an 'integrator') to indicate acknowledgment and acceptance of the Terms of Use set out in the 'Integrator Agreement' at Attachment B: Integrator Agreement – Application Programming Interface. Once the user has completed this process, they will be issued with a unique Key that is linked to their organisation.

## Reference library and test data set

To obtain access to the reference library and/or the test data set, please contact [support@logicly.com.au](mailto:support@logicly.com.au). Access requires the user (referred to as an 'integrator') to indicate acknowledgment and acceptance of the Terms of Use set out in the 'Integrator Agreement'. Once the user has completed this process, they will be issued with access to the materials.

## Data security and privacy issues

It is not necessary to transmit or have stored any personally identifying information in order to make use of the digital decision support tools.

The stand-alone online decision support tool:

- Does not require the capture of any identifying information; and
- Does not require authentication.

Similarly, the online API:

- Does not require the capture of any identifying information other than the individual organisation making the request, and the organisation which they are acting for.
- Requires the integrator to use an API key linked to their organisation.
- An integrator may include a "label" when requesting an IAR-DST measure that is to be completed by a health practitioner. The sole purpose of this label is to identify to the health practitioner who is invited to complete the Decision Support Tool which client is the intended subject. The label information will be displayed on the page presented to the health practitioner completing the assessment when they access it via the unique link. The label persists only until such time as the assessment is submitted by the practitioner. At that point the label is removed permanently ensuring that the IAR ratings and identifying information are never stored together within the OMSSS, nor transmitted together through the internet.

For PHNs that are seeking to implement digital solutions within their current operating environments, the Department cautions against PHNs working with vendors to develop their own programming code or API for the decision support logic. The following risks for doing so have been identified:

1. Independently developed programming code may not be subject to the same rigorous testing that the Commonwealth has required of its vendor (Logicly).
2. Independently developed programming code will not have access to changes in and updates to the code and API that may emerge.

To access the Digital Decision Support Tools, email [MH.IARProject@health.gov.au](mailto:MH.IARProject@health.gov.au)

# Attachment A: Terms of Use for the Online Decision Support Tool

## SHORTFORM

I agree to the Terms of Use [hyperlink] and acknowledge that my use of the Online Decision Support Tool is not a substitute for independent professional knowledge and clinical judgement.

[Accept button] [Cancel button]

## FULL TEXT

Welcome to the Initial Assessment and Referral for Mental Healthcare (IAR-MH) Online Decision Support Tool. As a condition of Your use of the Online Decision Support Tool and its documentation and guidance material (“Online Decision Support Tool”) You must agree to these Terms of Use each time you use the Online Decision Support Tool.

In these Terms of Use, the terms:

- “You” and “Your” refer to the user of the Online Decision Support Tool.
- “Permitted Purpose” refers to the conduct of an assessment and referral of one or more individuals presenting for assistance with a mental health condition.

The Commonwealth of Australia as represented by the Department of Health (the “Department”) may at its discretion update these Terms of Use. By continuing to use the Online Decision Support Tool, You accept the Terms of Use as they apply from time to time.

### LICENCE

Subject to these Terms of Use, the Department grants You a non-exclusive, non-transferable and royalty free licence to use the Online Decision Support Tool for the Permitted Purpose, revocable at will.

### LICENCE CONDITIONS

You must:

- a) use the Online Decision Support Tool in accordance with any guidelines and directions that may be issued by the Department from time to time.
- b) not sublicense, commercialise or sell the Online Decision Support Tool.
- c) not, in conjunction with your use of the Online Decision Support Tool, use the Commonwealth Coat of Arms or any other Commonwealth or Department logos at any time.
- d) not attempt to undermine the security or integrity of the Online Decision Support Tool; and
- e) not use or misuse the Online Decision Support Tool in any way which may disrupt or impair the functionality of the Online Decision Support Tool or other systems used for the Online Decision Support Tool.

### YOUR OBLIGATIONS

In consideration of Your use of the Online Decision Support Tool, You:

- Acknowledge that use of the Online Decision Support Tool is not a substitute for professional knowledge and clinical judgement. Systems and processes for initial assessment and referral should consider the unique and personal circumstances of the individual client, including other health or social issues, their preferences and choices, and any risk or safety issues.
- Acknowledge that the intellectual property rights in the Online Decision Support Tool are owned by or licensed to the Department and nothing in these Terms of Use operates, or is intended to operate, to give You any ownership rights in the Online Decision Support Tool.

- Indemnify the Department for any loss or damage the Department suffers in connection with Your use of (including reliance on) the Online Decision Support Tool or any breach of these Terms of Use.

## **DISCLAIMERS AND RISK**

You acknowledge and agree that:

- Your use of the Online Decision Support Tool is at Your own risk, and You have made an independent assessment as to the risks of using the Online Decision Support Tool.
- The Department may at any time add to, remove or otherwise modify any or all of the content in the Online Decision Support Tool at its discretion and without prior notice to You.
- The Department may remove your access to the Online Decision Support Tool at any time without prior notice to You.
- The Online Decision Support Tool may include the views or recommendations of third parties and does not necessarily reflect the views of the Australian Government or indicate a commitment to a particular course of action.
- The Department does not guarantee and assumes no legal liability or responsibility for the accuracy, currency, completeness or interpretation of the Online Decision Support Tool.
- The Department gives no warranty or guarantee in connection with the Online Decision Support Tool. Among other things, the Department makes no guarantee that the Online Decision Support Tool will be available for use, that the Online Decision Support Tool is error-free and free of defects, viruses or harmful code, that defects and errors will be corrected, or that use of the Online Decision Support Tool will be uninterrupted.
- To the maximum extent permitted by law, the Department excludes all liability and responsibility to You (or any other person) for any loss (including loss of information, data, profits and savings) or damage (including injury and harm) resulting, directly or indirectly, in connection from Your (or any other person's) use of, or reliance on, the Online Decision Support Tool.

## **GENERAL**

These Terms of Use are governed by the laws of the Australian Capital Territory, Australia, and You agree to submit to the exclusive jurisdiction of the courts of the Australian Capital Territory.

If either party waives any breach of these Terms of Use, this will not constitute a waiver of any other breach. No waiver will be effective unless made in writing.

You agree and acknowledge that these Terms of Use constitute the entire agreement between You and the Department in relation to the use of the Online Decision Support Tool and replace all previous agreements, licences, understandings, representations and warranties in relation to this subject matter.



## Attachment B: Integrator Agreement – Application Programming Interface

You must agree to this **Integrator Agreement** to integrate and use the Initial Assessment and Referral for Mental Healthcare (IAR-MH) Online Decision Support Tool API **made available by the Commonwealth of Australia as represented by the Department of Health (the “Department”)**.

In this Integrator Agreement, the terms:

- “API” means the Application Programming Interface and associated documentation and source code, executable applications, unique access key and other materials including the Digital Tools.
- “API Client” refers to the client information management system, software or local system in which the API will be integrated.
- “Digital Tools” means the reference implementation and the test data set.
- “Harmful Code” means any virus, denial of service, disabling or malicious device or code, worm, trojan, time bomb, or other harmful or destructive code.
- “Online Decision Support Tool” means the Initial Assessment and Referral for Mental Healthcare (IAR-MH) Online Decision Support Tool as amended by the Department from time to time.
- “Permitted Purpose” means the integration of the API with the API Client to allow Users to access the Online Decision Support Tool through the API Client; and
- “User” means the end-user of the Online Decision Support Tool.
- “Term” means the period which commences on the date on which You accept this Integrator Agreement and continues until the earlier of:
  - You cancel Your use of the API and access to the Online Decision Support Tool by notifying the Department in writing; or
  - The Department terminates Your use of the API and Your access to the Online Decision Support Tool; and
  - “You” and “Your” refers to you, being an organisation or person seeking to use the API and integrate it in the API Client and includes your officers, agents, and employees and subcontractors.

The Department may at its discretion update this Integrator Agreement. By continuing to use the API, You accept the terms of the Integrator Agreement as they apply from time to time.

### LICENCE

Subject to this Integrator Agreement, the Department grants You, during the Term, a revocable, non-exclusive, non-transferable and royalty free licence to use and integrate the API for the Permitted Purpose.

### LICENCE CONDITIONS

You must:

- a) use and integrate the API in accordance with any guidelines and directions that may be issued by the Department from time to time.
- b) not sublicense the API (whether or not as part of the API Client) to any third parties without the prior written consent of the Department.
- c) not commercialise or sell the API.
- d) not, in conjunction with your use of the API, use the Commonwealth Coat of Arms or any other Commonwealth or Department logos at any time.
- e) not attempt to undermine the security or integrity of the API or the Online Decision Support Tool.

- f) not use, or misuse the API in any way which may disrupt or impair the functionality of the API, the Online Decision Support Tool or other related systems.
- g) not use the API (whether or not as part of the API Client) to transmit information or materials that contain a virus or other harmful components.
- h) store the unique API key and any other access credentials supplied by the Department securely and not provide these to any other person without the prior written consent of the Department. You must immediately notify the Department of any breach of this condition; and
- i) take steps to secure the API Client and Your systems and software against any Harmful Code that may be introduced to these systems due to the use of the API or access to the Online Decision Support Tool.

## **YOUR OBLIGATIONS**

In consideration of Your use of the API and access to the Online Decision Support Tool You:

- Acknowledge and agree that the unique API key and any other access credentials supplied by the Department are confidential to You.
- Acknowledge that the intellectual property rights in the API and the Online Decision Support Tool are owned by or licensed to the Department and nothing in this Integrator Agreement operates, or is intended to operate, to give You any ownership rights in them.
- Acknowledge that the Department has no obligation to provide any assistance or technical support in relation to the integration of the API into the API Client or the use of the API generally.
- Remain liable for the access and use of the Online Decision Support Tool through the API Client by any third parties to which you provide access.
- Indemnify the Department for any loss or damage the Department suffers in connection with the use or integration of the API, or access to the Online Decision Support Tool, by You or any third party to which you provide access, or any breach of this Integrator Agreement.

## **SOFTWARE DEVELOPMENT**

You may outsource the integration of the API into the API Client to a third-party developer as long as You:

- ensure the third-party developer is aware of, and complies with, the terms of this Integrator Agreement; and
- accept all responsibility and liability for the use and integration of the API by the third-party developer.

## **BREACH AND TERMINATION**

If You breach any of the terms of this Integrator Agreement, do not comply with any guidelines or directions issued by the Department regarding the API or the Online Decision Support Tool, or if you provide the Department with incomplete, inaccurate, false or misleading information (or if the Department reasonably believes that any of these things has occurred), the Department may without notice:

- terminate Your use of the API and access to the Online Decision Support Tool (including by revoking your unique API key or other access credentials); or
- suspend for any period of time Your use of the API and access to the Online Decision Support Tool.

## **DISCLAIMERS AND RISK**

You acknowledge and agree that:

- Your use of the API is at Your own risk, and You have made an independent assessment as to the risks of using and integrating the API.

- The Department may at any time add to, remove or otherwise modify any or all of the content in the API or the Online Decision Support Tool at its discretion and without prior notice to You.
- The Online Decision Support Tool may include the views or recommendations of third parties and does not necessarily reflect the views of the Australian Government or indicate a commitment to a particular course of action.
- The Department does not guarantee and assumes no legal liability or responsibility for the accuracy, currency, completeness or interpretation of the API or the Online Decision Support Tool.
- The Department provides the API and access to the Online Decision Support Tool 'as is' and gives no warranty or guarantee in connection with them. Among other things, the Department makes no guarantee that the API and access to the Online Decision Support Tool will be available, is error-free and free of defects, viruses or Harmful Code, that defects and errors will be corrected, that use will be uninterrupted, or that they will be compatible with any systems or standards.
- The Department does not make any undertaking as to service availability or performance of the Online Decision Support Tool, and access and usage limitations are subject to change at any time by the Department.
- To the maximum extent permitted by law, the Department excludes all liability and responsibility to You (or any other person) for any loss (including loss of information, data, profits and savings, and including any loss caused by Harmful Code) or damage (including injury and harm) resulting, directly or indirectly, in connection from Your (or any other person's) use of or reliance on, the API or the Online Decision Support Tool.

## **GENERAL**

This Integrator Agreement is governed by the laws of the Australian Capital Territory, Australia, and You agree to submit to the exclusive jurisdiction of the courts of the Australian Capital Territory.

If either party waives any breach of this Integrator Agreement, this will not constitute a waiver of any other breach. No waiver will be effective unless made in writing.

You agree and acknowledge that this Integrator Agreement constitutes the entire agreement between You and the Department in relation to the API, and replaces all previous agreements, licences, understandings, representations, and warranties about that subject matter. You acknowledge, however, that You may be required to agree to additional terms prior to using the Online Decision Support Tool.

# Appendix 3 – Interpreting Standard Assessment Tools to Guide Assessments on Domain 1 and Domain 3

Standardised assessment tools such as the K10, K5 (for Aboriginal People), PHQ-9, GAD-7 and the EPDS can be useful tools for guiding ratings on Domain 1 (Symptom Severity and Distress). The Work and Social Adjustment Scale (WSAS) can be a useful tool for guiding ratings on Domain 3 (Functioning). The thresholds should not be used to determine a rating on Domain 1 or Domain 3 but may be useful in understanding symptom severity and distress, and functioning. Indicative thresholds for the more commonly used instruments are summarised below.

## 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 from the consumer. 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.

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

## Kessler-10+ (K10+)

The K10+ is a simple consumer-completed measure of non-specific psychological distress and is a mandated assessment tool for monitoring outcomes in the Primary Mental Health Care Minimum Data Set (PMHC MDS). Thresholds for categorising K10+ scores provided below are used by the Australian Bureau of Statistics, based on population normative data.

Total score	Level of psychological distress
10-15	Low
16-21	Moderate
22-29	High
30-50	Very high

*Source for thresholds: Australian Bureau of Statistics (2012), 4817.0.55.001 - Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2007-08.*

It is essential to note that these thresholds are based on the distribution of K10+ scores in the **general population**, derived from general household surveys, and **do not reflect clinical samples** – that is, people who present for assistance with mental health problems. In general, people presenting for help have significantly increased K10+ scores compared with the general population. For example, based on PMHC MDS data, 84% of clients receiving mental health services commissioned by PHNs have K-10 scores in the High or Very high categories (Score 22+) compared with 13% of the general population; 58% report distress in the Very high (score 30+) range compared with 4% of the general population. These findings highlight that the K10+ scores when used alone should not be interpreted as aligning directly with Domain 1 rating levels (e.g., a rating of 4 'Very severe' on Domain 1 is not simply equivalent to a K10+ score of 30+). Remember

that the K10+ identifies **non-specific** distress and that high levels might be attributable to factors other than mental health problems.

### Kessler-5 (K-5)

The K-5 measure of psychological distress is based on a subset of five questions taken from the Kessler Psychological Distress Scale-10 (K-10) used to measure psychological distress among Aboriginal and Torres Strait Islander Peoples.

Total score	Level of psychological distress
5-7	Low
8-11	Moderate
12-14	High
15-25	Very high

*Source for thresholds: Australian Institute of Health and Welfare 2009. Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. Cat. no. IHW 24. Canberra: AIHW*

### Patient Health Questionnaire 9 (PHQ-9)

The PHQ-9 is a brief consumer-completed measure designed to gauge the severity of depressive symptoms. Thresholds for categorising PHQ-9 scores are provided below.

Total score	Depression severity
0-4	No depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

*Source for thresholds: Kroenke K, Spitzer RL. (2002). The PHQ-9: A new depression and diagnostic severity measure. Psychiatric Annals, 32, 509-52.*

### Generalised Anxiety Disorder Scale (GAD-7)

The GAD-7 is a screening and severity measure for generalized anxiety disorder, the GAD-7 is also suitable for three other common anxiety disorders – panic disorder, social anxiety, and post-traumatic stress disorder (though it is desirable to use additional disorder-specific questionnaires).

Total score	Level of anxiety severity
0-4	Minimal
5-9	Mild
10-14	Moderate
15+	Severe

*Source for thresholds: Spitzer, R. L., Kroenke, K., Williams, J. B. W. & Lowe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. Arch. Intern. Med., 166, 1093-1097.*

## Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a validated 10 item self-report measure designed to detect symptoms of depression during pregnancy and the postnatal period. Unlike the other assessment tools referenced in this Guidance, the EPDS is focussed on screening and identifying people who may be experiencing depression in the perinatal period (case finding). The EPDS thresholds below do not provide a reliable indicator of the level of severity and therefore should be considered with caution if being used to inform a rating on Domain 1.

Total score	Interpretation
0-9	Nil- or presence of some symptoms of distress that may be short-lived and unlikely to impact on functioning
10-12	Presence of some symptoms of distress that may be discomforting
13+	Symptoms indicating high likelihood of depression of varying severity

Source for thresholds: [Black Dog Institute](#)

## Work and Social Adjustment Scale (WSAS)

The WSAS is a measure of functional impairment pertaining to work and social functioning. WSAS is a 5-item self-report scale.

Total score	Interpretation
0-10	Nil to mild impairment
11-20	Significant impairment
21+	Moderately severe to very severe impairment

Source for thresholds: *Mundt, J.C. et al. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. The British Journal of Psychiatry, 180, 461-464*

# Appendix 4 – PHN Summary Report

A national PHN survey (Survey 1) was undertaken throughout November and December 2017 to inform the development of the National IAR Guidance. The PHN Summary Report, was made available to PHNs via SharePoint. The survey took the form of a structured interview with pre-determined questions designed to elicit consistent information from across the PHN network. The national survey was conducted via telephone.

For the interviews, each PHN was invited to include internal personnel relevant to mental health initial assessment and referral processes. In all instances, an executive or senior manager responsible for mental health participated in the interviews. All 31 PHNs participated in the survey. There was a strong indication of support for the development of national guidance for initial assessment and referral.

The questions sought to explore existing initial assessment and referral processes and where possible, secure access to copies of policies, procedures, tools, and other resources in use by each PHN. Finally, the survey examined PHN identified needs associated with National Guidance material and resources.

The PHN Summary Report confirmed that there are 4 typical intake and referral mechanisms in place across PHNs. These include:

1. Centralised intake process coordinated by the PHN.
2. Centralised intake process coordinated by a commissioned provider.
3. Direct to provider referral pathways.
4. A combination of the above (including where intake is facilitated for PHN commissioned and non-PHN commissioned services).

In some PHN regions there is a mix of mechanisms (e.g., central intake services for psychological interventions and referrer to provider direct pathways for suicide prevention services).

Irrespective of the intake and referral mechanism, the majority of PHNs indicated that referrers, and particularly GPs, are very influential when determining the most appropriate service type and intensity. Analysis by the Department of Health of the Primary Mental Health Care minimum data set – covering service delivery commissioned by PHNs – indicates that 75% of all referrals for PHN commissioned mental health services were made by GPs.

Where GPs are not the referrers, PHNs typically mandate that engagement with the GP occurs early in the episode of care.

This information is critical in understanding who is responsible for decision making and when. In recognition of the role of referrer influence, PHNs spoke about the importance of:

- Increasing the referrer acceptability of, and confidence in, new service models (e.g., low intensity), so that new service models are viewed as appropriate, effective and evidence based.
- Improving referrer capability regarding screening and assessment.
- Enhancing referrer knowledge of evidence-based interventions, and how to match individual clinical needs and goals with the most appropriate service type and intensity.
- Building familiarity with and confidence in the stepped care model and related concepts.

This reinforces the importance of PHNs developing and implementing appropriate support mechanisms for GPs and other providers to undertake initial assessment to ensure they are referred to the service which best targets their clinical need and recovery goals.

Survey 2 was undertaken during August and September 2020. The survey took the form of a structured interview process, with pre-determined questions designed to elicit consistent information from across the network. The national survey was conducted via telephone with each interview taking 1-1.5 hours.

Initial contact (via email) was made in August 2020 with all 31 PHNs to arrange a time for a telephone interview. Each PHN was invited to include internal personnel relevant to the implementation of the IAR Guidance. In all instances, an executive or manager responsible for mental health participated in the interviews. 28 PHNs participated in the telephone interviews.

This survey was conducted after the release of the National IAR Guidance. PHNs were asked to describe their progress towards implementation of the Guidance.

- 15 PHNs reported that implementation of IAR has commenced.
- 8 PHNs reported active planning for implementation.
- 8 PHNs identified that implementation or implementation planning has not yet commenced and were awaiting the outcomes of the Implementation Review.

Many implementation enablers were identified by PHNs. The following common enablers were identified during the interviews with PHNs:

### **Digital decision support tools and smart referral forms**

PHNs who already have a digital platform were able to fast track integration of the IAR-DST into smart referral forms where the logic and the recommended level of care was automated. Some PHNs were able to customise the information about the level of care with information about local services based on the level of care that had been generated.

### **Education and training**

PHNs who engaged the National Project Manager or local clinical champions to deliver training in IAR found higher levels of acceptability and enthusiasm for use of the IAR-DST. Training ahead of exploratory conversations and co-design workshops helped to ensure that stakeholders had good awareness of IAR and the IAR-DST and were better prepared to participate in discussions exploring the implementation of IAR in the region.

### **Collaboration and co-design with local stakeholders**

Whilst potentially resource intensive, PHNs who have invested time and resources in collaborating and co-designing with local stakeholders (including consumer and carer lived experience representatives, GPs, allied mental health clinicians, service providers) have reported higher levels of support for local implementation. Collaboration and co-design do not alleviate all challenges, but sector-led implementation of IAR has resulted in some exciting observations. PHNs who have situated IAR and stepped care in the context of Regional Mental Health and Suicide Prevention Plans are benefiting from LHN input and partnerships.

### **Implementation challenges**

Focussing implementation of IAR at the point of referral is widely acknowledged as the most resource-intensive and challenging change management approach. However, there are several reported benefits in doing so:

- The IAR-DST is utilised by a clinician/practitioner who may have some familiarity and rapport with the consumer.
- The IAR-DST is used as early as possible in the consumer's journey, matching treatment need to treatment options. This may result in a consumer locating the right care in a timely way- reducing the delays. Early challenges in locating an appropriate service can lead to further deterioration of mental health and contribute to a person giving up on help seeking.

### **Acceptability and uptake of Level 1 and Level 2 services**

Most PHNs are still working hard to build acceptability of the evidence around Level 1 and Level 2 services and increase uptake. Many PHNs reported that commissioned Level 2 services are under-utilised. Where



utilisation has improved, is generally where the decision is centralised or controlled by the commissioned provider, limiting the option for referrers to default to Level 3 care (which is the most common default option reported by PHNs). Equally, Level 3 services continue to be over-subscribed with many PHNs identifying unmet demand.

### **Limited steps in a stepped care approach**

For some PHN regions, or sub-regions, there are limited services available and for some communities- some of the levels of care or components of the levels of care do not exist. Furthermore, many services may be place-based and integrated within existing local services (e.g., Aboriginal Community Controlled Health Services). For PHNs in this situation, it is not one major system reform, but multiple micro-system reforms.

### **Implementation review**

The Implementation Review aimed to identify the implementation strategies and approaches being adopted by PHNs; explore the barriers and enablers to implementation of the Guidance and; determine the overall engagement with the Guidance to support the Initial Assessment and Referral Processes for stepped care in mental health. There were seven key review questions, which are as follows:

1. To what extent do PHNs consider the Guidance useful in supporting initial assessment and referral?
2. To what extent have the various elements of the IAR project been delivered (fidelity), how well have they been delivered (quality) and are they appropriate? For example, use of the assessment domains for informing the initial assessment and referral, the 5-level of care schema to service delivery contexts, and the decision support tool.
3. To what extent have differences in implementation affected the use of the initial assessment and referral?
4. To what extent did the Guidance assist PHNs to establish clinical governance systems and policies? What has been the influence of these systems and policies on implementing the initial assessment and referral?
5. Have PHNs allocated sufficient resources to implement the project?
6. What are the barriers and enablers to the implementation of the initial assessment and referral in primary mental health care? How can the barriers be overcome?
7. What change management approaches will be required to support clinicians and service providers?

The Implementation Review report represents the overall findings of the Implementation Review which was conducted to examine how the Guidance was implemented by PHNs. There were nine participating PHNs in the Implementation Review which was conducted by The University of Melbourne 2019-2020. Four PHNs were engaged in what was termed, Round 1 (2019) and the remaining five were engaged in Round 2 in 2020, the locations are described within the introduction to the report.

A major finding of the Review was that there was overwhelming support for the DST by providers and referrers but there was a need to understand where and how both an assessment or a review of mental health needs would be undertaken in the health system and a need for greater articulation of step up and step-down approaches within the stepped care model.

In addition to this, the review identified that:

- Engagement with general practitioners and other primary care providers of mental health would be beneficial.
- Considering the need for greater integration within primary care, understanding the GP clinical workflow alongside other providers is important for thinking about the integration of the DST within this context. This includes the question of how a provider might access the DST from their current electronic systems to complete an assessment and if this is within the consultation how this fits within the flow, and how do GPs easily maintain a record of the outcome (e.g., referrals made) for future reference and review purposes within electronic medical records.

- With the COVID-19 pandemic in the picture, thinking about DST integration and referral pathways in the telehealth context is also required.
- The Guidance document would benefit from further work to provide users with at-a-glance formats to support wider implementation and application. Similar feedback was received for the supportive information provided within the online DST. Providers and referrers valued reading about the indications for care for each level and the types of services that support this, but to review in detail within a busy consultation would be challenging. Clearly, many providers will develop familiarity with the content over time, however, the at-a-glance format is worth further consideration.
- There is no consumer interface within the current assessment process of the DST. To embed collaborative models of care and supported decision making approaches this should be a next step in the DST adaptations – this might be an avenue for PHNs to explore within the local contexts of their regions and the operating systems they have in place. Is there scope for example for greater integration with Health Pathways systems?
- Further development of technological tools that can assist a provider to match a person to available services in specific regions based on the identified level of care and needs would be a logical next step.
- Clinical governance structures and systems are in place, however, monitoring the appropriateness and effectiveness of these is required. Identification of who ought to conduct this monitoring and how would be important in the next stages for the implementation of the Guidance.
- The training offered to PHNs to use the DST and implement the Guidance through webinars has undoubtedly been an enabler. Round 2 established that integration of the DST within the general practice setting for use by GPs or mental health nurses would require further education and understanding of the clinical workflows for implementation.

# Acknowledgements

The Expert Advisory Group provided expert clinical advice regarding the development of the Guidance. Their expertise included regular meetings over 12-months, considerable out of session work, and sharing valued expertise with the project team. Members included:

## Current membership

Member	Position, Organisation
Dr Caroline Johnson (Member, Stages 1-4, Chair, Stage 5)	General Practitioner, Senior Lecturer, University of Melbourne
Vikki Ryall (Stage 5)	Executive Director, Headspace National
Amelia Callaghan (Stage 5)	Director, Clinical Services Reform, Orygen
Vinita Godinho, PhD (Stage 4-5)	General Manager, Policy and Advocacy, Australian Psychological Society
Dr Cathy Andronis (Stage 5)	Representative, Royal Australian College of General Practitioners
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Member	Position, Organisation
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Hayley Solich (Stage 5)	Carer representative
Anthea Raven (Stage 5)	Department of Health
Christine Presland (Stage 5)	Department of Health
Sarah Coleman (Stage 5)	Department of Health
Lisa Bentley (Stage 4-5)	Department of Health
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Angela Scarfe	Senior policy advisor, Australian Association of Social Workers
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Jenni Campbell (Stage 1-5)	National Project Manager, Morgan Campbell Health Consultants