Australian Government

Department of Health

PHN Initial Assessment and Referral (IAR) for Mental Healthcare

STATE OF PLAY REPORT

February 2021

Contents

LIST OF ACRONYMS

ACCHO	Aboriginal Community Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
AOD	Alcohol and other drugs
ASD	Autism spectrum disorder
CALD	Culturally and linguistically diverse
CIM	Client information management system
CPD	Continuing professional development
DOH	Department of Health
DST	Decision support tool
EAG	Expert Advisory Group
GP	General Practitioner
HHS	Hospital and Health Service
HEADSS	Home & Environment Education & Employment Activities Drugs Sexuality Suicide/Depression Assessment
IAR	Initial assessment and referral
K10	Kessler Psychological Distress Scale
LHN	Local Hospital Network
MHTP	Mental Health Treatment Plan
NMHSPF	National Mental Health Services Planning Framework
NSW	New South Wales
NT	Northern Territory
PICS	Primary integrated care and supports
PHN	Primary Health Network
PMHC-MDS	Primary mental healthcare minimum data set
PSS	Psychological support services
QLD	Queensland
RACGP	Royal Australian College of General Practitioners
SDQ	Strengths and Difficulties Questionnaire
WA	Western Australian

SECTION 1- INTRODUCTION

The National Initial Assessment and Referral (IAR) in Mental Healthcare Project is an initiative of the Australian Department of Health (DoH) and aims 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 healthcare settings. The Project has included the development of National Guidance for PHNs and an **Implementation Toolkit**. The Guidance and Implementation Toolkit brings together information from a range of sources including Australian and international evidence and advice from a range of leading experts.

Based on PHN feedback, the IAR guidance was made available to all PHNs as in March 2019 on the understanding that the Guidance would be subject to ongoing improvement and modification based on experience in its use. To expedite the improvement process, the IAR guidance was the focus of an **implementation Review** throughout 2019/2020, with 9 PHNs selected to participate. The Implementation Review was commissioned by DoH and led by the University of Melbourne.

DoH also funded the development of automated **digital decision support tools** 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. The online decision support tool can be viewed by visiting: https://iar-dst.online/#/

This **State of Play Report** was prepared for DoH. The report was requested to examine current initial assessment and referral systems used by PHNs for individuals presenting for mental health services. The interviews informing this report also explored current progress towards implementation of the National IAR for Mental Healthcare Guidance. This is the third State of Play survey. The first survey was focused on building a picture of the activity across PHNs regarding initial assessment and referral. The second survey was to capture updates and progress.

SECTION 2- SURVEY METHOD

The Summary Report is informed by a national survey of PHNs. 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. 27 PHNs participated in the telephone interviews.

All 6 Victorian PHNs have been active in implementing IAR within the HeadtoHelp hubs, and IAR underpins the intake processes for the hubs. Therefore, some information about the progress of these PHNs is also noted in Section 3.

1 PHN did not respond to requests for interview (Darling Downs West Moreton PHN).

Each PHN was provided with an opportunity to review their summary, check accuracy and/or provide an update. Each PHN gave approval for individual PHN summaries to be included in this report.

Responses were coded, and then analysed using thematic analysis, and presented as a national snapshot in Section 3. Results are also made available at the individual PHN level (Section 5).

Table 1: List of survey questions

We are interested in your experience of using the National IAR for Mental Healthcare Guidance. The following questions ask you to provide some feedback on how the guidance material has been implemented by your PHN.

1. Since the release of the IAR Guidance, how would you describe your PHNs progress towards implementation? What has worked well? What have been most challenging aspects? What have been the main benefits?
2. In 2017, your PHN participated in an interview to inform the national project. Have there been any changes to that mechanism/process? What was the rationale for that change?

We are hoping to understand the role of GPs in implementing the Guidance, including their reactions and responses to the Guidance. The following questions are focused on the GP role, reaction, and response to the Guidance.

3. What has your PHN done to inform General Practitioners (GPs) and other stakeholders about the Guidance? What has worked well and not so well?
4. Overall, how would you summarise the GP response/reaction to the Guidance?
5. Can you tell me about the role of the GP in:
    - Rating the initial assessment domains?
    - Making a decision/recommendation about an appropriate level of care?
    - Informing decisions about changes to service type and intensity (step up/down)?
6. What has influenced your decision to involve GPs in this way?

We are hoping to understand the role of commissioned providers in implementing the Guidance, including their reactions and responses to the Guidance. The following questions are focused on the commissioned provider role, reaction, and response to the Guidance.

7. What has your PHN done to inform Commissioned Providers about the Guidance? What has worked well and not so well?
8. Overall, how would you summarise their response/reaction to the Guidance?
9. Can you tell me about the role of commissioned providers in?
    - Rating the initial assessment domains?
    - Making a decision/recommendation about an appropriate level of care?
    - Informing decisions about changes to service type and intensity (step up/down)?
10. What has influenced your decision to involve commissioned providers in this way?

We are keen to ensure that the IAR guidance material continues to meet the changing needs of PHNs. The following questions ask you to provide feedback on some additional resources that might be required.

11. What implementation resources or support do you think would be helpful for:
    - The PHN?
    - Consumers and carers?
    - GPs?

- Commissioned providers?
- Local Hospital Networks/Local Health Districts/Health Hospital Service partners?

12. Can you tell me about the clinical governance arrangements in place or planned for IAR processes in your PHN region? What addition resources or support do you think would be helpful for your PHN in implementing clinical governance arrangements?

Finally, we would like to understand the early impacts of the Guidance across PHNs.

13. How will your PHN know if the Guidance has been implemented effectively? What data are you using, or considering using, to judge the appropriateness or effectiveness of the IAR process?

14. Has your PHN noticed any impacts (positive or negative) with implementation of the Guidance on:

- Appropriateness of care
- Timely access to care
- Consumer experience and/or outcomes

15. **During the next stage of the project (stage 5), DoH will be undertaking adaptations to the National Guidance for use with children and young people.**

- Please describe the referral process for children and young people in your PHN.
- Does your PHN require the use of a standard assessment measure as part of the referral or initial assessment process (e.g., Strengths and Difficulties Questionnaire (SDQ))?
- Looking at the levels of care within the IAR Guidance, could you comment on their appropriateness for children and young people?
- Is there a defined process for step up/down for children or young people in your PHN?
- When thinking about adaptations to the national guidance for children and young people, what type of advice/content is likely to be most useful to your PHN, referrers and commissioned providers?

SECTION 3- NATIONAL SNAPSHOT OF IMPLEMENTATION PROGRESS

Of the 31 PHNs:

- 15 PHNs reported that implementation of IAR has commenced *
- 7 PHNs reported active planning for implementation
- 8 PHNs identified that implementation or implementation planning has not yet commenced, and are awaiting the outcomes of the Implementation Review
- 1 PHN did not participate in the interview

Table 2: Implementation progress

Implementing or actively planning for implementation		**Awaiting findings of IAR Implementation Review**	
1	Central Eastern Sydney*	23	South Eastern NSW
2	North West Melbourne*	24	Murrumbidgee
3	Adelaide*	25	Nepean Blue Mountains
4	Country SA*	26	North Sydney
5	South Western Sydney*	27	Northern Territory
6	Brisbane North*	28	Western NSW
7	Eastern Melbourne*	29	Brisbane South
8	Western QLD*	30	Western Sydney
9	Northern QLD*		
10	North Coast*		
11	Central QLD, Wide Bay and Sunshine Coast*		
12	Murray*		
13	Western Victoria*		
14	Gippsland *		
15	South Eastern Melbourne PHN*		
16	Australian Capital Territory		
17	Hunter New England Central Coast		
18	Gold Coast		
19-21	WA (3)		
22	Tasmania		

REACTIONS AND RESPONSES TO THE IAR GUIDANCE

All PHNs indicated general acceptance of the Guidance and the IAR decision support tool (DST). PHNs reported having confidence in the development process and satisfaction that a formal Implementation Review had been commissioned by DoH to build the evidence base around the IAR approach.

Some PHNs who have progressed with implementation or implementation planning, were able to give feedback about GP, referrer, and commissioned provider reactions to the Guidance. Reaction to the IAR Guidance and IAR DST has

been, for the most part, positive. Where concerns have been raised by stakeholders, these generally relate to the implementation of the Guidance and DST in the local context.

Reactions and responses to the IAR Guidance and DST are also measured through the online anonymous survey available to participants who have participated in training. The question asked is:

Please provide thoughts or comments regarding your overall impression of the IAR Guidance and the IAR-DST. Responses to this question are included in Appendix 1. As of October 2020, more than 600 people across Australia have participated in IAR training by the National Project Team.

IMPLEMENTATION ENABLERS

Many implementation enablers were identified by PHNs. The details are included in each PHN interview summary. 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, as opposed to PHN-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

Socialising the Guidance

The IAR Guidance document is viewed as appropriate for a PHN audience, but less appropriate for individual clinicians and service providers- this is largely attributed to the length of the Guidance and content that is less relevant to a non-PHN audience. Many PHNs recommended a quick reference guide. The online digital decision-support tool and the various PHN iterations of this tool (developed independently by PHNs) provide an opportunity to consider the information that is essential for individual clinicians and service providers, whilst balancing the requirement to not over-simplifying the information.

Minimising the assessment burden on consumers

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.

In terms of assessment burden, when looking at a GP referral pathway, the following assessment steps may be included:

1. Mental health assessment and treatment plan by GP
2. Screening, triage, or IAR-DST by central intake
3. Comprehensive initial assessment by commissioned provider or other treatment provider.

This pathway incorporates 3 assessments before an individual reaches care. For some people, this may be an unacceptable assessment burden.

Reluctance or lack of resources needed to 'over-rule' the referrer or consumer recommendations

Over-ruling or over-riding referrer or consumer recommendations or care choices is not the focus of the IAR Guidance and the IAR-DST. As the PHN sector gets more experience with implementing IAR, some successful strategies are emerging. In particular, the focus on supported decision-making and activation of supported decision-making strategies are of considerable importance.

Some PHNs have elected to create a 'practitioner determined level of care' where a referrer can review the IAR-DST recommended level of care but may choose an alternative and be asked to articulate the reasons why. PHNs have also found it useful to engage with referrers who are frequently over-riding the recommended level of care, working with them to build knowledge of the range of other service options.

Over-riding the recommended level of care, is often associated with referrers seeking a higher intensity intervention and this has certainly been observed by PHNs. However, some PHNs have also observed that GPs may refer to the widely accepted 'default' option (level 3 psychological interventions) without realising that a suicide prevention specific intervention might be more appropriate, or a service option incorporating psycho-social supports is available.

Diagnosis or condition specific interventions

The trans-diagnostic nature of the IAR Guidance and IAR-DST has been widely accepted and celebrated. Where levels of care are not associated with a specific diagnosis but selected through a more holistic understanding of a person's experiences across the 8 identified initial assessment domains.

However, in many PHN regions there are diagnosis or condition specific interventions (e.g., eating disorder clinics, or clinical interventions for people with Borderline Personality Disorder). Some interventions are commissioned by the PHNs directly or are available as a service choice within the local service context. This does not always track neatly back to a Level of Care. Some PHNs are now grappling with how these diagnosis or condition specific interventions align with the levels of care.

The same is true for suicide prevention specific interventions. One PHN has matched local services by level of care, and level of care-based interventions are generated for the referrer based on the IAR-DST logic. However, when to generate suicide prevention specific services is less straightforward. This same PHN is trialling a temporary solution, wherein suicide prevention specific interventions are included in the service options wherever an individual is rated as a 2 or 3 on Domain 2 (risk of harm).

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-prescribed 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.

SECTION 4- PHN RECOMMENDATIONS

PHNs were asked to provide guidance as to the implementation resources and supports that were required to support regional implementation of the IAR Guidance. It is important to note that all PHNs have different regional contexts, opportunities, challenges, and implementation plans and that no single recommendation is shared by all PHNs nor is prioritising the recommendations possible. The following recommendations are a summary of common resources and supports noted by PHNs.

1. Ongoing access to training in IAR (introduction, orientation, and application of the decision support tool). Some PHNs were not aware that this support is already available for PHNs through the National Project Team and can be tailored to suit their local implementation plans and circumstances. This is funded by the Department of Health and delivered via the National Project Manager. Discussions with PHNs further supported the concept of a train the trainer model, whereby local clinicians and clinical champions could be trained to deliver the training locally. This concept further supports sustainability planning for the project.

2. PHNs expressed an interest in having the IAR training modules formally accredited and supported by professional colleges for GPs and allied mental health clinicians. Accredited training delivered in partnership with professional colleges is a potential pathway to engagement of key professionals and has the benefit of having professional development points for participation. Partnerships to deliver training with the Mental Health Professional Network and various peaks was also recommended.

3. Implementation resources suggested by PHNs included the range of resources available within the IAR Implementation Toolkit. The IAR Implementation Toolkit has not yet been made available to PHNs beyond the 9 participating PHNs at the time of interviews. The Department of Health approved the release of the IAR Implementation Toolkit to the 6 collaborating Victorian PHNs involved in rolling out the HeadtoHelp sites in Victoria in response to the Covid-19 pandemic. It has always been viewed as important that the Implementation Review be allowed to conclude, and the findings considered, before untested tools be made more universally available. Subsequently, many implementation tools suggested have already been developed but have not yet been made widely available by PHNs. In addition to the implementation tools already developed, the following suggestions were also common:
    - Example communication and engagement plans
    - Example implementation plans
    - Example informal evaluation plans
    - Example Health Pathways integrating the IAR domains and level of care
    - A shorter quick reference guide targeted towards a clinician/practitioner audience

4. PHNs consistently noted the importance of digital platforms to support IAR implementation- particularly as that relates to automation of the decision support logic (the DST). The Digital Decision Support Tools have not been made available to PHNs beyond the 9 participating PHNs at the time of interviews. The Department of Health approved the release of the IAR Digital Decision Support Tools to the 6 collaborating Victorian PHNs involved in rolling out the HeadtoHelp sites in Victoria in response to the Covid-19 pandemic. It has always been viewed as important, that the Implementation Review be allowed to conclude, and the findings considered, before untested tools be made more universally available. Subsequently, some of the Digital Decision Supports tools suggested by PHNs have already been developed (e.g., online DST, automated programming interface, and the code library) but are not yet widely available by PHNs. Additional digital tools suggested by PHNs included an IAR-DST GP integrator for seamless accessibility within GP software

5. PHNs widely acknowledged the challenges of monitoring system performance when the Primary Mental Health Care- Minimum Data Set (PMHC-MDS) does not align with IAR. PHNs suggested a review of the PMHC-MDS to explore alignment with IAR, whilst also allowing the PMHC-MDS to align with the expectations of PHNs. PHNs also acknowledged that some data is context specific, and therefore sharing local data sets with IAR related performance indicators and measures is a high priority for some PHNs.

6. Many PHNs are seeking national leadership regarding Mental Health Treatment Plan (MHTP) revisions and Medicare Benefits Schedule (MBS) reform to align with the IAR Guidance. PHNs are generally interested in GP use of IAR and the IAR-DST, however commonly cited the importance of considering IAR implementation in the context of the GP workflow (e.g., through or alongside the MHTP process) and concerns about the remuneration limitations for GP time via the MBS.

7. PHNs consistently suggested facilitating opportunities to share implementation experiences from across the PHN network. The State of Play report and Implementation Review report are much anticipated by the PHNs. Further options for sharing information included online spotlight forums and Q&A panels. Similarly, PHNs suggested an online sharing platform for PHNs to request 'examples of…' where other PHNs could respond and share their work. Creating an online repository of resources for use or adaptation by PHNs.

8. Many PHNs encouraged national leadership to promote the IAR Guidance beyond PHNs, so that there is broader and deeper understanding of the IAR Guidance throughout the sector. This point was reinforced by PHNs who would like to see system wide implementation of the IAR Guidance. PHNs noted the Mental Health Commissions and peak bodies as key stakeholders in this regard.

SECTION 5- INDIVIDUAL PHN SUMMARIES

GIPPSLAND PHN

Background

Gippsland PHN has implemented the IAR Guidance and IAR-DST within the newly established Head to Help Hubs. Gippsland PHN will use this experience to plan for broader regional implementation.

IAR implementation progress

Gippsland PHN has implemented to IAR decision support tool under the HeadtoHelp initiative. Gippsland PHN reported that the IAR provides a standardized intake and assessment tool for mental health which is being use consistently by all providers operating HeadtoHelp services. Gippsland reported that the benefits of the IAR include the decision support function, clearly defined levels of care, reporting capabilities (from PHN perspective) and introduction of a standardised intake procedure for mental health services. Gippsland PHN has taken this opportunity to socialise the local Area Mental Health Triage service to the IAR, who have provided positive feedback to date.

HeadtoHelp Hubs in Gippsland are operated by local general practices. This has provided more in-depth insights to GP response to IAR. While it is working well in some settings, stepped care is still a new concept to many GPs, therefore the IAR can be more difficult to comprehend. Gippsland PHN acknowledge that GP is the cornerstone of healthcare and that therefore the GP involvement and use of IAR is essential to deliver effective, efficient and patient centered health care services.

Adaptations for children and young people

Gippsland PHN reinforced the importance of the IAR Guidance and DST incorporating changes that ensure smooth translation to the child/youth context. Gippsland PHN advocated for a strong focus on the role of the family and primary caregiver in supporting access to interventions.

NORTH COAST NSW PHN

Background

North Coast PHN commissions the Connect to Wellbeing service being delivered by Neami National and intake for PHN commissioned mental health services is delivered by the provider. This initial transition is part of a broader intake, assessment and referral service for mental health and drug and alcohol supports across the North Coast that the PHN is exploring in partnership with the 2 x LHDs.

IAR implementation progress

NCPHN made use of the IAR Guidance to inform the procurement approach for intake services for PHN funded mental healthcare. NCPHN has since integrated the IAR domains and DST into the referral form. The intake team within the commissioned provider service utilise the IAR-DST to recommend appropriate service allocation.

NCPHN are now trialing the Innowell Platform alongside the IAR Guidance, using digitally enhanced consumer-facing assessment and a digital platform, streamlining availability of information for decision-making, and ensuring that the consumer can contribute information from their perspective directly. Consumers are currently being recruited to the trial, and involvement is entirely voluntary.

Where a consumer has consented to participate in the trial, the consumer completes the information using an interactive app- this information is then reviewed by the intake practitioner, along with information contained in the referral, and the IAR-DST is then used. NCPHN reports that by giving the consumer the opportunity to

contribute information directly, the triaging clinician gets a much better view about the consumer perspectives on their experience without the need for a lengthy clinical interview.

NCPHN acknowledged that GPs are not typically thinking about other intensity levels (e.g., low intensity options, practical psychosocial supports). As such, the referral pathway defaults to psychological services, and referrers risk not making use of the wide and growing range of services available.

The Innowell trial is in first phase- a mid-term review is scheduled, and trial ends in March 2021.

NCPHN reported that the Connect to Wellbeing number became the core pathway for mental health trauma counselling and support throughout the bushfire. NCPHN reflected that the work undertaken to incorporate IAR into local processes made managing a rapid growth in referrers and referrals so much easier- allowing optimal use of the variety of services available to address unprecedented levels of community distress.

Through the Healthy North Coast Collaborative, the two partner LHDs in the region have considerably developed knowledge and understanding of the stepped care continuum and sought after outcomes. The IAR Guidance and approach is part of the dialogue around the care continuum, stepped care approach and local referral pathways.

Adaptations for children and young people

NCPHN commissions 6 headspace centres and has prioritized funding for child psychological services. The system and pathways to care for children look quite different when compared to adults. Most referrals come via the Connect to Wellbeing intake or directly to headspace centres.

Children and young people aged 18 and under must be referred to a fully credentialed mental health clinician for a comprehensive initial assessment. An SDQ is administered on entry to treatment.

ADELAIDE PHN

Background

Adelaide PHN participated in the Implementation Review as a Round 1 site. During the review, Adelaide PHN trailed the IAR Guidance and DST with a selection of referrals within the 'in-house' Central Referral Unit (CRU), and the tool was performed over the phone by Clinical Triage Officers who were assessing people referred for suitability for primary care mental health services.

Implementation progress

During the Implementation Review, Adelaide PHN observed that the time to undertake an assessment and score the DST was 30 minutes. Overall, including admin, it took an average of 40 mins – 1 hour to process a referral through this method. This overall length of time included the time spent to ensure all information was entered into the Adelaide PHN clinical records management system MasterCare +.

The CRU is still in place, and the PHN is exploring how to improve the efficiency in the current processes. This is likely to include exploring the role of the GP in scoring the domains and making a recommendation about a level of care. Adelaide PHN are also exploring alignment between the Mental Health Treatment Planning process and IAR. Finally, Adelaide PHN are considering how technology could improve both efficiency and uptake.

Given the Implementation Review was focused on internal adjustments and changes within the CRU, Adelaide PHN did not introduce the Guidance to referrers. However, some commissioned providers have responded with enthusiasm to the Guidance.

Implementation resources and supports

Adelaide PHN recommended the following resources and supports be made available:

- Training and webinars for GPs to introduce them to the IAR
- Simple statements about the potential system and consumer benefits of IAR
- Mental Health Treatment Planning template aligned with IAR
- Ensuring software that embeds the IAR is compatible with the range of different GP Practice software utilized in General Practice.

IAR adaptations for children and young people

There are broad referral pathways for child and youth services within Adelaide PHN, designed to minimise access barriers for children and young people. A MHTP is not required on referral to a PHN commissioned child or youth mental health program, however there are expectations children and young people be linked into the GP for assessment following referral if it is deemed that psychological therapies is required.

For children, a typical referral is through the GP via a MHTP or paediatrician. Provisional referrals can be made by schools, parents, and community services.

The SDQ is not required at referral, with many GPs finding the measure to time consuming. The SDQ is often done once the child or young person has been seen initially at the provider level.

There are agreed pathways for step-up and down between commissioned providers and LHNs, however there is room for improvement. Adelaide PHN are presently facilitating a project focused on improving and articulating referral arrangements and pathways. This is complicated by having 4 LHNs all with different youth models of care- however an action within the Regional Plan is focused on articulating and formalising youth pathways.

Incorporating a more developmental focus could make the IAR more applicable for use with children and young people.

GOLD COAST PHN

Background

GCPHN commissions a central intake service. The provider also has funding to deliver PHN commissioned mental health services. There is an expectation of referrals to both PHN-commissioned services and other services.

IAR implementation progress

GCPHN is facilitating an *improving system navigation project* which is underpinned by the IAR Guidance. The project is multi-faceted and involves:

- Implementing the IAR Guidance
- Further developing and integrating the referral and triage service (externally delivered)
- Working with the Health and Hospital Service (HHS) to develop a pathway and protocol for callers to the 1300-MHCALL (HHS service), to be supported to access primary mental healthcare services when suitable and appropriate to do so.
- Updated referral forms using the IAR domains within the referral form. The referral form comes to the intake team, who can then see the responses to each domain when processing referrals and

determining appropriate service. Team have been trained in the tool and have the guidelines. Planning a regular annual review of the referral forms. With the support of the practice support team, GCPHN will be ensuring referral forms are available seamlessly within the GP software.

- GCPHN has provided the commissioned provider with funding for a dedicated project officer and their role is to integrate the IAR guidelines into the commissioned provider environment (aligning the provider's brief assessment tool to the domains and making use of the DST).
- GCPHN is working with local HHS to look at all components of the intake and referral system to identify opportunities to enhance the coordination between state funded and Commonwealth (PHN) funded intake services. The IAR tool has been identified as a potential resource to develop a shared language and understanding of stepped care. This work is linked to a *crisis response and stabilization project* underway within the region, with the potential for IAR to be embedded in the workflow.
- As part of the *improving system navigation project,* awareness and education focused activities for GPs are planned for later in the year

GCPHN referenced the Alcohol and Other Drugs GP Education Program as a model they would see as being beneficial for the implementation of IAR amongst GPs. RACGP and ACRRM have been given funding to develop training packages and GPs are incentivized to participate. PHNs are funded to support implementation. In the absence of a project like this, GCPHN reported feeling dependent on GPs having an interest to engage.

GCPHN recently revised the referral forms, so that GPs score the 4 primary domains, choose a provider within the level of care, or choose to allocate the referral to the intake team for further advice. Out of 100 randomly selected referrals over a 3-month period, only 21 referrals had no clear service preference recorded by the GP. Out of the 100 referrals reviewed, 59 referrers needed to be followed up by the central intake team- usually involving the intake team seeking clarity about missing information. GCPHN referral form is also consistent with billing requirements for the MHTP.

GCPHN are pleased that the Clinical Governance advice in the IAR Guidance is aligned to the National Standards for Mental Health Services. Alignment with standards that most commissioned providers must uphold or strive for anyway has smoothed the way for discussions between the PHN and providers about these expectations.

Implementation resources or support

- 1 pager simple explainer that can be co-branded by the PHN and Commonwealth focused on summarising IAR, rationale and how to use- background information where the drive is coming from, what is the case for change
- Allow GPs to use the online version of the tool (the online DST)
- MHTP templates incorporating IAR DST
- Service specific flowcharts establishing where IAR sits (e.g., low intensity pathway for NewAccess).

Adaptations to the Guidance for children and young people

GCPHN reported that GPs are central to decision making when referring children to PHN commissioned mental health services. Psychological services for children in the GCPHN region require a GP assessment and referral.

GCPHN has focused on creating variable levels of intensity and service types with the headspace centres, so that young people are more likely to access a service within the centres that best meets their treatment needs and so that young people can move more seamlessly through levels of intensity where required.

GCPHN suggested strong engagement with headspace National as part of the next stage of the National IAR project, with opportunities for alignment between the HEADSS assessment and the headspace model integrity framework.

GCPHN anticipates challenges matching the levels of care with the more complex system of child health and mental health services at the regional level- citing the broad range of providers (e.g., HHS services, disability services, child health services, schools, child protection services and community organisations) as all having planning and service delivery responsibilities associated with child mental health. GCPHN noted the lack of coordination across the entire child mental health system. GCPHN also noted the complexity associated with neurological, behavioural and psychological diagnoses and experiences, and the difficulty identifying what belongs in child mental health IAR guidance, and what is out of scope.

MURRAY PHN

Background

Murray PHN has a decentralised referral pathway, with referrers sending referrals direct to commissioned providers. Murray PHN participated in Round 2 of the IAR Implementation Review. As Murray PHN has no central intake function for Primary Mental Health providers across catchment, it was an important project to be involved with to capture the differences and commonalities across intake and referral processes in the catchment.

IAR implementation progress

The PHN reported that they and commissioned providers see enormous value in the IAR Guidance. The small-scale test during the implementation review indicated strong levels of acceptability amongst key stakeholders. There have been some exceptional small-scale results associated with the review. For example: a state funded health service has introduced IAR into every level of their service, and Murray PHN is excited now to have a provider who can work with them and communicate the real-world impacts, benefits, opportunities, and challenges.

The Implementation Review reinforced the importance of socializing IAR to referrers and the commissioning providers- giving context and background. This messaging included information about what it is, how it works, how it has been implemented and capturing/sharing the perspectives of the organisations involved in the review.

- One Service Provider continued with use of the DST and inserted the Domains into their COVID Risk Assessment for consumers referred to their programs.
- GPs felt the tool was easy to use and made the process of assessing for referral to a relevant program easier.
- Service provider level of involvement was high. 1 provider withdrew but the other 3 remained highly engaged and involved even after Covid-19 changed the landscape.

The Exemplar Report written by Murray PHN is included in Section 6.

Additional supports and resources

Murray PHN recommended that the Department be clearer about implementation expectations and timeframes- enabling PHNs to be clearer about a national mandate reinforcing regional implementation.

The PHN advised that getting GPs to use IAR nationwide is likely to require national policy changes and/or leadership, specifically:

1. MBS reform- Medicare billing to remunerate GPs for their time.

2. MHTP template changes to align with IAR.

3. IAR-DST integrated within practice software.

4. National mandate for use.

5. Education processes through PHNs with Continuing Professional Development (CPD) points.

6. Train the trainer options for PHN clinical champions.

7. Training for provider support teams who are the key interface with general practice.

Murray PHN recommended additional funding for PHNs to engage a project manager to dedicate time and resources to implementation.

Murray PHN recommended the production of short sharp fact sheets and information sheets.

- Why are we doing this (state the case for change)
- What is the evidence?
- What is stepped care?
- What are the levels of care?
- How do we match people with the correct level of care
- IAR in action summaries

IAR adaptations for children and young people

Murray PHN reported that an increasing proportion of referrals for children and young people are initiated by non-GP professionals (e.g., school principal, school counsellor, family member, pediatrician).

Murray PHN recommended that adaptations to the Guidance around children and young include:

- information and advice about how IAR fits with clinical staging.
- consideration of the services available to the parent or caregiver with a focus on improving the emotional wellbeing of the child (as per PHN Guidance).

Murray PHN recommended that the EAG include representation from pediatricians, a person with the lived experience of caring for or supporting a child or young people and a GP experienced in child or youth mental health.

Post-note from Murray PHN:

Murray PHN has partnered with other Victorian PHN's to fifteen new Mental Health Hubs to support the mental health and wellbeing of people in Victoria impacted by COVID-19. Two of these hubs are in the Murray PHN region. Rapid model development and implementation took place over 4 weeks to 14-09-2020, inclusive of a single central intake system across Victoria.

The IAR has been built into the system and is a foundational component of the model. As a result of Murray PHN's involvement in the IAR pilot, and exceptional support from the National IAR project team we have been able to deploy the guidance and tools rapidly and are well placed to support their implementation.

Just as COVID-19 derailed our ability to complete the pilot project to our satisfaction, it has enabled us to deploy the IAR into practice.

NEPEAN BLUE MOUNTAINS

Background

In the NBMPHN region, referrals are prepared by the GP and sent to the PHN facilitated central intake service which then forwards the referral to a provider who can accept the referral. The provider then contacts the client to arrange an appointment. For SOS referrals the provider will conduct triage at this point. The central intake service is non-clinical and is solely administrative.

Implementation progress

NBMPHN have not yet implemented IAR guidance- NBMPHN is keen to review the findings of the implementation review prior to introducing changes in the region- however a contracts and project officer within the PHN has been initiating contact with a large number of PHNs as the NBMPHN begins planning for implementation. NBMPHN is anticipating a major focus on change management- with the local sector likely to be seeking clear evidence, rationale, and resources to support implementation. In this regard, NBMPHN suggests that a clearer expectation of implementation by the Department of Health would be useful- including the incorporation of IAR implementation into annual activity plans and reports.

NBMPHN identified concerns relating to funding for implementation and reinforced the importance of having resources within the PHN dedicated to implementation- including resources within the practice support environment and funding for improving technological infrastructure and automation of referral processes. NBMPHN highlighted the importance of funding for technology and project management as the key to being able to implement the IAR. NBMPHN would like to focus on building engagement, awareness and knowledge amongst GPs and commissioned providers but has insufficient resources for these tasks.

As NBMPHN considers implementation, the intent is to preserve GP/consumer centrality and decision making.

Additional resources and supports

NBMPHN identified that the following resources and supports would be especially useful:

- Clearer and more concise expectations relating to implementation.
- An implementation toolkit.
- IAR incorporated into example referral pathways.
- A way to implement the guidelines that results in the best outcomes for consumers for the lowest possible cost, with the least risk of resistance.
- MHTP alignment with IAR requirements and example templates (with remuneration via the MHTP seen as a major enabler for IAR).

Adaptations for children and young people

In the NBMPHN region, the GP is required to prepare a MHTP and complete the referral form, with the GP selecting a service or clinician and sending the referral information directly to the selected provider. There are no standard assessment tools used during the referral, however the SDQ is administered on entry to treatment as per the PMHC-MDS requirements.

There are 5 headspace centers in the NBMPHN region all with open referral pathways as per the headspace Model Integrity Framework. NBMPHN reflected the regulated model for headspace centres is welcome and there are clear expectations for delivery and commissioning.

NORTHERN QLD PHN

Background

North Queensland PHN participated in Round 1 of the National IAR Implementation Review. NQPHN commissions the *Connect to Wellbeing* service – a central intake for psychological therapies, integrated coordinated care for people with severe and complex mental health issues, psychosocial services and RACF mental health services. *Connect to Wellbeing* is also designed to connect people with non-PHN commissioned services and supports. This is enabled by extensive service mapping undertaken in the region. This additional function of central intake acknowledges that GPs cannot be expected to know all of the social and community services available.

GPs are asked to provide a MHTP or complete the Connect to Wellbeing referral form in detail if a MHTP is not supplied. The referral form captures the programs available and the GP can select the option. Most of the time the *Connect to Wellbeing* team will do a clinical assessment with the consumer- which is a comprehensive assessment that builds on the information from the GP. If the GP has sent through enough detailed information for a comprehensive assessment, a brief assessment may be done. Additionally the role of the *Connect to Wellbeing* team is to explore engagement/motivation and discuss service options with the consumer, as the role of the central intake team includes connecting consumers with a range of options as appropriate, as well as stepped care services.

IAR implementation progress

When planning for implementation, the *Connect to Wellbeing* service reviewed their existing assessment tools against the IAR domains and used them as an adjunct to the existing clinical assessment. The clinicians within then incorporated the DST into their existing processes to generate a recommended level of care.

NQPHN reflected that Round 1 of the IAR Implementation Review was too quick and processes had to be put in place very quickly. However, IAR had broad acceptance- particularly by the commissioned provider who found that the IAR Guidance was very compatible with existing tools and processes in use with the DST being complimentary to existing practices.

Whilst IAR is now implemented in the centralised intake service, NQPHN is now planning for implementation within the place-based and remote services throughout the region. The NQPHN region is diverse, and several remote areas (Cape York, Torres Strait, Etheridge/Croydon Shires, and Richmond/Flinders Shires) rely on visiting or fly-in fly-out mental health service delivery, with few services on the ground. This is likely to involve important conversations and input from stakeholders about the appropriateness of the IAR Guidance for Aboriginal and Torres Strait Islander communities and people and identifying necessary regional adaptations.

The exemplar report prepared by NQPHN is included in Section 6.

Clinical governance- access, safety, quality

As an Implementation Review site, NQPHN had access to the Clinical Governance Checklists included in the IAR Implementation Toolkit. These checklists outline requirements for commissioned providers and requirements for commissioned providers- matched with the National Standards for Mental Health Services. Personnel within the PHNs reviewed the Checklists and mapped these against current guidelines and processes to identify areas for improvement.

NQPHN then developed an additional checklist for the place-based services- with a focus on preparing these service providers for IAR implementation with a focus on quality improvement.

NQPHN reflected on the usefulness of the clinical governance checklists within the toolkit- noting that clinical governance information is often full of vague principles- the Guidance and checklists are more practical and there has been good feedback from contract managers. NQPHN reflected that tracking the clinical governance requirements back to the National Standards for Mental Health Services was especially useful and suggested that matching the requirements to the National Framework for Recovery-Oriented Mental Health would be worthwhile as well.

Additional resources and supports

NQPHN recommended that the National Project team develop:

- MHTP template aligned with IAR
- Clinical Governance guidance and checklist matched against the recovery-oriented services framework
- Guidance around service mapping aligned with levels of care (examples)
- Vignettes that reflect population groups (e.g., Aboriginal and Torres Strait Islander Peoples
- Adaptations to the Guidance developed in partnership and collaboration with Aboriginal and Torres Strait Islander peaks, Aboriginal Community Controlled Health Organisations (ACCHOs) and communities.

Adaptations for children and young people

There are 3 headspace centres in the NQPHN region including one headspace outreach servicing two rural areas, and two recently funded satellite services – all with broad and decentralised referral pathways.

For people under 12 or young people who do not want to go to headspace, referrals are directed to *Connect to Wellbeing*, resulting in two different types of referral and assessment for youth. A broad range of individuals refer in for child and youth mental health services, including pediatricians, GPs, and schools as the major referrer types. NQPHN noted that there are well-understood escalation requirements for referral to level 5 (specialist and acute services), however understaffing in this part of the sector can lead to a surge in inappropriate referrals to primary mental healthcare. The commissioned provider *Connect to Wellbeing* has well established systems in place to manage these surges.

NQPHN cautioned against a focus on pathologizing mental health issues in children and young people- and is seeking that the adaptations to the Guidance strike a balance between good clinical interventions and holistic child/youth wellbeing + recovery.

NORTHERN SYDNEY PHN

Background

Northern Sydney PHN (NSPHN) has facilitated a Mental Health Triage service since 2017. The Mental Health Triage service provides a central point in the NSPHN region for receiving and assessing referrals for people who are not in crisis and require mental health services (including psychology), drug and alcohol, and suicide prevention services. An experienced clinician reviews all referrals and matches the person to the most appropriate service to meet their needs. With referrals from GPs, the Mental Health Triage takes on a wayfinding and navigation function- supporting GPs determine the most appropriate service for the individual. Mental Health Triage clinicians proactively engage with GPs to provide in-practice education and guidance on the referral process and available services. Referrals for PHN commissioned psychological therapies are required to be made via Mental Health Triage. All other programs can receive direct referrals.

Progress towards implementation

NSPHN have been focused on the implementation and ongoing quality improvement of the central intake service. The implementation of this service has been a major change management project. There was initial resistance to the changes being introduced- with some referrers concerned about the amount or type of information requested as part of the referral process- NSPHN has identified that automating processes wherever possible, and focusing on minimising the burden (time and resources) on the GP has been important.

NSPHN has discussed the IAR Guidance with some key stakeholders and commissioned services. The feedback is generally that the Guidance is very comprehensive, and the consensus is to wait until implementation review results are available from the University of Melbourne to inform regional implementation. With regards to implementation, NSPHN reported that communication and effective change management will be key. Also important, will be the ability of the PHN to sell the rationale for change- hence the importance of waiting until the implementation review results are available- what are the outcomes?; what are the inputs?; what is the effort that will be required?

NSPHN uses Redicase for intake and the vendor (Redbourne) have developed IAR-compatible modules. The collaboration across multiple PHNs, including 2 involved in the implementation review, means that SNPHN has a fast-tracked technology solution available when implementation gets underway.

Additional resources and supports

NSPHN recommended an ongoing focus on training and education from live online workshops with Q&A components. NSPHN also suggested that training in the application of the Guidance would continue to be important- including the use of consumer vignettes. Further support needs included:

- An implementation communication strategy
- Short summary of the rationale behind IAR and information on the development process (build trust)
- User testimonials from clinicians involved in the implementation review
- Practical support for implementation from the national project manager

Adaptations for children and young people

NSPHN commissions psychological therapies for children and young people, headspace services, mental health services for young people with severe and complex mental illness and a telephone coaching service (Way to Wellness) for young people. For PHN commissioned psychological interventions, children and young people require a MHTP, Mental Health Triage referral form and relevant assessment tool (SDQ) There are no additional assessments required on referral. The SDQ is also completed by the commissioned service in accordance with the PMHC-MDS requirements.

Referrers to psychological therapies for children and young people are mostly GPs and pediatricians- however, anyone can refer to all other services commissioned by the PHN.

SOUTH EASTERN NSW PHN

Background

In the SENSW PHN region, referrers send referrals directly to the commissioned providers. There is one major provider who delivers a varying range of service types and intensities and several other providers delivering a range of services.

SENSW PHN has not yet started implementation of the IAR Guidance and is awaiting the outcome of the Implementation Review conducted by the University of Melbourne.

Implementation progress

SENSW PHN commissions one major provider, with that provider being responsible for delivering a range of intensities (from low intensity, headspace, psychological services, mental health services for people with high intensity needs) and a number of other providers. All providers control their own referral and intake systems. Commissioned providers have not yet commenced use of IAR.

SENSW PHN has been focused on increasing acceptability and uptake of services such as low intensity interventions. There is still a lack of familiarity with and acceptance of low intensity interventions amongst some GPs. SENSW PHN has found it helpful to have a GP Champion involved in discussions with GPs about low intensity interventions.

As yet, the GP reaction and response to the Guidance has not been tested by SENSW PHN. SENSW PHN recognises the ideal arrangement is for GPs to implement the IAR decision support tool, but there are considerable barriers with GP time and capacity. This will be a longer-term plan for the PHN, and in the meantime, the change focused at the commissioned provider level is potentially more feasible.

SENSW PHN is keen to focus on exploring the integration of IAR and HealthPathways, given the ongoing investment in time and resources associated with the HealthPathways platform.

Note: while preferred, the MHTP is not a mandatory requirement for entry to SENSW PHN commissioned primary mental healthcare services.

Implementation resources and supports

- A regional implementation planning template for the PHN and commissioned provider
- Issues paper or brief that includes a summary of the development process, a brief overview of IAR and the DST, and a summary of the benefits (presenting the case for change)
- National project manager support for relevant sector meetings (e.g., regional planning implementation committee meetings)
- Change management advice and guidance
- Need to ensure that the guidance includes the ability to commission out the intake function.

Adaptations for children and young people

In SENSW PHN, there are diverse referral pathways into mental health services for children and young people. Provisional referrals (e.g., through schools) are common, and a GP referral is less common than observed in services for adults. Pediatricians do refer to PHN commissioned mental health services, however this represents a small proportion of overall referrals.

SENSW PHN commissions 5 headspace centres (Queanbeyan, Wollongong, Nowra, Goulburn, and Bega). SENSW PHN currently also have an interim bushfire headspace service run as a collaboration between COORDINARE and headspace National. Self-referrals (from the young person) and referrals from family members are common referral types in to the centres. There is an increasing variety of service types and intensities available within the headspace centres. Despite this, psychological services remain the most likely intervention to be offered within the centres. Demand management funding that was recently made available

is stretching possibilities and resulting in a broader range of treatment options for young people (e.g., brief interventions, family-focused therapies).

The headspace centres use the HEADSS assessment on entry to the service.

SOUTH WESTERN SYDNEY PHN

Background

SWSPHN has implemented a non-clinical central intake function, the intake function processing referrals and directing to the most suitable service. Referrers rate the IAR domains and review the recommended level of care.

Implementation progress

SWSPHN rolled out rediCASE as their Client Information Management System (CIMS) in July 2020, with IAR modules built into the online referral form. Currently provisional referrers are using the online referral form, and this will be rolled out to GPs later in 2020. SWSPHN has needed to make adjustment to workflows to reflect regional variation (e.g. High proportion of provisional referrals requiring different workflows). Referrers rate the IAR domains and review service options with the consumer. The referrer can select a practitioner determined level of care, overwriting the calculated level of care. The referral is then directed to the most suitable program and service provider.

In South Western Sydney, approximately 40-50% of all referrals to PHN commissioned services are through provisional referrals (non-GP referrers, including self-referrals). Therefore, SWSPHN has different workflows depending on the referrer type (GP or provisional referrer), and whether clinical decision-making is available during the referral process. The workflows developed so far include:

1. GP referral workflow: GPs will score the IAR domains and submit a referral to central intake based on the recommended or practitioner determined level of care. The referral is then directed to a suitable program and service provider by the central intake team. This pathway (using IAR) is not yet active and is in planning stages.
2. Provisional referrals (clinician) workflow: if the provisional referrer is a clinician, the IAR domains will be rated by the clinician during the referral process and the workflow is consistent with the GP workflow.
3. Provisional referrals (non-clinician or self): The IAR domains will be rated by the referrer, and the referral is sent to a suitable program and service provider, however the IAR decision support tool is reviewed by the treating clinician during the first contact with the client. SWSPHN is considering adjusting the referral form to enable the referrer to bypass the IAR domains when clinical oversight when scoring the IAR domains cannot be provided – such as for self-referrals, which in most cases are input by the admin/intake officer of a service provider.

SWSPHN worked with the National Project Manager to develop and facilitate several training sessions for PHN representatives and commissioned service providers. The workshops provided an introduction and orientation to IAR and included the CIMS vendor (Redbourne) presenting on the new form and responding to questions about new processes. These sessions were well received by participants, with many participants expressing enthusiasm.

Engagement with GPs and introduction of IAR to GPs is planned for October/November 2020- with changes to the GP referral process expected to be in place by the end of 2020.

Implementation of IAR within a low intensity pathway (SWSPHN commissions the NewAccess model) has not been as straightforward. SWSPHN is seeking additional guidance regarding how IAR fits with NewAccess and is keen to be involved in further discussions with the IAR project team and beyondblue.

SWSPHN reported that matching the technology so that it meets the requirements of the PHNs established workflows and commissioned-provider data requirements has been challenging. SWSPHN suggested that other PHNs articulate workflows, functions, and data requirements as early as possible.

Examples of local workarounds have included:

- Bypassing domains within the electronic referral process for self-referrals and referrals for children;
- Meeting information requirements within the referral for some services, where the same information requirements do not apply to other services;
- One referral form for all programs- but different programs have different requirements.

https://phnswsws.redicase.com.au/#!/referral/create

In terms of indications of acceptability amongst key stakeholders, the PHN reflected that the response to the IAR guidance within the PHN has been positive, and changes have been well-received by the commissioned providers. However, introduction of IAR within GP referral processes is in planning stages and SWSPHN is prioritising clear communication and access to education/training for GPs.

Additional supports and resources

- Clinical governance resources (e.g. checklists)
- Training for referrers, intake teams and commissioned providers
- Summary of IAR Guidance for referrers (clear about the rationale and the requirements)

Adaptations for children and young people

The three local headspace centres have a longstanding interest in, and use of, clinical staging and the PHN is keen to understand the relationship between IAR and clinical staging in the headspace environment. The headspace centres each have different service types and intensities covering levels 2-4 (including low intensity (thought NewAccess), moderate intensity (though private practitioners and psychological services for underserviced groups funding), and high intensity interventions (through youth enhanced funding).

Referrals for children use similar workflows for other population groups (identified above). SWSPHN previously required use of the Pediatric Symptoms Checklist. There is no current requirement to use a standard assessment tool during the referral process.

Commissioned providers use the SDQ as per the PMHC-MDS, and several commissioned providers use the Connors Assessment Tool- although this is not a contracted requirement.

SWSPHN recommended engagement with Orygen and headspace National at the National EAG level and wondered if Emerging Minds and beyondblue might be useful to include in the project either through the EAG or less formally through engagement.

SWSPHN expressed issues with appropriateness of some referrals for children where the mental health need was not clear- but the focus of the referral related to behavioural, developmental or neurological issues- and no mental health symptoms or issues are referenced. SWSPHN suggested it would be important to clarify within the adapted Guidance, what is and is not the role of primary mental healthcare services.

TASMANIA PHN

Background

Tasmania PHN has a decentralised referral pathway for commissioned mental health services, with referrals going direct to the commissioned provider from the referrer. GPs are the primary source of referrals for many programs. However, referrals also come from a variety of other professions including social workers, mental health nurses, psychologists, and Aboriginal health workers. For low intensity, many clients are self-referred.

Implementation Progress

Tasmania PHN are currently working alongside key partners to finalise the Regional Mental Health and Suicide Prevention Plan, which will be released in November 2020.

To support the implementation of the regional plan, PHT will undertake the Mental Health Service System Integration Project. The project will focus on 8 streams of activity:

1. Implementation of the Regional Plan
2. Co-commissioning policy
3. Service realignment (review of mental health model)
4. Implementation of IAR
5. Development of a system navigation tool to support IAR
6. Sector reform
7. Priority populations
8. Integration hubs

Project plans have been developed for each stream. Tasmania PHN is planning for IAR implementation in the context of the next commissioning cycle scheduled to begin in July 2022. In the interim, Tasmania PHN are planning to develop and test the IAR approach in the primary care sector on a small-scale before region-wide implementation planning for July 2022.

Referrers (including GPs) using IAR is part of the longer-term plan. To facilitate this, Tasmania PHN is hoping to work with peak bodies and other key stakeholders to focus on awareness and training and identify a group of local clinical IAR champions. Tasmania PHN are also factoring in the requirement to have technology in place to integrate and automate IAR processes wherever possible.

Tasmania PHN has had a positive response from stakeholders with whom the IAR Guidance has been shared- particularly amongst the regional planning group who are keen to introduce a single tool that supports a uniform approach to how people are assessed and referred across the system. The PHN reported there is variability in system response depending on where you are and depending on the tools used. Desire to have a single tool is high

The PHN also shared the Guidance with the headspace centres who had a very enthusiastic response. The headspace centres have recently gone through a demand management project and review and have a clear direction of where they want to move to and see IAR as being able to assist them on their journey.

Tasmania PHN noted that the IAR Guidance is a lengthy document and a clinician document needs to be developed and streamlined (including presentation in an interactive online tool).

Resources and supports required

- Health pathways examples aligned to IAR + a HealthPathways and IAR working group across PHNs
- Lots of training for different groups of stakeholders
- Train the trainer model to increase internal confidence and capability in IAR
- Advice for quality teams and provider support teams (e.g., focused live training) so that internal supports are prepped and ready to support GP engagement and onboarding

Adaptations for children and young people

Children can self-refer or be referred by the GPs or other services. There is no MHTP needed for children or young people to access services.

TASPHN do not require the use of the SDQ assessment tool. However, it is offered as an option to any service providing care to children and is used by providers.

TASPHN reflected that the IAR Guidance is likely to require some adjustments to the rating descriptors and the levels of care to be more context specific regarding children and young people. TASPHN would like the input of pediatric mental health specialists at the EAG level to fine tune the IAR Guidance.

WESTERN VICTORIA PHN

Background

Currently the PHN has a decentralised intake model, with GPs having responsibility for assessment and referral to a commissioned provider. Some issues the PHN has detected include:

- Generally, GPs do not have a clear understanding regarding the services available and their focus/eligibility.
- Low uptake of low intensity interventions, with a strong preference for psychological interventions amongst referrers. Exacerbated by our region not having any formal Low Intensity referral pathways or programs.
- Where the assessment is not undertaken well to begin with, there is inefficiency and increased assessment burden on the consumer and family.
- None of the current assessment processes in the region engage with the entire system of care or consider all care/support options.

IAR implementation progress

Western Victoria are developing an implementation strategy that coincides with the re-contracting of primary mental healthcare services by June 2022. In each of the 4 sub-regions, the PHN will work to co-design an outcome based seamless continuum of service which IAR will support. To begin with, the Adult Mental Health Centres will act as a small test to see what the challenges and opportunities with IAR integration are likely to be. The longer term-plan includes:

- Review of current arrangements and future model will be completed by the end of the year.
- The co-design process will commence at the beginning of 2021

Region-wide implementation by June 2022 to coincide with contract reviews and recommissioning activities (Likely to be fast tracked now that hubs have been implemented.)

Head to Help (Hubs) work has now commenced by necessity and fast tracked the implementation of IAR. WVPHN are currently thinking through implementation, including working with commissioned mental health suppliers to commence IAR this financial year.

Adaptations for children and young people

In Western Victoria PHN, GPs and pediatricians make up the bulk of referrals to PMHC for children. A referral form is required; however, a Mental Health Treatment Plan is not for children under 12. The Strengths and Difficulties questionnaire is expected to be administered on entry into treatment by practitioners, consistent with the requirements of the PMHC-MDS.

Headspace centres within the region have been supported with PHN and other funding to adopt a precinct approach to service delivery- with various service intensities and types available. Filtering level of service to treatment need is a high priority. There are no formal protocols for stepping care up and down or agreed care pathways from headspace centres to other services.

WESTERN SYDNEY PHN

Background

Western Sydney PHN (WentWest) operate a central Triage team with 4 triage officers and one Team Leader. The GP's perform an assessment, complete a referral form along with a Mental Health Care Plan and forward to the Triage team via secure fax or healthlink. The Triage team will check appropriateness and eligibility, then pass on to WSPHN inhouse clinicians to refer the patient to the most suitable provider dependent on the patient needs. Many GPs will specify a clinician or service type they are seeking for the consumer.

IAR implementation progress

IAR is being implemented in to the centralised intake process. The IAR Guidance is being implemented within the Triage team and the Triage officers and clinicians have given positive feedback. Triage officers and clinicians have been open to the changes surrounding the implementation of the IAR guidance in the future.

WSPHN are reviewing the technology and processes to assist in implementation of IAR and will use a focused system review scheduled this year/early 2021 to understand the systems and processes that will assist IAR implementation and integration. WSPHN are working on switching over to digital platforms such as HealthLink and have the referral template available on their website. WSPHN are working with GPs to ensure they use the new referral template as some GPs are still using the old method of referring.

WSPHN noted that GPs are generalists, and whilst some may have an interest and additional training in mental health, the PHN acknowledges that mental health assessment and referral tools, and information about referral options must be clear and well-communicated. WSPHN reflected that the Guidance in its current form is too lengthy to expect busy GPs to become familiar with.

WSPHN are actively exploring application of the IAR Guidance within the Patient Centred Medical Homes. How this might look is yet unclear.

What implementation resources or support do you think would be helpful?

- Simple 1-page communication with key information about IAR.
- Support to assist providers and GPs adapt to IAR guidance.
- More funding to employ staff and project managers to assist with implementation.

Adaptations for children and young people

Children and young people are typically referred by GPs. The initial assessment and referral processes are largely the same, however children and young people do not need a mental health care plan straight away but will be required to obtain one from their GP some time during treatment. The mental health treatment plan is the only resource used to determine an appropriate service type and intensity.

WWSPHN requires the use of standard assessment measures (the SDQ), which is performed by the clinician (commissioned provider end).

WSPHN reflected that the IAR Guidance is likely to require some adjustments to the rating descriptors and the levels of care to be more context specific, but otherwise suggested that there is nothing obvious that stands out as requiring adaptation.

WESTERN QLD PHN

Background

WQPHN was involved in Round 1 of the National IAR implementation review. During the implementation review, WQPHN undertook a small-scale test with a selection of general practices. Region-wide, full-scale implementation planning continued after the Implementation Review concluded. Region-wide implementation is about to get underway. Western QLD PHN is using an electronic referral platform (refeRHealth) and is currently working with the developers to integrate the IAR decision making tool so that referrers can choose to use this application.

In WQPHN there is a direct from referrer to commissioned provider pathway. When the IAR tool is embedded within the refeRHealth to the GPs will have the option of scoring the initial assessment domains and, in collaboration with the consumer, the GP makes a referral to an appropriate service. This approach was determined by WQPHN as the approach that will maintain the centrality of the GP in the person's care and recovery.

Implementation progress

WQPHN has focused on adjusting and fine-tuning the electronic referral platform- prioritising technology as a critical enabler. The Implementation Review was seen as useful in that it helped WQPHN to socialize the IAR Guidance and decision support tool with some local clinicians and develop a better sense of what works and does not work when onboarding and orienting clinicians. Whilst WQPHN has invested heavily in the technology to support implementation, the PHN also plans to facilitate training (e.g., webinars) targeting key personnel within the general practice setting and other referral groups.

Western QLD PHN is concerned that the full Guidance (and associated resources) is potentially overwhelming for many busy clinicians- and therefore targeting change leaders at the practice level and having a summary of key information in an easy read form (e.g., 1-page IAR summary) will be especially important. A major challenge has been change management – the default for many referrers in WQPHN continues to be psychological services and full uptake of low intensity services and the National Psychosocial Support measure has not been achieved. WQPHN views IAR as an enabler for improving uptake of new service models.

WQPHN reported that there is potential for consumers to be central to implementation through a modified-version of IAR so that it is 'consumer-facing' whereby consumers self-assess against the domains and consider the recommended level of care generated for them.

Given the focus on IAR adaptations to the electronic referral platform, communication about the changes to the referral process will be central to the communications strategy. In addition, WQPHN will look for opportunities to facilitate access to training as required.

The Implementation Review created an opportunity to test the acceptability of the Guidance amongst a small set of local clinicians. The responses were overwhelmingly positive. With broader roll out, WQPHN is preparing for wider variety of responses, but is more hopeful following the responses observed through the implementation review.

WQPHN noted there are still some barriers with stakeholder knowledge of stepped care- with some clinicians still thinking of stepped care to mean "step up and step down from the hospital." WQPHN also noted that some clinicians do not understand what stepped care means at all. Therefore, WQPHN is also keen to see more training and CPD include content on stepped care as well.

During the small-scale implementation, WQPHN observed no opposition or resistance to the Guidance- but acknowledged that during region-wide implementation there may be some GPs who are not as accepting of the Guidance and/or local implementation of the Guidance.

WQPHN highlighted the importance of clinical champions in implementation of IAR. WQPHN reported that a Mental Health Nurse who participated in the implementation review and attended the IAR training, introduced the IAR Guidance to the GPs within the local practice. The GPs in the practice are now using the IAR Guidance and decision-support tool consistently and the feedback has been incredibly positive. WQPHN sees the opportunity for GP and clinical champions to be a key part of the implementation strategy in the future.

WQPHN did suggest that without MBS reform, some GPs may not engage as remuneration is insufficient. However, a practice involved in the implementation review has reported to WQPHN that using the IAR Decision Support Tool is adding only a couple minutes to a mental health treatment planning- with efficiency increasing the more the tool is used.

The IAR Guidance has not been fully tested across all commissioned providers, but with those commissioned providers we have taken a change management approach. Ensuring a solid understanding of IAR is a key first step. The focus in WQPHN is on GP/person decision-making. Commissioned providers engage with the GP if there are any changes to the service type/intensity (e.g., if further psychological therapy sessions are required). With a focus on multi-disciplinary team-based care, case conferencing between the consumer, GP and the commissioned provider is an expectation when adjustments to the intervention are being considered and when outcomes are being reviewed.

Implementation resources and supports

WQPHN recommended the following resources and supports be made available:

- Simple 1-page communication with key information about IAR.
- An example mental health focused HealthPathway with adaptations for IAR requirements (potential for an IAR + HealthPathways focused working group with representatives from across PHNs to come together).
- National leadership with general practice software vendors (e.g., Best Practice, Medical Director, Genie) so that the automated programming interface for the IAR-DST is available.
- Pre-recorded video-training clips on various IAR topics- 'sectioned' in to focused content so that each webinar is less than 20 minutes in length.

IAR adaptations for children and young people

GPs are central to decision making for referrals for children and young people. There are some commissioned services where the service is initiated and provided within the school- so a slightly different pathway exists for these services. However, ReferHealth is used in all instances, and across all settings. There are also 2 headspace centres in the WQPHN region (Mt Isa and Roma).

WQPHN requires the use of standard assessment measures (the SDQ) as per the PMHC-MDS requirements.

WQPHN reflected that the IAR Guidance is likely to require some adjustments to the rating descriptors and the levels of care to be more context specific- but otherwise suggested that there is nothing obvious that stands out as requiring adaptation. WQPHN would like to see headspace National, Orygen and paediatrician representation as part of the EAG. Incorporating a more developmental focus could make the IAR more applicable for use with children and young people.

CENTRAL AND EASTERN SYDNEY

Background

CESPHN operate a central intake service, which accepts referrals for psychological therapies suicide prevention services, and primary integrated care supports for people with higher intensity service needs. CESPHN have introduced a new referral form incorporating the IAR Domains, DST, and levels of care (matched to local commissioned services). CESPHN use the RediCASE platform, and anyone referring to CESPHN commissioned programs is required to complete the new referral form. The IAR domains and DST in the referral form are currently completed for two commissioned services.

IAR implementation progress

Prior to embedding IAR into the referral form and tools, CESPHN facilitated a consultation with GPs, supported by the National Project Manager. During this consultation, GPs reinforced:

- GPs thought the IAR decision tool was a great tool for their clinical practice
- GPs thought that they were best placed to complete the IAR tool at the time of referral
- GPs were concerned about the potential length of the referral form with the addition of the IAR
- GPs were supportive of inclusion of the IAR tool if the form could also be made to be compliant with a Mental Health Treatment Plan (MHTP)
- GPs were supportive of CESPHN's involvement in the project.

CESPHN designed their referral tools so that GPs could meet the requirements for billing for a MHTP under Medicare- integrating IAR and the MHTP requirements for the benefit of GPs. The unintended consequence of this was making the referral processes appear longer.

Due to the fast pace of the Implementation Review, CESPHN promoted the new online MH referral from via their website and weekly e newsletter however were not able to facilitate an education program for GPs and other referrers. This is something that CESPHN intend to focus on in the future.

In terms of responses and reactions from GPs, CESPHN has observed the following:

- Many GPs have adjusted smoothly to the incorporation of IAR into the referral process
- GPs have also provided positive feedback about integrating the IAR and MHTP requirements into one form

- Some have expressed concern, not so much about the implementation of IAR, but the requirement that all referral forms must now be sent electronically using the Redicase platform (removing the option for fax referrals)
- A few GPs have expressed that the new referral process is too onerous and there are too many questions.

CESPHN has reflected on the importance of having their internal mental health team, digital health and practice support teams available to assist GPs who are having difficulties with understanding the referral and IAR requirements, privacy or adjusting to the technology requirements.

CESPHN reinforced that there were two major changes in the one process- the incorporation of IAR and the requirement to lodge referrals electronically- representing two significant changes for GPs in a very short period of time. Online referral forms were previously only required by non-GPs. CESPHN questioned if referrals were already online, whether the change would have been so challenging for some GPs.

CESPHN reiterated that having monitoring mechanisms in place to determine changes to referral patterns (e.g., are some referrers no longer referring?) will continue to be important. Through monitoring of referrals and referral patterns, CESPHN reported that a large percentage of referrers have just embraced the changes- and there is an increase in GPs using the online form from week to week. Fortnightly monitoring of referral patterns will continue for the foreseeable future. CESPHN plans to do some targeted outreach if the team identifies a drop off in referrals from a practice or GP.

Prior to implementing IAR, CESPHN reflected that a large % of referrals were blank- except for a name, contact information, and a sentence about the presenting issues. IAR and the online form have introduced mandatory fields, automated response options and open text options- this has the added benefit of providing the commissioned service provider with more information than they had previously.

Within Redicase, CESPHN designed it so that a referrer can see the IAR-DST recommended level of care, and also add their own practitioner determined level of care if this differed from the level of care recommended based on the domain ratings. CESPHN will monitor discordance between the recommended level of care and practitioner determined level of care over time.

If the central intake team does not think the GP has made the appropriate referral decision, the intake clinician will contact the GP and discuss other service options.

CESPHN has turned their attention to examining the uptake of services across levels of care. This monitoring will inform future engagement relating to acceptability of low intensity options. With increasing demand attributed partly to the Covid-19 pandemic (and subsequent public health restrictions), CESPHN is focused on fast-tracking work around low intensity options.

CESPHN identified the following focus areas:

- Education of GPs regarding IAR.
- Data monitoring and system performance.
- Uptake of low intensity and IAR in the low intensity workflow.
- Working with the LHD to examine the interface between PMHC levels and L5 care, with agreed referral pathways articulated.

CESPHN benefited from internal project leads implementing IAR who were experienced clinicians- making engagement with other clinicians and the delivery of local training more straightforward. CESPHN also noted the importance of clinical champions involved in engagement and training activities.

The CESPHN team reflected on the importance of messaging about this being a clinical decision support tool- not a new assessment tool, and not something that automates decision-making, removing clinical judgement and consumer choice.

Additional resources and supports

CESPHN reinforced the intensive change management expected of PHNs and reflected on the additional support that could be provided through professional colleges and peaks- e.g., is there a role for RACGP in educating GPs around IAR and how do we embed this into their way of assessment? CESPHN noted that PHNs can only lead so much, but the whole sector should be engaged in supporting change.

Resources developed nationally should consider the broad audiences within the PHN. CESPHN reported that it is important that the digital health, practice support, communication and marketing teams were all involved in supporting implementation and communicating with the sector. CESPHN noted that it took a lot of different units within the PHN to make implementation of IAR possible.

CESPHN recommended communication and training materials that can be designed nationally but customized locally to reflect local processes and systems.

Adaptations for children and young people

CESPHN facilitate central intake for most referrals for children and young people (excluding headspace centres which also run their own intake processes for direct referrals). GPs, schools and CAMHS are the main referrers. IAR has been incorporated into all referral processes and systems in the PHN, and therefore referrers sending referrals for children or young people score the domains and review the recommended level of care. This is over-ruled by the referrer if they do not agree with the recommended level of care. The level of care is then reviewed by the intake clinicians within the PHN before being allocated (electronically) to a suitable provider.

Referrers are asked to include a K10 where possible. The SDQ is administered on entry to the intervention by the commissioned provider.

One headspace centre was involved in the Implementation Review in the CESPHN region. CESPHN facilitated a training session to help onboard. The feedback from the centre was that IAR fits nicely alongside the HEADSS assessment and it is easy to see where IAR fits in the flow and supports decisions about service intensity.

BRISBANE SOUTH PHN

Background

In Brisbane South PHN there are a number of referral pathways available to access Mental health and suicide prevention commissioned programs.

- Self-referral - accepted for low intensity programs, or for higher levels of care the commissioned provider will determine eligibility and will allow the person to engage in care (provisional referral pathway), while the person is supported by the provider to get a mental health care plan if required. If the person isn't eligible they will be supported to access more appropriate supports.
- GP Mental Health referral service - the GP or other referrer (eg. MH Call) will send a referral to the Referral Service who will determine eligibility and assign the referral based on information provided

on the referral, a follow up call to the Referrer and a call to the consumer to confirm which provider they would like to go to depending on the level of care identified by the referrer.

- Direct to the commissioned provider – a GP undertakes an assessment/completes MHTP and makes a referral directly to the commissioned provider.

IAR Implementation Progress

BSPHN are awaiting the Implementation Review report from the University of Melbourne and have not yet implemented the IAR Guidance. BSPHN are still unpacking all the information provided to them and are trying to understand each aspect of the IAR Guidance. BSPHN are keen to work with other PHNs to brainstorm ideas and learn from those who have had success in implementing IAR Guidance. BSPHN have access to the Redicase platform, where there are pre-existing IAR modules that can be introduced in to the BSPHN referral arrangements, however understanding how IAR can be successfully introduced into the current referral arrangements is still being unpacked.

BSPHN is working collaboratively with the HHS to integrate MH-CALL (the HHS calls that may not be appropriate for specialist and acute services). There is currently a focus on eligibility, way-finding and a 'no wrong door' philosophy.

With a direct to provider referral pathway, the implementation of the IAR Guidance and IAR-DST will take considerable resources. BSPHN identified that funding to employ dedicated staff to support IAR implementation is a barrier.

Future implementation supports and resources required

- BSPHN is keen to learn from other PHNs regarding implementation of the Guidance.
- Training sessions to better understand IAR within and external to the PHN

Adaptations for children and young people

The BSPHN referral process for children and young people is similar to the referral process for adults. BSPHN reported that GPs are the main referrers for child and young people. Currently, there are no low intensity options commissioned by BSPHN for children under 12, headspace centres in the Brisbane south region have been funded to deliver low intensity services as part of an enhanced wrap around, stepped care model. A MHTP is a requirement for referral for Psychological Therapies, however if required, children and young people can access up to 3 sessions of psychological therapies before requiring a MHTP.

BSPHN reported very high demand across the headspace centres in the region.

BRISBANE NORTH PHN

Background

BNPHN were involved in Round 2 of the Implementation Review undertaken by the University of Melbourne. The exemplar report prepared by BNPHN is included in Section 6. BNPHN facilitates an in-house service navigation team called My Mental Health Service Navigation- this team is responsible for supporting consumers, community members, and referrers to identify an appropriate local service option. This is a non-clinical team- thought the members of the service navigation team may hold clinical qualifications they do not provide a clinical service. Via the software system, RediCASE, referrers and commissioned providers are responsible for use of IAR and DST as present in the referral form.

Implementation progress

Brisbane North PHN implemented the IAR Guidance using the referral software *RediCASE*. This software supports a referral form that is available to all referrers in the region and enables conditional logic and routing to suggest the service options most suitable to the clients' needs. The recommended level of care is available automatically, and the referrer can select a practitioner determined level of care- which may be different to the level of care generated by the DST.

All mental health providers commissioned by Brisbane North PHN region are required to use the *RediCASE* software for two purpose:

1. To receive and send referrals
2. To collect the PMHC-MDS

BNPHN has worked with their vendor to develop a GP integrator, allowing GPs to integrate the smart referral form within practice software.

IAR implementation has focused on referrers, however BNPHN is also working with commissioned providers to integrate IAR and the DST. For commissioned providers, IAR represents a checkpoint for those clients who do arrive at the service provider of their own accord and are classified as 'walk-in' clients. As the intake clinician at the service takes the walk-in client through the *RediCASE* referral form and IAR triaging, it may eventuate that the client would be more suited to attend a different level of service. For this reason, Brisbane North PHN needed to facilitate IAR decision-making at the service level, so that walk-in clients may still be afforded the necessary IAR triage process and end up in receipt of their required level of care.

One challenge that BNPHN has had to address, is accommodating a logic for suicide prevention specific services. Currently the flag sits within Domain 2 (risk of harm) wherein a rating of 2-3 indicates a need for suicide specific services. This is an ad-hoc solution that the PHN has developed, and likely needs greater guidance and evidence to support its utility in practice. A rating of 4 indicates a need for specialist and acute services. There is an emergent need for those scoring '4' to be simultaneously referred to lower levels of care, even when an acute service is immediately appropriate. This is to ensure community services are available to the person upon their discharge from an acute service. However, this is not straightforward and BNPHN will continue to monitor the appropriateness of these flags.

Implementation Observations and Feedback

<u>Diagnosis-Specific Referral Pathways</u>

Another challenging aspect that BNPHN has encountered lies in the trans-diagnostic nature of the tool. For example, if someone has a specific diagnosis (e.g., an eating disorder or borderline personality disorder), there may be specific programs targeting this particular diagnosis, BNPHN needs to be able to display these diagnosis specific options to referrers, however the IAR itself has limited utility in this regard. The PHN has the capacity to address this problem via the rediCASE referral form, however this does not address the lack of specificity in the IAR guidance itself.

<u>Implementation Feedback from GPs</u>

The feedback from referrers and other stakeholders to the changes has been fairly balanced. Many referrers loved the changes introduced and reported feeling clearer about what to do next in terms of referral options and appropriateness. Around 20% of GPs are still using old referral forms and faxing referrals, and so the change management process is a little more intensive, with the service navigation team providing pro-active support for referrers to adapt to the changes.

<u>Discrepancies between Levels of Care</u>

It was noted that the Severe and Complex Mental Health Hubs sometimes had discrepancies between the Calculated Level of Care and the Practitioner Determined Level of Care. The trend was an override of the IAR result to ensure alignment with the Level 4 service provision. While it is not possible to determine the reasons for this, the PHN suggested that there may be disincentives for on-referring to another level of care when indicated. Potential suggestions ranged from concerns around meeting KPIs to reluctance to turn away a client who has contacted the particular service for assistance.

Referrers Learning Over Time

BNPHN is noticing a growing level of familiarity and capability amongst referrers and commissioned providers- wherein they've gone through the process multiple times and can predict the recommended level of care- where the DST is applied through knowledge of the DST rather than actual use of the DST.

Clinical Governance Checklists

BNPHN has used the clinical governance checklists in the Implementation Toolkit to support system performance monitoring.

Implementation resources and supports

BNPHN suggested the following additional resources and supports be made available:

- Focus on data governance and consistency with PMHC-MDS. Potential for future adaptations to PMHC-MDS to incorporate the IAR data.
- Continued flexibility for implementation but an expectation of alignment to best practice and evidence, including consideration or guidance of referral pathways for disorder-specific and suicidal presentations
- Continued leadership by the Department of Health to socialise the Guidance and promote broader awareness across the sector- the Guidance is not just for PHNs and can be more broadly adopted.

Adaptations for children and young people

BNPHN commissions Brisbane MIND4KiDS (psychological therapy for children 0-11 with mild-moderate mental health difficulties). Referrals typically follow the same process as for adults, with the key difference being that the services options populate based on the child's age selected by the referrer, instead of the level of support required. BNPHN noted a limited range of child mental health services for GPs and others to refer to.

When thinking about the service system, there is less agreement and vision as to what constitutes a stepped care approach for children – and intensity is not necessarily driven by the intensity of the treatment needed but rather the complexity of the child's environment and the need to involve education, family, disability services, child protection services (for example) and other support systems that sit beyond the mental health system. Teasing out behavioural, neurological and developmental from mental health issues also represents a complex issue for further exploration.

BNPHN commissions headspace centres in Caboolture, Nundah, Strathpine, Redcliffe and Taringa. BNPHN also commissions a school based counselling service and a mobile outreach service for vulnerable young people (aged 12–25) who have or are at risk of developing a severe mental illness.

WESTERN AUSTRALIA PRIMARY HEALTH ALLIANCE

Implementation Progress

WA Primary Health Alliance (WAPHA) has prepared a detailed project plan to guide the development of the IAR model for Western Australia over the next 2 years, including project governance and resourcing, work program, timelines, and milestones. Effective engagement with GPs and other stakeholders is core to the plan.

WAPHA has designed governance arrangements including a project steering committee, and a GP Advisory Group. The GP Advisory Group's participants will provide real world expertise and input into the design of the Initial Assessment and Referral gateway, by contributing to key decision making within the project's scope and identifying preferred solutions, in building the basic service model architecture.

There are four phases to this work:

1. Stage 1 - Discover: engagement with multiple stakeholders to understand current experiences and start thinking about what the future state should look like to best suit consumers and other end-users.
2. Stage 2 - Draft: Building on early thinking from Stage 1, WAPHA will work closely with experts to develop a high-level draft of the service and all of its components.
3. Stage 3 - Develop: We will continue to work with experts and other stakeholders, including consumers to further develop the detail of the service.
4. Stage 4 - Deliver: Once the service is designed in full, WAPHA will begin to test it with a small sample of consumers. Based on how this testing goes, WAPHA will improve the service ready for a full pilot with a bigger sample.

WAPHA has already undertaken mmarket research reaching over 240 consumers and results have been presented to the core project team. WAPHA has also facilitated the initial design workshops with GPs and peak bodies.

- Final high-level service model (Late November 2020)
- Final clinical composition (February 2021)
- Final Detailed service model (May 2021)
- Conduct beta pilot (July 2021)

Importantly, WAPHA are actively exploring an overlay of IAR and clinical staging, mapping what this will look like from a consumer journey point of view, baselining their approach on the IAR guidance but building in additional specification that reflects scale and reach of the proposed statewide service model. WAPHA are working with key stakeholders, using expert and tacit knowledge, and are keen to build out a model that further extends this work pursuing personalised care planning and care delivery.

WAPHA noted that in terms of GP-led decision making, they are hearing feedback that GPs want the choice of doing the assessment themselves or the option to 'hand it on.' There is not a one size fits all approach and the perspectives of GPs through the GP advisory group will be critical throughout the design.

WAPHA are interested in developing a GP dashboard, so that the GP can see beyond the front door and know quickly if the intervention is making a difference to the person or how that person is responding to treatment using 4-5 select metrics.

Additional resources and supports

WAPHA identified the following resources and supports as being potentially useful:

- Opportunities for sharing across the PHNs, helping to get a sense of how each PHN is progressing relative to others and learn from within the sector
- PMHC-MDS alignment with IAR (and system performance monitoring potential)
- Opportunities for showcasing work underway across the network
- Examples of IAR operationalised (plans, job descriptions, commissioning criteria, contract examples).

Adaptations for children and young people

The above work is in scope for all age groups and all population groups in the region- however WAPHA is starting with a scaffolding approach noting that the children/adolescent workflow is far more involved and that a more cautious approach will be needed.

MURRUMBIDGEE PHN

Background

In 2018/19, Murrumbidgee PHN conducted a review of stepped mental healthcare in the region- this review included a focus on the role of central intake and how services were designed and commissioned. The Centre for Rural and Remote Mental Health was commissioned to review the Murrumbidgee mental health stepped care framework using a co-design approach, along with a clinical governance framework to support the model.

'MyStep to Mental Wellbeing' was subsequently commissioned by MPHN. The program bundles mental health services using a multi-intensity service approach, by geography. My Step includes low, medium, and high intensity interventions (including funding for people with severe and complex mental illness, RACF funding, and suicide prevention focused psychological interventions). Some place-based services (e.g., social, and emotional wellbeing services through Aboriginal Community Controlled Health Services and headspace centres) are not included in the suite of services.

MPHN delivers an access and navigation service (in-house), whilst the two providers are responsible for intake.

IAR implementation progress

The National IAR Guidance was included in the MyStep RFP, and MPHN have ensured there is a contract lever requiring that each provider implements the IAR Guidance and decision support tool once the implementation review is complete. Murrumbidgee PHN intends to work closely with the commissioned providers to understand how IAR might best be implemented in the region. This will include exploring the roles and functions of the commissioned providers and referrers (including GPs).

Murrumbidgee PHN have a clinical governance framework and have a data analytics platform in place to help monitor indicators of effectiveness.

Additional implementation resources and supports

Murrumbidgee PHN identified the following resources and supports as being of value:

- Training in IAR application
- Activities that promote sharing across PHN regions
- Digital decision support tools including a GP software integrator

Adaptations to the Guidance for Children and Young People

'My Step to Wellbeing' services are available for all age groups. Referrals for children and young people follow the same general process as for adults, with the exception being that GP referrers can complete a Child Treatment Plan (CTP) rather than Mental Health Treatment Plan. Children and young people can commence services without a CTP or MHTP, but the provider is asked to support the child or young person to access a plan following assessment if they require more than a low intensity service, though including GPs in client care is considered best practice.

No standard assessment tool is required as part of the referral. The SDQ is completed by the commissioned providers on entry to service. Whilst GPs represent the bulk of referrals for children and young people, a range of provisional referral pathways are in use including from paediatricians, schools, non-government organisations, and parents.

Murrumbidgee PHN reflected there are very few referrals requesting a low intensity intervention for children, hypothesising that GPs and other referrers may be trying lower intensity options before making a referral to PHN commissioned interventions. Murrumbidgee PHN also suggested that given the nature of services for children, the treatment course is naturally slower and more intensive when considering the rapport building process, involvement of family members, interactions with schools and other members of the care team. Subsequently, the intervention is quite intense, even if the treatment itself is lower intensity.

The headspace centres include NewAccess (low intensity coaching) interventions. There is a process in place for identifying young people who are likely to benefit from a low intensity intervention, and internal processes for stepping up to more intensive interventions if required.

NORTHERN TERRITORY PHN

Background

NT PHN commission a central intake for mild to moderate psychological interventions in the Greater Darwin region. Most mental health programs commissioned have place-based referral and intake pathways led by the referrer and commissioned provider or local primary health care clinic (in rural and remote areas). The MHTP via the GP is a key component of the referral requirements.

Implementation progress

NT PHN are planning a staged approach to implementation of the IAR Guidance. With a large statewide region, NT PHN is conscious of coordinating implementation in a way that is sensitive to the various service contexts, service models, and systems across remote, rural, and urban communities throughout the NT. For some communities within the NT, there are minimal services which means all levels pf care may not exist outside or one clinic/service delivers the full spectrum of stepped care activity. In other communities (e.g., urban centres), a greater diversity of service types and intensities are generally available.

NT PHN will coordinate the implementation of an Adult Mental Health Centre in Darwin and is currently exploring the implementation of IAR within the service model. This will represent the first small-scale introduction of IAR in the NT PHN region. Importantly, engagement with and input from the Top End Mental Health and the local governance group will be critical.

NT PHN are embarking on a review of mental health and suicide prevention related health pathways. NT PHN are exploring opportunities to integrate IAR within the health pathways available to referrers and clinicians.

Reactions and responses to the Guidance

Overall, the reactions and responses to the Guidance have focused on the readiness of the region for implementation and therefore considering IAR implementation in the context of regional mental health and suicide prevention planning is important. Within regional planning NT PHN have been looking to:

- Co-design what the stepped care approach looks like for the NT, but with a place-based and context-specific lens reflective of local workforce
- Situate IAR implementation within the context of these broader reforms and co-design actions.

NT PHN are also focused on developing the relevant mental health capabilities amongst GPs and other referrers that are necessary for IAR implementation. Activities like mental health focused CPD, the introduction of the GP Psychiatry Support Line, and pathways for increasing the uptake of GP mental health skills training were all identified as important activities for developing MH capabilities across GPs, however NT PHN recognised that more discussion and consultation around other capability development strategies will be important as the region prepares for IAR implementation.

NT PHN suggested it would be helpful for RACGP and ACRRM to be involved in facilitating training related to IAR and IAR capabilities.

NT PHN reported that a peak body had recently made contact enquiring about the PHN's plans for implementation of IAR. This reinforces other feedback that the broader sector is now showing an interest in IAR and an interest in being involved as PHNs explore implementation.

Additional resources and supports

NT PHN identified the following resources and supports as important to local implementation of IAR:

- Access to training about IAR
- GP focused training about IAR and related capabilities
- Facilitated opportunities to come together with other PHNs to explore implementation opportunities and challenges
- Engagement with the QLD/NT PHN mental health collaborative and CEO collaborative.

Adaptations to the Guidance for Children and Young People

The initial assessment and referral process for children and young people in NT PHN is consistent with the requirements for adults (excluding headspace centres).

NT PHN expressed concerns about the lack of policy directives and funding relating to system reform and stepped care for children. With funding for child mental health services 'coming straight in the door and back out again.'

NT PHN commissions 3 headspace centres (Darwin, Katherine, and Alice Springs). The Darwin headspace centre has early psychosis funding. The Darwin and Katherine Centres have the same lead agency, whereas the Alice Springs centre is led by an Aboriginal Community Controlled Organisation with a variety of social and emotional wellbeing initiatives also available to young people and their families.

COUNTRY SA PHN

Background

In Country SA PHN commissioned providers facilitate intake- with weekly clinical triage in place for review of referrals. Referrals are predominantly via the GP with a MHTP required.

IAR Implementation Progress

Country SA PHN have supplied the IAR Guidance to the 5 larger suppliers of adult commissioned mental health services, with an expectation of use although not formalised at present.

Country SA PHN has worked in partnership with 3 headspace centres and Orygen (through the Implementation Labs initiative) to pilot the IAR Guidance and DST within headspace settings which also provides Youth Complex and Severe Mental Illness services onsite. The pilot is midway through, with Orygen facilitating a mid-review meeting and report, noting that:

- IAR tool used: 61 clients
- Suitable to identify severity of presentation and complicating factors
- Easy to use with practice
- Appropriate for settings which have a variety of referrals with differing levels of need and complexity
- More objective
- Easier to provide feedback to referral sources/ or articulate reasons for needing other services
- Potential use of IAR for development of a review/ outcome measure

Team members using the IAR DST applied the DST following the HEADSS assessment. Team members reported increased time-based efficiency with practice and experience, and that the DST would require about 15 minutes additional work for YP with significant complexity- and less if the young person's experiences were more straight-forward.

Some early feedback from clinicians suggested further exploration of:

- Extra weighting for social connectedness and social/environmental stressors when using IAR DST for young people
- Prompts that capture disorder-specific requirements and considerations
- Safety planning flags and prompts

The pilot is anticipated to conclude on 31 October 2020, and a decision will be made to continue using the tool in the headspace setting or not. It is important to note, that headspace National does not recommend the integration of IAR into headspace settings preferring that centres wait until the process for reviewing the Guidance for youth focused adaptations is complete. The findings from the work of Country SA PHN, Orygen and the local headspace centres will be part of the evidence based considered by the EAG as adaptations to the Guidance for young people are considered.

Country SA PHN are keen to step to a more formal plan for region-wide implementation of IAR and the DST. The approach to working with larger commissioned providers is simpler than considering implementation with referrers and single clinicians- therefore a staged plan with input from key stakeholders is a future goal for the PHN.

Additional resources and supports

- Access to IAR Training
- Example implementation plans from other PHNs
- Resources that help to support referrer practice and process change

- Health Pathways focussed working group to explore integration of IAR and health pathways across PHNs
- Clearly stated rationale and objectives for communicating the case for change.

Adaptations for children and young people

The process for referrals for children and young people follows similar requirements to adults- with a GP referral using the MHTP the major pathway. Country SA PHN reported that the stepped care system for children looks very different than for adults. Country SA PHNs commissions psychological services for children and some place-based low intensity interventions (e.g., school focused low intensity service).

CENTRAL QLD WIDE BAY SUNSHINE COAST PHN

Background

CQWBSC PHN facilitates an in-house centralised intake. This transition occurred more recently, with a focus on improving a consumer's first experience and engagement with mental health supports, providing more control over the stepped care approach regionally, and improving the timeliness of service responsiveness to referrals. CQWBSC PHN funds 1 FTE clinical escalation support to be available for more in-depth clinical assessment that might be warranted, and support responses to crisis. The in-house team is comprised of service navigators and a clinical lead.

IAR implementation progress

CQWBSC PHN was involved in round 1 of the Implementation Review with the University of Melbourne. IAR is used as a clinical decision support tool within the intake team- removing subjectivity and more easily identifying reasons to escalate for clinical review. Some consumers may be contacted for further information if needed.

CQWBSC PHN is keen to explore use of IAR by referrers, but not the timing is not currently right for this work. CQWBSC PHN forecasts concerns relating to GP remuneration, the need to integrate the MHTP and IAR, and competing priorities for GPs during the pandemic. CQWBSC PHN acknowledges that a smart referral system would be required to streamline integration of IAR with existing referral processes.

Additional resources and supports

- Policy alignment regarding IAR, MHTP and MBS
- Ongoing training for stakeholders
- Sharing examples from across the PHN network

Adaptations for children and young people

CQWBSC PHN anticipates challenges matching the levels of care with the more complex system of child health and mental health services at the regional level- citing the broad range of providers (e.g., HHS services, disability services, child health services, schools, child protection services and community organisations) as all having planning and service delivery responsibilities associated with child mental health. CQWBSC PHN noted the lack of coordination across the entire child mental health system. CQWBSC PHN also noted the complexity associated with neurological, behavioural and psychological diagnoses and experiences, and the difficulty identifying what belongs in child mental health IAR guidance, and what is out of scope.

CQWBSC PHN noted the following challenges to anticipate:

- Age breakdown for the work (e.g., 0-4, 4-6, 6-8, 8-12, 12-16)

- Identifying the workforce- what are the capabilities and skills
- Alignment with early interventions thresholds within the NDIS
- IAR and family-inclusive expectations
- Significant variations in system from region to region, and across states/territories

SOUTH EASTERN MELBOURNE PHN

Background

SEMPHN facilitates an in-house Access and Referral Team (A&R Team). This team was restructured in July 2020 and it is now a full clinical team- the workforce includes social workers, mental health nurses, psychologists, and clinical psychologists with mental health assessment training. One of the reasons for introducing an in-house clinical team was due to the increasing range of referrer types (including self-referrals), the increasing levels of complexity in referrals and the changing scope of services within the local landscape. The A&R team redirects some referrals to more appropriate providers (commissioned and non-commissioned providers) following discussions with the referrer and/or consumer.

IAR Implementation Progress

SEMPHN has a multi-faceted plan for implementation of IAR, and some actions are already underway of nearing completion.

- SEMPHN are working alongside the 6 Victoria PHNs to implement IAR within the intake systems serving the HeadtoHelp Hubs. This has involved the development of an IAR operational manual for use by a statewide intake service, PHN central intake teams, and 15 HeadtoHelp Hubs. This is providing a unique opportunity to test implementation strategies ahead of region-wide roll out.
- The SEMPHN A&R team has now all been trained in IAR through training facilitated by the National Project Manager.
- More broadly, the SEMPHN A&R team manage enquiries that come in via telephone (consumer, carers), traditional faxed referrals, and SEMPHN has an online link where other referrers can refer using an online form. The A&R team uses the IAR-DST for all referrals coming through.
- The SEMPHN referral form now includes the IAR domains- SEMPHN are using the Redicase platform. The referral form will be used by non-GP referrers to begin with. SEMPHN will target roll-out to high traffic referrers in the first instance.
- SEMPHN is considering GP focused implementation but SEMPHN is conscious of getting the timing right given the impacts of the Covid-19 pandemic on the GP and broader healthcare sector.
- SEMPHN are developing a communications plan for engagement with GPs and are keen to ensure GPs have access to training.
- The Redicase Platform has an integrator so that IAR can be seamlessly accessed via existing GP software.

As part of the staged approach to implementation, the IAR domains will not be mandatory for the first few months, however SEMPHN will establish an expectation of IAR domain completion with time.

Feedback from the SEMPHN workforce has been positive. It is too early to formally capture feedback from other stakeholders, but SEMPHN is presently exploring performance indicators (including referrer and consumer experiences).

SEMPHN are actively exploring performance indicators and appropriate measurements.

Additional resources and supports

SEMPHN are interested in understanding more about integrating the MHTP with and understanding the benefits for GPs.

In addition, SEMPHN suggested the following resources and supports:

- Sharing what others have done
- National online IAR forum - bring to life the State of Play Report
- Resources relating to measurement of effectiveness of IAR implementation and IAR approach
- IAR evaluation framework
- Basecamp for sharing resources and documents across PHNs
- Ongoing access to training
- Facilitated peer supervision for intake clinicians/practitioners

Adaptations for children and young people

Referrals for children and young people follow the same process as for adults. An SDQ is required at the point of assessment by the commissioned provider. No standard assessment tools are required as part of the referral.

WESTERN NSW PHN

Background

All intake in WNSW PHN is done by the individual commissioned organisations. Commissioned organisations receive the referral information from the referrer and typically contact the consumer to check the recency and accuracy of the information- this may be a telephone contact, or the information may be reviewed during the initial face-to-face service contact. Referrals are typically from GPs, community organisations and self-referrals. If a service determines this is not an appropriate service option for the consumer's treatment needs, all commissioned providers are expected to sign-post and warm refer to another more appropriate service. WNSW PHN are keen for commissioned providers to utilise an agreed mechanism for stepping up, down and out depending on appropriateness.

IAR Implementation progress

WNSW PHN have not yet implemented IAR guidance- WNSW PHN is keen to review the findings of the implementation review prior to introducing changes in the region. WNSW PHN is keen to learn from the implementation review, from other PHNs and have access to training as they begin to explore implementation in the region and what this looks like. There are many context specific considerations for WNSW PHN, particularly as it relates to partnership with Aboriginal Community Controlled Organisations and place-based services. WNSW PHN would like to focus on building engagement, awareness and knowledge amongst key stakeholders and have early exploratory conversations with key stakeholders about what implementation might look like.

Additional resources and supports

- Implementation Guidance would be wonderful

- Demonstrations and examples of how the IAR can work
- Education, workshops, and training
- Ideas for workshopping IAR with providers and consumers to find out their thoughts and what it might look like, potential challenges and opportunities
- How has this worked in PHN regions where a high proportion of the population is Aboriginal and/or Torres Strait Islander.

Adaptations for children and young people

WNSW PHN commissions 5 headspace centres, the Rural Youth Mental Health Service (for young people experiencing severe mental ill health) and NewAccess teams are being trained in delivering interventions for 12-16-year-olds. WNSW PHN also prioritise funding for psychological interventions for children and young people.

Currently, providers are using an outcome measure on entry and at every clinical service contact, with WNSWPHN building an expectation of therapeutic use of outcome measures.

WNSW PHN were supportive of engaging headspace National, Orygen, and Emerging Minds in the EAG and suggested representation from an Aboriginal Health Service.

SECTION 6- PHN IMPLEMENTATION REVIEW SITE EXEMPLARS

NORTH WEST MELBOURNE PHN EXEMPLAR

Describe the IAR process/activity implemented.

North Western Melbourne Primary Health Network (NWMPHN) was selected to take part in Phase 2 of the Initial Assessment and Referral (IAR) pilot which commenced in November 2019. However, the NWMPHN has been involved in previous discussions with the Commonwealth since 2018, gathering a broader understanding of the development and use of standardised assessment guidelines.

Why was this activity important to IAR implementation in your region?

The IAR pilot was recognised as an important activity for NWMPHN. These reasons included:

- Providing a model that enables consistent responses and allocation decisions by NWMPHN services
- Being an enabler for Stepped Care
- Providing clarity regarding step up and down care (movement through the steps)
- Better allocation of scarce resources
- Providing a well-developed framework for referral decisions
- Assisting in promoting clarity, consistency, collaboration (with consumers and providers) and a high standard of clinical decision making (i.e. Clinical governance)
- Assisting in building future assessment guidelines for regional mental health and Alcohol and Other Drugs (AOD) services
- Promote more consistent and informed reviews of consumers' current needs, appropriate service levels and a rationale for difficult decisions (transparency)

How did you go about this activity? What were the steps? What resources were needed?

November 2019

- Formed the IAR Implementation Group with regular scheduled meetings
- Identified key stakeholders. Early engagement with mental health leaders through the PHN clinical council and expert advisory groups (mental health and AOD).
- Appointed a project lead.
- Early engagement with key NWMPHN leaders and several information sessions to NWMPHN mental health and AOD staff
- Regional engagement. Presented IAR pilot information to NWMPHN collaborative conversation event (City of Melbourne LGA focus). The purpose was to bring providers from a range of NWMPHN funding streams together to facilitate discussion across the health system and promote cross-sector collaboration. The event was mainly attended by providers funded through AOD, mental health, suicide prevention, homelessness, chronic disease/integration.

December 2019

- Weekly meetings with the IAR implementation group
- Engagement with consumer advocacy groups

- Engagement with Comms and marketing to precipitate PHN involvement and plan for use in the region
- Participated in IAR teleconference meetings via Mental Health Liaison to identify upcoming issues and current models used for Round 1
- Recruitment of stakeholders GP's, CAREinMIND and Drummond Street Services.
- Reviewed existing CAREinMIND referral and intake processes, current tools, and forms against guidance
- Developed guide for referrers

January 2020

- Weekly meetings with the IAR implementation group
- Mapped GP referral pathway for eligible pilot participants (attached)
- Telephone conference with National Project Manager
- Information sessions/meetings with GP's
- Surveys sent to stakeholders
- Training in use of the online guidance tool

February 2020

- Weekly meetings with the IAR implementation group
- IAR Project – Implementation Review Site Meeting
- Online training for CAREinMIND staff
- Regular contact with GP's and Drummond Street Services

March 2020

- Weekly meetings with the IAR implementation group
- Regular contact with GP's and Drummond Street Services
- Distribution of IAR survey and survey reminder to regional stakeholders
- IAR consumer 4-week audit period begins

April 2020

- IAR consumer 4-week audit period ends

May 2020

- IAR Workshop with Melbourne University and CAREinMIND staff
- IAR Upload to Commonwealth/Uni Melbourne??

What were the enablers for the activity?

The NWMPHN identified the value of the IAR and prioritised resources for the pilot.

- An IAR implementation group was formed to direct the pilot
- A dedicated project worker was allocated to implement the pilot

- Availability of the Commonwealth and University of Melbourne to assist particularly in the early stages with understanding pilot information
- Access to consultant groups (EAG, GP Advisory Group and the Clinical Council)
- Good existing relationships with providers (such as Drummond Street and GPs) who participated in the pilot
- Positive staff expectations as to the value of introducing a consistent set of guidelines in the IAR and recognition of the suggested domains included in the pilot.
- Articulating our own processes internally via process mapping assisted us in understanding key steps and where IAR could be embedded

How has the pilot benefitted the PHN and participating stakeholders?

Drummond Street Services (DSS) and CAREinMIND (CiM) have utilised the IAR successfully and incorporated the guide easily into their referral process. CiM operates as a centralised intake service where (mostly) GP referrals are assessed by CiM staff members based on the information provided in the referral.

Because the pilot required participating staff to contact the client directly, the IAR guide elicited much more information about the client's needs. Staff were also able to assess the urgency and priority of some of the referrals. CiM staff found the process rewarding although time intensive (approximately 40 minutes phone assessment time and 20 minutes attempting to make contact).

Clients have been positive in their responses and participation. The IAR has promoted a client centred collaborative and holistic approach to service provision. Clients expressed that their experiences and concerns are validated by assessing and exploring their counselling and support requirements within the range of domains. The extra information collated by the process has been particularly useful for the allocated mental health practitioner's planning and service delivery.

Clients agreed with the IAR levels of care recommended by the guide and have shown an interest in what other levels of care are available.

What were the challenges for the activity?

- The main challenge has been with GP's enacting the use of the IAR – even with training and support. Unfortunately, the COVID restrictions and resulting GP priorities had an impact on the level of GP participation, although the participating GP's expressed positive expectations in the lead-up to the audit period.
- Large scale regional GP engagement and continuity in the use of the IAR may require further investigation.
- Clients have been reluctant to accept level 1 treatment options after the GP has told them they are referring for face to face counselling.
- Another challenge has been in navigating and recommending different support options (substance use, housing, mediation,) and then having the referrer or the provider follow up on those services). Related to this is the level of access to alternative services and referral pathways.

What would your PHN do differently?

If NWMPHN was to implement the IAR pilot again some of the suggested changes would include:

Simplification of IAR literature and documents. Several drafts were released and information provided that was not directly relevant to the pilot (but to broader long term PHN implementation of the final IAR). There was considerable time spent understanding what the critical information was.

Further comment:

The pilot presented many opportunities to engage in dialogue about the advantages of a more targeted assessment for entry into mental health services. Currently, GP assessments are varied, with some providing comprehensive mental health plans and others offering templates that provide incomplete, scarce, and sometimes incorrect information.

The pilot enabled discussion within the CiM team about different models and pathways that might allow better assessments to be conducted.

Assessments provide information in relation to client need but there needs to be a stronger emphasis on enabling consistent, reliable, and timely referral to a range of services (homelessness, domestic violence, addiction, parenting, specialist services including forensic).

The trial has highlighted the value of more stepped care options for clients and a need to build acceptability of these.

What types of measures indicate success or otherwise?

- Of the 5 GP's who agreed to participate, only 2 followed through with the training and only one completed an assessment. This was largely due to the impact of Covid-19.
- K10 scores correlated well with client self-assessment outcomes
- IAR has allowed NWMPHN to gather comprehensive and rich client information. It has Informed the client of services available that they could access and encouraged broader discussion of client needs.
- NWMPHN CAREinMIND team recognise the value of a standardised approach to enable stepped care decision making and matching
- The trial has successfully been delivered despite the challenges associated with Covid-19.

What advice do you have for other PHNs considering a similar activity?

- Engage consumers with lived experience to inform the design of templates (University of Melbourne templates) and test these prior to implementation.
- Consider combining client consent with assessment in the same session.
- When using the online DST, ask the client if they agree with your rating on each domain.
- Be prepared to offer or suggest other services if the client is struggling in other areas (financial, homelessness, domestic violence, mediation, parenting etc).
- Keep in regular contact with the National Project Manager.

VICTORIAN HeadtoHelp EXEMPLAR

Implementation of IAR within the HeadtoHelp Hubs

15 HeadtoHelp Hubs were established in response to the Covid-19 pandemic in Victoria. The 6 Victorian PHNs. The HeadtoHelp Hubs have been designed to provide high quality, evidence-based treatment, information, and support to people of any age who may be experiencing distress or mental ill health, and their families, carers, or support networks. The HeadtoHelp Hubs have been embedded in existing community settings and will facilitate a holistic approach to care which addresses a broad range of social, physical, and emotional needs.

High quality and effective intake and referral processes are a key component of the strategy, ensuring that the individuals seeking assistance for mental ill health and distress are supported to access the most appropriate level of care that will best meet their treatment needs and recovery goals.

Intake services have been dispersed across several settings. These include:

- One state-wide central intake service.
- PHN referral and access teams (and their commissioned providers).
- HeadtoHelp Hub providers.

The state-wide central intake, the PHN referral and access teams, and the HeadtoHelp Hubs are assessing the needs of people seeking access to information, resources and/or services using the Initial Assessment and Referral (IAR) Guidance and IAR Decision Support Tool (IAR-DST).

The implementation of IAR in the context of the Victorian HeadtoHelp Hubs required considerable and coordinated effort by the 6 Victorian PHNs. The Victorian PHNs were able to rapidly:

- Develop a state-wide smart referral form using the data library and test data set developed by Strategic Data and commissioned by the Department of Health.
- Develop an operational manual for standardised application of the IAR and IAR-DST.
- Develop level of care referral protocols with further customisation for each local PHN region.
- Question prompts to align with the 8 initial assessment domains.

The 6 Victorian PHNs facilitated access to IAR training for more than 400 clinicians/practitioners through the National IAR Project Manager, via 2.5-hour online workshops with positive feedback from participants (measured via an anonymous online survey).

NORTH BRISBANE PHN EXEMPLAR

Background

Brisbane North PHN implemented the Initial Assessment and Referral Guidance (IAR) via the referral software *RediCASE*. This software supports a referral form that is available to all referrers in the region and enables conditional logic and routing to suggest the service options most suitable to the clients' needs.

All mental health providers commissioned by the PHN in the Brisbane North PHN region are required to use the *RediCASE* software for two purposes:

1. To receive and send referrals
2. To collect the PMHC-MDS

The referral form is available throughout the whole Brisbane North PHN network. It is used widely and beyond a select group of either internal or external referrers. As such, integrating the IAR guidance into the form meant it would be undertaken by a multitude of referrers including GPs, PHN staff, other health practitioners and service providers themselves. Service providers use the referral form to make referrals into their own program – when a client walks in the door, or calls the service, for instance.

In the context of the IAR, service streams were aligned with specific levels of care:

Level 1 – Self Management	(no PHN commissioned services)
Level 2 – Brief Therapies	(five PHN commissioned services)
Level 3 – Psychological Therapies	(five PHN commissioned services and multiple providers)
Level 4 – Severe and Complex	(three PHN commissioned services)
Level 5 – Hospital Care	(recommendation to contact the hospital)

The IAR represents a checkpoint for those clients who do arrive at the service provider of their own accord and are classified as 'walk-in' clients. As the intake clinician at the service takes the walk-in client through the *RediCASE* referral form and IAR triaging, it may eventuate that the client would be more suited to attend a different level of service. For this reason, Brisbane North PHN needed to facilitate IAR decision-making at the service level, so that walk-in clients may still be afforded the necessary IAR triage process and end up in receipt of their required level of care.

Examples

1. A client who presents for the *NewAccess* Brief Therapy service (Level 2). Upon completing the referral form and intake with the coach, a higher level of risk is indicated warranting a referral to a Level 3 one-on-one psychological therapies program.
2. A client who presents to a Severe and/or Complex Mental Health Hub (Level 4) seeking mental health nursing/care coordination. Upon completing the referral form and intake with the psychosocial support worker, a lower level of distress is revealed indicating a referral to a Level 3 one-on-one psychological therapies program.

As this point of referral or entry to a service is arising at the service provider level, Brisbane North PHN needed to facilitate decision-making and referral pathways beyond the internal PHN processes, and into the realm of service providers.

Building a Referral Form with Conditional Logic

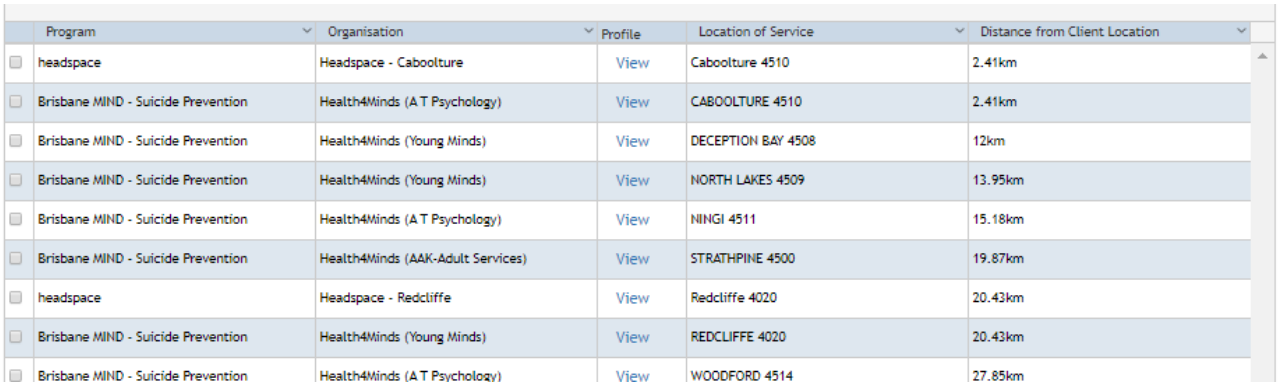
The *RediCASE* referral form was designed to be self-standing and self-sufficient for all referrals into the network of PHN-commissioned mental health services. The IAR guidance was embedded into the *RediCASE* form (Figure 1). The larger form also gathers key PMHC-MDS fields regarding client demographics, and referrer information. A copy of the full form is available below.

Using the IAR domains and algorithm, a Calculated Level of Care is generated for all clients for all referral entry points. This Calculated Level of Care should be used to inform the referral pathway but can ultimately be overridden by the Practitioner Determined Level of Care.

Note: While the IAR algorithm is still in a testing phase, we felt it necessary to offer referrers the capacity to override the Calculated Level of Care

In addition, certain demographic variables are used to navigate referrals to the most suitable service. For instance, there is a conditional age limit of 0-11 for children accessing the Brisbane MIND for Kids psychological therapies program. As mentioned previously, these patterns of referral responses are assigned to a range of treatment "levels" or service options for the client. Once the referral form has been completed and submitted, the appropriate service options will display in a list ordered by their proximity to the client's place of residence (see Figure 2).

Figure 2: RediCASE – Select Service Provider Screen



Program	Organisation	Profile	Location of Service	Distance from Client Location
headspace	Headspace - Caboolture	View	Caboolture 4510	2.41km
Brisbane MIND - Suicide Prevention	Health4Minds (A T Psychology)	View	CABOOLTURE 4510	2.41km
Brisbane MIND - Suicide Prevention	Health4Minds (Young Minds)	View	DECEPTION BAY 4508	12km
Brisbane MIND - Suicide Prevention	Health4Minds (Young Minds)	View	NORTH LAKES 4509	13.95km
Brisbane MIND - Suicide Prevention	Health4Minds (A T Psychology)	View	NINGI 4511	15.18km
Brisbane MIND - Suicide Prevention	Health4Minds (AAK-Adult Services)	View	STRATHPINE 4500	19.87km
headspace	Headspace - Redcliffe	View	Redcliffe 4020	20.43km
Brisbane MIND - Suicide Prevention	Health4Minds (Young Minds)	View	REDCLIFFE 4020	20.43km
Brisbane MIND - Suicide Prevention	Health4Minds (A T Psychology)	View	WOODFORD 4514	27.85km

The referrer may then select the preferred provider at the 'level' indicated and send the referral through. When appropriate, a service provider will see their own organisation appear as a referral option. In the case of a walk-in client, the service provider simply sends the referral on to themselves.

If the IAR process has not identified the service provider's service as appropriate for the client, the referring service provider will still see a list of options of other services more suitable. They may either choose here to override this (and select their own service), or instead refer the client to the level of care that is nominated by the IAR algorithm and intake process.

This referral process is also available once the client has commenced an Episode with a particular service provider. If, through a more comprehensive assessment, the client is identified as requiring a different level of care, the service provider may "on-refer" or "step up/down" the client through this same process. This ensures that the service contact activity with the initial provider is still recorded for the purposes of the PMHC-MDS

Challenges with Implementation

While the technological capacity was supported, several types of challenges have emerged from the process. Notably, it is not yet common for services to on-refer clients to the service that is congruent with their presenting level of care. Rather, they opt to retain the person in the current service – unless there is a level of risk that is not able to be addressed appropriately.

The inclination to accept all walk-in referrals is driven by a couple of factors:

- Not wanting to 'refuse' the client
- Not wanting to override a client's preferred option for service
- Lack of sector integration that means confidence in other providers cannot be guaranteed
- Is then perceived as riskier to on-refer rather than retain
- The additional administrative burden of sending on a referral and following up

These concerns were compounded by the 'Trial' status of the IAR Guidance. The algorithm did not yet have enough testing to warrant this additional step. As a result, we have seen many service providers opt to retain all clients who walk-in.

This trend has been noted through the discrepancies between the Calculated Level of Care and the Practitioner Determined Level of Care data items. In this, it has been possible to observe when the former has been overridden by the referrer. While this is a convenient way for providers to nominate their own level of care, it should not be discounted that this item also can truly reflect practitioner judgement.to enable a feedback mechanism on the accuracy of the algorithm itself. Unfortunately, these two constructs have been difficult to detangle in the way the form was designed.

Advice to Other PHNs

From our learnings and the use of a centralised referral form, Brisbane North PHN would make the following recommendations to other PHNs engaging in similar processes:

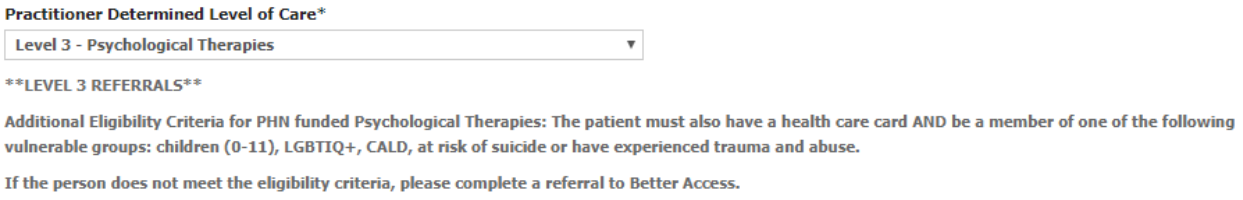
- Engage with the mental health sector (your commissioned providers and more broadly) to introduce the IAR guidance
- Ensure that roles as referrers into the stepped care continuum are understood and that referral pathways and relationships between (or within) steps are established

At Brisbane North PHN, we regularly invited different members of the Stepped Care continuum to stakeholder meetings of another section: e.g., Brief Therapies providers meeting the Severe/Complex providers

- Develop a form that is informed by the needs and wants of referrers. Ensure that there is cyclical feedback that means the form can be improved quickly and often as required.
- Engage specific parties to work more closely with the form and provide more comprehensive feedback. These may be providers who are using the form more often than others
- Creating a consultant group of engaged and motivated service providers means that champions of the form and IAR guidance are naturally established
- Engage in evaluation activities such as surveying the sector on the implementation to gauge buy-in, relevance and ideas for improvement.
- Utilise the data from the referral form to gain insights as to common presentations and referral pathways

At Brisbane North PHN, we noticed a large skew in presentations towards Level 3 – psychological therapies. Unfortunately, our psychological therapies programs have restricted access based on belonging to a vulnerable population group. This meant that some referrals resulted in no service options available.

We identified this issue and were able to build information into the form itself that advised when limited or no referral options would be available (see below)



In a referral form environment, indicators of success can be

- Process-driven: that the form is adaptable, easily adjusted, flexible, navigable
- Outcomes-driven: that it gets the client to the right level of care at the right time
- Input-driven: that it is the most efficient and cost-effective method of referral

CENTRAL AND EASTERN SYDNEY PHN EXEMPLAR

CESPHN operates a centralised intake process for two of our main commissioned mental health programmes - Psychological Support Services (PSS) and Primary Integrated Care Support (PICS). We were interested in embedding the IAR decision making tool into our referral forms for these programmes and identified a few key issues for consideration:

1. GP uptake – adding the IAR decision support tool into our forms would mean that the referral form would be longer for GPs and other referrers to refer into the programmes, and given that they are often time poor this would be a potential barrier and could result in increased complaints, GP dissatisfaction and potential barrier to appropriate level of care for clients.
2. CIMS – how would we work with our CIMS provider in adding the IAR decision support tool into our online referral form and would it be possible to develop an algorithm in the back end so that the referrer gets real time advice on the appropriate level of care without having to use the Departments web-based algorithm tool? Do we have enough time to develop this?
3. Scope - do we identify a subset of referrers/ or population and pilot this approach in that setting only e.g. CALD community or headspace centres only, or do we apply it across the programmes? How do we find a pool of referrers that would want to be involved in the IAR project?
4. Whose decision is it? - our centralised intake team consists of triage clinicians who review each referral to determine that they meet eligibility to our programmes and if not, they recommend an alternative level of care/programme to the referrer. We discussed whether the IAR decision tool should be part of the referral form (i.e. completed by the referrer) or whether the triage clinicians complete it by directly triaging the consumer (a major change to the functioning of the triage team).
5. Confidence in the algorithm - we were aware that the IAR decision support tool was a tool to support the referrers decision about the level of care required for their client, however we were concerned that if the referrer was given a recommended level of care, without proper training in the IAR tool, that they would ignore their clinical decision making and use the result of the algorithm only. This was problematic, as clinical judgement should trump the algorithm predicted level of care, but also because the algorithm had not been independently validated for its accuracy.
6. Education – how do we educate referrers in the appropriate use of the IAR for the purposes of the project and beyond? What level of support would GP practices require?

These issues were thoroughly considered, and the result was to engage in the following activities:

1. Hold a GP consultation event to get informed input on the potential integration of the IAR decision tool in the CESPHN intake forms and processes, and how this might look.
2. Liaise with other PHN's in the second tranche of the research study who use the same CIMS and work together with the CIMS provider in the inclusion of the IAR tool and development of the algorithm in the referral form.

A GP consultation prior to commencement of the project design was extremely important in our region as we have a strong GP community that sit on our Clinical councils, Member Chairs, as well as our Board, that provide regular feedback and have strong interest in our PSS and PICS programmes. We have also learnt from previous consultations that a large proportion of our GPs and referrers prefer to choose the specific programme and at times, the specific clinician, that they are referring to so a decision support tool that recommends a level of care and its associated service might be disconcerting to the GPs.

We felt that the best place to start would be an open conversation with interested GPs so that we could progress the project design and address the considerations and issues that we had identified, rather than providing the GPs with a proposed model.

In terms of form development, we reached out to Brisbane North PHN and together we set up a small group with a few other organisations currently providing intake services for PHNs to work together on how to progress the project and develop an online referral form as well as establishing a small community of practice.

How did you go about this activity? What were the steps? What resources were needed?

GP Consultation

We sent out an expression of interest to GPs to be involved in the GP consultation. We held a consultation in the evening and remunerated the GPs for their attendance. We conducted a presentation on current referral pathways/ process at CESPHN and introduced the IAR Implementation Project. We invited the National Project Manager, Initial and Assessment Referral Project, to present. We broke up into two groups and then brainstormed solutions to the key questions and considerations that we had identified. At the end of the consultation we collated the responses, and the main feedback was that:

- GPs thought the IAR decision tool was a great tool for their clinical practice
- GPs thought that they were best placed to complete the IAR tool at the time of referral
- GPs were concerned about the potential length of the referral form with the addition of the IAR
- GPs were supportive of inclusion of the IAR tool if the form could also be made to be compliant with a Mental Health Treatment Plan (MHTP)
- GPs were supportive of CESPHN's involvement in the project.

Form development and Implementation Design

We met regularly with relevant staff at BNPHN to share draft versions of our referral form and discuss how the forms would function, differ etc. This sharing of ideas was instrumental in the development of the form and supporting each other through the process. We met regularly with our CIMS provider to explain what was required, make modifications specific to the needs of our region and referrer preferences, and troubleshoot problems. We also asked for a "Practitioner determined level of care" be included in our form to ensure that referrers could determine their own level of care, if that differed from what the algorithm recommended. We also wanted to use this for future evaluation on the accuracy of the algorithm compared to practitioner recommendations and the actual level of care obtained.

We finalized the project design and agreed that the IAR tool was something that we wanted to include in our referral form beyond the scope of the project as we felt that it was clinically useful, relevant to stepped care and covered very important assessment questions. There was considerable overlap with the content required for the purpose of billing a MHTP so we embarked on the task to embed the requirements into the referral form so that GPs could use just one form to make a referral and bill to our PSS and PICS programmes. We liaised with the National Project Manager to ensure that the form captured the relevant components and it was reviewed by multiple clinicians.

For the purposes of the project, we approached the GPs involved in our GP consultation, sent out an EOI to other GPs in our region, and approached two of our headspace sites to be part of the project and commit to being trained to use the form correctly, obtain informed consent from their clients to be involved in the study, and attend a follow up workshop held by the University of Melbourne on their experience in using the IAR tool. This would also ensure that we had GPs and Allied Health Professionals using the referral form.

You can access our referral form here. Select "Mental Health Services" as the service type, and the IAR decision tool can be found under "Clinical Assessment".

Future Activities

Now that the IAR tool is part of our form, we are moving to the next phase: educating and supporting the referrers in completing the tool. As part of this we plan to develop:

1. Webinars about the IAR tool, and how to complete it
2. Promotional work in our media channels about the IAR tool, its uses and relevance in primary care.

We also plan to collate data: algorithm determined level of care, practitioner determined level of care, and actual level of care that the client ended up engaging in, to see if there are correlations and evaluate the utility of the algorithm. This will then inform whether the IAR decision making tool could be used to triage and refer directly to other PHN services, in the future.

What were the enablers for the activity?

1. Good relationship with our Clinical Council, local GPs, other PHNs, and our headspace centres.
2. Committed Clinical Lead driving the project and a Project Officer driving the referral form changes.
3. Clinical Lead and Mental Health Manager with clinical experience
4. Support from our Marketing and Communications Team and Events team
5. Supportive Executive Manager
6. Regular contact and support from the National Project Manager, Initial and Assessment Referral Project
7. Motivated GPs and headspace staff with clear passion
8. Flexible CIMs provider willing to take on the challenge of building the IAR tool into the CIMS
9. Talented data analyst at BNPHN to drive and develop the algorithm
10. Supportive intake and triage team at CESPHN

What were the challenges for the activity?

1. Tight timeframe
2. Getting GPs to attend the consultation was difficult to start but we achieved a good number in the end
3. Form development - very time consuming, lots of liaising back and forth with CIMS provider
4. Project changes from the University along the way e.g. consent forms, processes, staff timeframes meant an ever-changing environment
5. Guidance document was lengthy and concern that referrers would not read it
6. Getting GPs and referrers not involved in the project to embrace the IAR tool in the referral form.
7. Instigating change to referral form and pathways in our region.
8. Gaining access to uploading required deidentified client files to the secure health data portal

What would your PHN do differently?

Overall, we feel pleased with our approach to incorporating the IAR into our intake processes. If we had more time, we would have provided further opportunity for community consultation e.g. with allied health professionals and another GP consultation.

We have learnt that change to processes is difficult in a PHN of our size. CESPHN is home to 1.6 million people, 2230 GPs working in approx. 600 practices, and 5043 Allied health professionals making communication difficult and

information needing to be repeated on an ongoing basis. There has been some resistance from GPs in using our online form citing issues such as it being too long but also not liking having to leave their own medical software to make a referral. This has meant that we have had to develop forms for Healthlink secure messaging that replicates the online form. Unfortunately, these forms do not have the functionality that a web-based referral form does, so has led to further problems.

A missing piece to this implementation has been education and training. The referrers involved in the project received face to face training or email support and access to the IAR Guidance documents so were well acquainted and informed about the purpose and relevance of the IAR decision making tool. Our community referrers have not had any training therefore do not understand the significance of the IAR component in the referral form. If we had more time, we would have liked to offer some online webinars to explain the IAR form and how to complete it so that all referrers could access it on our website. This is in the process of being developed and we hope to roll out this and other communication to our GPs in due course.

What types of measures indicate success or otherwise?

Uptake is a good measure of success, as is referrer feedback. Our referrers involved in the project all agreed that the IAR decision tool was easy to complete, and relevant. Appropriate referrals to the most suitable level of care for consumers is also a measure of success, and as stated earlier we hope to review our data to evaluate the effectiveness of the IAR tool.

We have been tracking referral numbers into our programmes since prior to the launch of the new referral form, to keep abreast of changes to referral habits and have not observed a decrease in utilisation of the PSS and PICS programmes since the incorporation of the IAR into our referral forms.

Our GP community is vocal and has been engaging with our Intake team since the introduction of the referral form, seeking assistance and giving feedback and criticism. We have also ceased our fax referral pathway in recent times which has further added demand and increased communication with our referrers. This has given our Intake team an opportunity to engage with referrers and explain to them the changes to the form (e.g., the inclusion of the IAR questions, and to assist with difficulties in its completion).

What advice do you have for other PHNs considering a similar activity?

1. Once you have decided how and where the IAR would be incorporated into your programmes, ensure that you have detailed discussion with your digital health teams, practice support teams and data governance committee to brainstorm any potential issues that may arise from implementation and how the PHN as a whole can support the process.
2. Potentially look at piloting the IAR tool with a smaller group e.g. specific service, specific underserviced group, to be able to implement change, educate and troubleshoot any difficulties before rolling it out across larger programmes.
3. Have your educational resources and training options/materials ready before rolling out the use of the IAR tool!
4. Consider having an algorithm built into your online referral forms (if you have one).

MURRAY PHN EXEMPLAR

Murray PHN took the following steps when implementing IAR for the Implementation Review:

- Development of an IAR Work Plan
- Identification and engagement of Service Providers across the catchment
    - Email and telephone communication with Service Providers who were chosen to be involved in project inviting them to participate in Pilot Project.
    - Established a shared Murray PHN online folder and communication platform (Service Providers did not utilise this as we hope and requested documents via email).
    - Initial video-conference consultation meetings with Project Lead, Project Support and Service Provider key stakeholder staff. These meetings covered brief Project overview and objectives, service provider requirements and training.
    - Work with Service Providers to identify GPs who would participate in project.
    - Identify and engage with GP's (email and telephone communication with identified GP's)
    - Comprehensive review of Service Provider referral and initial assessment tools and processes as well as Clinical governance capability against Guidance document (service provider and PHN requirements)

IAR training provided by National Project Manager to:

- PHN Project Lead and Project Support,
- Four video-conferencing sessions with key Service Provider Clinical staff
- General Practitioners (joined in 2 service provider workshops and conducted separate workshops x 2).

Why was this activity important to IAR implementation in your region?

Inconsistent initial assessment and referral processes across the catchment. The need was seen to streamline/improve referral and initial assessment processes. As Murray PHN has no central intake function for Primary Mental Health providers across catchment, it was an important project to be involved with to capture the differences and commonalities across intake and referral processes in the catchment. It was an opportunity to engage and understand the GP role in initial assessment and referral of consumers to PMH providers and to bring service providers together (network). Importantly, Murray PHN was keen to test the viability/usability of DST and Guidance Material, and to prepare the catchment for the forthcoming national implementation and requirement for IAR and Guidance

What resources were needed?

- Project Lead and Project Support (external consultant) worked closely together and split tasks.
- Project Lead and Project Support provided information to all service providers and referrers for the life of the project.
- Established training workshops for all stakeholder service providers and GP referrers.
- Established the evaluation workshops with UoM and stakeholders.

The project used videoconferencing, phone, and email communication. Meeting face to face was minimal. Project Lead and Project Support had intended to lead site based IAR training with IAR National Manager utilising videoconferencing platform. The Project Lead attended 1 Service Provider and GP Training on-site (at Health service and Medical Practice). The Project Lead and Project Support attended on-site training for one other Service Provider (at which 1 GP also attended). The other service provider and GP training sessions occurred via videoconferencing.

All GP referrers were paid for their time during training sessions, travel to if required, and this was paid in accordance with the Murray PHN clinical advisory committee renumeration policy. The Project Support (an External Consultant) was also paid for time spent on project work.

What were the enablers for the activity?

- Previously established positive relationships with the PHN (and the Project Lead and Project Support) and Service Providers
- Understanding of Service Provider initial assessment and referral process through previous clinical governance reviews/audits undertaken by Project Support (external consultant).
- Enthusiastic GPs
- The DST – great to use
- High Level of service provider engagement (Murray PHN approached the 4 provider organisations who participated in the pilot due to their history of being consistently high performers in service delivery, innovation, and engagement)
- Strong commitment and valuing by Murray PHN Mental Health Project Team of the project, the guidance material and DST
- Murray PHN IAR project team selected due to subject matter interest and high level of communication skills and relationships with the broader mental health landscape and service providers.

What were the challenges for the activity?

- Time to engage – it took longer to engage service providers and GPs than was initially anticipated. We were able to get 5 GP's trained in the context and use of the DST
- GPs were hard to pin down. Took perseverance and much telephone and email communication – not always with the GP's – went through Practice Managers for 2 GP Practices (Echuca and Cobaw Health Services). GP's at one of the Service Providers GP was employed by the service, the other GP was in GP Advisory role at Murray PHN.
- During the middle of March 2020, the project was halted due to Victoria entering a state of emergency in response to COVID-19 pandemic. Stakeholders all contacted Murray PHN expressing their concerns and inability to progress with the pilot as their resources were diverted to localised pandemic responses. After consultation with IAR national project manager and UoM if was determined that the project would be suspended immediately, and future steps be considered later.
- After some week's services providers were invited voluntarily to participate in an evaluation session with UoM, knowing this was entirely optional. 1 service provider organisation chose to remain withdrawn, but 3 organisations went ahead and met via zoom with UoM on 19/5/2020.

HUNTER NEW ENGLAND CENTRAL COAST PHN EXEMPLAR

Describe the IAR process/activity implemented.

HNECCPHN have commissioned a consortium to deliver a centralised triage service for the whole of region to replace the former direct referral to service approach from primary care. The consortium is a group of three providers including a lead agent (For the purpose of this document the consortium will be referred to as IAR Provider throughout).

GPs complete a Mental Health Treatment Plan (MHTP) and forward this information to the IAR provider for assessment per the IAR Guidance. Once received the IAR provider determines if the information provided within the MHTP is adequate to assess the eight domains to determine the appropriate level of care.

If further information is required, the IAR provider contact the GP / Consumer to obtain the required information to complete the triage assessment. If adequate information has been provided the IAR provider completes the triage assessment. Once the level of care is determined the IAR provider then refers the consumer to the appropriate PHN-funded mental health service provider.

Why was this activity important to IAR implementation in your region?

HNECCPHN implemented the IAR process as a key component of the transition to a stepped care model. Following an extensive consultation, review and redesign/co-design process, a centralised point of access was identified as the crucial entry point to the system. Assuring improved equity of access compared with previous structures, it would also potentially improve appropriateness of referrals through a formally structured and consistent assessment process, while maintaining clinician autonomy in selection and consumer input to service allocation. From an operational sense it would also provide the PHN with a clearer picture of the service demand levels and regional variations, both in level of care and type of service needs, as current structures were at capacity but the underserviced element was not clearly defined nor accounted for.

How did you go about this activity? What were the steps? What resources were needed?

HNECC undertook a Request for Proposal seeking a suitable partner organisation to collaborate with the PHN to develop the service across the region. The standard open tender process was undertaken, with an evaluation panel including subject matter experts from HNECC and external organisations, as well as input from HNECC leads in Risk, Aboriginal Health, Finance and IMIT. Scoring of responses was independently completed without visibility of pricing; then a shortlist determined. A specially convened Clinical Review Committee which included representative GPs provided feedback on the submissions and assisted in identification of gaps and questions for interviews. The key themes considered critical were:

- the ability to deliver a functional service from July 2019
- the ability to provide a locally relevant service, and
- strong organisational and operational structures.

With the support of an independent consultant, work was undertaken to develop a governance structure that included PHN involvement.

What were the enablers for the activity?

The concurrent work that had been undertaken to redesign the Mental Health commissioned services to implement a stepped care approach aligned well with the need to implement the Department Guidance and avoided the need to retrofit services already in place in order to align with the Guidance. The Guidance also provided an additional, formal, and external structure which assisted in the development and specification of the service design and operational requirements to some extent.

What were the challenges for the activity?

The need to undertake a Request for Proposal rather than a specific Request for Tender provided a greater challenge in assessing the potential providers, as a range of different concepts of service provision were presented. The subsequent requirement to develop contractual arrangements based on an agreement to work together to develop a service, rather than a contract based on a specific service specification for delivery from the commencement of contract also proved challenging.

The three providers working to deliver the Access and Referral service are also providers of the mental health services. This is not deliberate, and it adds both benefits and risks to the delivery of the service.

What would your PHN do differently?

- Stronger structures within the agreement with the providers around the codesign process – particularly with milestones and agreed formal structures for development and review
- More specific deliverables in the contract, though this is easy in hindsight; at the time it was challenging to dictate to a provider what was feasible from an operational perspective for them to achieve in short timeframes.
- Structure and present the Access and Referral service as a process-driven component of the mental health services system, with emphasis on separation, scalability, and flexibility. This could allow more focus on efficiency and quality rather than seeing it as an embedded part of the service arm. This would not be at the detriment of the clinical component of the service, as this is delivered to an appropriate level by specific staffing and clinical governance structures, plus the strong focus on the Guidelines-based assessment and decision-making tool. Through the process, the PHN has developed a better understanding of the potential use of the service and how it might be expanded into other areas beyond the current mental health service. This will prove challenging, as the service has been developed by the provider as a specific structure with the mental health clinical component at the centre, rather than a procedural structure with the clinical component directing its use.
- A provider having the internal technological infrastructure already in place could have been weighted much more heavily in the assessment process, as various assumptions made about readiness and implementation have proved incorrect and led to significant delays in delivery of the infrastructure and thus the transition to centralised triage.

What types of measures indicate success or otherwise?

HNECCPHN is continuing to develop the IAR process, at present the current measure is throughput. Throughput is reported via HNECCPHNs contract management system and the information captured includes:

- Referrals received per local government area
- Source of referral (Midwife, GP. Social Worker etc)
- Number of referrals per Level of Care

As the service develops further measures will be used to measure success, these may include:

- Linkages/referrals to other services beyond PHN commissioned mental health services
- Development of referral pathways and connections with LHD services and internal regional pathways

WESTERN QUEENSLAND PHN EXEMPLAR

The WQPHN engaged in a direct recruitment process to identify 4 trial participants based on the following points:

- Colocation of a Clinical Care Coordinator within General Practice
- Different qualifications of the P4 coordinator- CMHN, RN and a Cert IV in MH
- One well engaged GP without the support of a P4 coordinator
- Different sizes and locations of General Practices ranging from one located in Mt Isa with multiple GPs to smaller remote General Practices with smaller doctor numbers.

The direct recruitment approach resulted in the 4 sites approached agreeing to engage in the IAR trial. Participants were offered remuneration for engaging in the trial through a short-term contract which outlined the outputs and outcomes expected. A WQPHN program officer was identified as the Project Manager and was the contact point for trial participants and the DoH IAR project lead.

The WQPHN utilises a web-based referral system that is a fundamental enabler in the WQPHN stepped care approach to ensure the patient gets the right care at the right time. Due to the remoteness and sparsity of population in the WQPHN region the system reform around stepped care has identified the General Practice as one of the main access points for community when reaching out for Mental Health support

Whilst the initial plan was to build the decision-making tool in to the WQPHN web-based referral system it was decided that until the review was completed the paper-based tool and online decision-making matrix supplied by DoH would be utilised.

Why was this activity important to IAR implementation in your region?

Through the WQPHN Mental Health, Suicide Prevention and Alcohol and Other Drugs Strategic Plan 2017-2020 it was proposed that a model of primary care innovation be established with the objective of ensuring the centrality of the patient in the provision of care; a general practitioner (GP led Multidisciplinary team model of care), better access to an appropriate level of help in your local community, continuity of support, improved self-care and improved population-based health outcomes.

The general practice team, in collaboration with HHS and NGO providers networks will have a pivotal role in identifying and managing the at-risk population and people with mild to moderate mental illness, matching interventions to patient need across the stepped care model, integrating service delivery and monitoring progress over time. It was identified that building general practice capacity and capability to identify and manage the at-risk population through to the severe and complex mental illness including AOD issues was a priority and the IAR tool was an enabler to this.

Due to the well documented challenges around attracting a Mental Health workforce in rural and remote areas GPs have defaulted to the referral pathways that they know and are confident and comfortable with. This workforce has historically been based on the medical model and primarily consisted of WQPHN funded psychological services. There has been a general lack of uptake of other services outside of this workforce due to lack of awareness of what a 'Low Intensity' service provides the consumer, inconsistency of service delivery with the fly in fly out model and a general lack of 'professional credibility' in the NGO sector.

The above conditions resulted in the Psychological Services for Hard to Reach providers being the first point of referral and having to manage long wait lists and at risk of practitioner burn out due to working in isolation whilst other WQPHN funded services were struggling to attract referrals.

In short this tool provided the opportunity for GPs to have an evidenced based tool that would assist them in triaging the consumer ensuring they get the right care, at the right time ,by the right service provider and for the right length of time resulting in an increased in referrals to other WQPHN funded services.

How did you go about this activity? What were the steps? What resources were needed?

As identified previously, WQPHN implemented a direct recruitment approach to secure a broad range of General Practice environments and ensure optimum and timely engagement in the trial. It was identified that providing funding to the 4 trial sites was paramount in the full engagement of the trial as training, engagement in the evaluation process and implementing the tool all took up resources in this time poor environment. The funding was fully utilised to compensate for time related activities as all trial participants identified that they did not require any further IT infrastructure.

When approaching the potential trial participants around their engagement the WQPHN project officer had worked with the DoH IAR National Project Manager to develop a brief introduction to the IAR tool which outlined the following points.

- How the IAR tool was developed
- When the IAR tool would be utilised
- Benefits of utilising the IAR tool
- Expectations of trial participants- both the users and the consumers
- The expected national roll out of the IAR tool
- Support offered both through the WQPHN and the DoH IAR National Project Manager

Once the trial participants were happy to progress the WQPHN executed a short form agreement with those involved and established a timeline document that clearly identified the milestones to be achieved. One of the first activities was to provide the guidance material developed by DoH as the trial was focused on gaining insights as to the usefulness of these documents in implementing the IAR tool. Trial participants were given some time to review these documents, questions fielded by both the WQPHN project officer and the DoH National Project Manager were mainly around the process for recruitment of consumers, consent to share their information with the evaluators rather than the actual application of the IAR tool. Trial participants reported that their knowledge of the application of the tool was reinforced through a series of short webinars facilitated by the DoH National Project Manager and the implementation guide.

The WQPHN project officer contacted the trial participants on a weekly basis and was also available to field any phone calls to trouble shoot where necessary. One of the questions that was common amongst the 4 trial participants was around the use of the IAR tool as a replacement assessment tool for their clinical assessment tools such as a K10, DASS etc. It was confirmed that this was not the case and was helpful to couch the use of the IAR tool rather as a Triage tool.

No further resources were required by the trial participants.

What were the enablers for the activity?

One of the main enablers for engaging the trial participants was explaining that the IAR tool will assist them in making an evidenced informed decision on the level of care indicated for the presenting consumer. All trial participants identified that they were struggling to identify what presenting issues would align with each level in Stepped Care as it was such a new concept to them. Providing a possible solution to this issue made initial and ongoing engagement easy.

The provision of the web-based version of the IAR tool was another major enabler. It was reported that the ease of access and having ready access to the explanatory notes for each of the 8 domains was especially useful, particularly in the early stages of utilising the tool.

The webinars that were facilitated by the DoH National Project Manager were reported to be particularly useful in providing a visual demonstration of how the tool was developed and then the implementation process. All trial participants were reassured by the rigor around the development of the tool informed by the expert advisory group.

Initial ongoing support through the WQPHN project officer was reported to be appreciated but reinforcing that most of the concerns raised were more about the actual recruitment of the consumers to the trial rather than the actual implementation of the IAR tool.

Obviously having good IT connectivity is an enabler but this was not an issue through the trial and by providing the paper-based copy a back-up was in place if needed.

Ensuring the guidance material provided was relevant to both the GP and the other trial participants was another crucial point in engagement. Whilst the guidance material was extremely comprehensive it was reported that it was 'heavy going' therefore translation of this material to a more concise and targeted document would be another enabler. The WQPHN project officer did spend some time with the trial participants pointing them to crucial points within the guidance material.

It was reported by all trial participants that having the IAR tool built in to the existing WQPHN web -based referral tool would optimise the use of the tool as GPs are often reluctant to step outside of their practice software to access any other resources. As this was not available providing the web link to the trial participants was a major enabler.

Another enabler noted in engaging the trial participants was to provide a comprehensive explanation around the WQPHN stepped care approach, why it is being implemented and the benefits to all. This was reinforced by identifying how it will assist in achieving some of the outcomes identified in the MHSP&AOD strategic plan. The trial participants reported that they could identify with the bigger picture aspirations of achieving better health outcomes for our consumers.

The WQPHN acknowledges that having P4 practitioners (Primary Mental Health Care Services for People Living with Severe Mental Illness) collocated in General Practice has been a major enabler for the implementation of the IAR tool during the trial period. By utilising these resources who are fully funded by the PHN to introduce the tool into each unique General Practice setting 'champions' were created who could educate and advocate the use of the tool on an individual basis. Having said that the one GP engaged in the trial was highly motivated to continue to utilise the tool. This point highlights the identification and use of a 'champion' as effective in promoting uptake.

What were the challenges for the activity?

The General Practice that was recruited with the Mental Health Nurse being the trial participant reported that they were time poor due to high workload demands and that the early engagement in the trial impacted heavily on this. It was reported that as they became more familiar with the workings of the tool and overcome the demands around training and consent this burden eased. It was reported that they could also see how the implementation of the tool at the coal face with their GPs would in the end save time and in fact this has been the case. The practice has implemented the use of the IAR with most of their GPs when previously the GPs would send the consumer to the Mental Health Nurse to perform the assessment and triage process.

Another challenge reported by one of the trial participants was around the availability of the full suite of stepped care services to consumers in rural and remote areas. In some areas the WQPHN does not offer face to face services across all levels of stepped care and when the tool was applied to consumers that identified a recommended level of care and that was not available in that area it created a professional dilemma for the user. On the flip side of this it also provided the opportunity for the WQPHN to record these gaps in service delivery to inform future planning.

From a consumer perspective it was reported that the application of the IAR tool and subsequent recommendation of a level of care might conflict with consumers expectations. It was reported on several occasions that consumers were expecting to be serviced by a psychologist and were not content with the recommendation for a Low Intensity service. This can be overcome through ongoing consumer and health provider education around the benefits of implementing

a stepped care approach and not by default mentioning that you should see a psychologist. The importance of ensuring all users understand that the use of the tool does not over-ride clinical decision making is critical.

It was reported that the IAR guidance documents were too detailed and lengthy. This was identified by all participants but particularly the GP involved. The provision of a summary document that referred to the full document would assist in overcoming this issue with initial training supported by the webinars and a dedicated PHN project officer to answer any questions.

The WQPHN acknowledges that by recruiting trial participants through a direct approach might have made the engagement easier the learnings can be implemented when rolling out the tool across all General Practices.

What would your PHN do differently?

The WQPHN is in the process of building the IAR tool into their existing web-based referral system. Whilst the trial participants managed to utilise the tool through the provided web-based link it is acknowledged that when full implementation takes place, having this tool embedded in the clinical software via the web-based referral system will assist in the uptake of the IAR Guidance and subsequent change in referral habits. This function could be further enhanced by customising the tool to provide actual referral options to the user. This process would eliminate a stage in the web-based referral tool providing a more efficient referral resource.

On reflection the WQPHN will review the way that they introduce the IAR tool to prospective referrers through presenting the concept first, utilising the pre-recorded webinars and then demonstrate how this will work through the web-based referral system. A summary document or quick reference guide of the IAR guidelines could be developed by DoH that would be presented alongside the webinar. Once the interest has been generated then the provision of the full IAR implementation guidance documents can be presented. There is a lot of information in those documents that is not relevant depending on the referral system implemented by each PHN (e.g., Central Intake vs GP referral).

What types of measures indicate success or otherwise?

When considering this question, the first point that comes to mind is around measuring the user's interpretation of the guidelines are in line with the expected outcome as defined by the expert reference group. Some form of self-checking or quality system should be developed and implemented to ensure the person is in fact receiving the right care at the right time etc.

The WQPHN would measure success by the following indicators

- An increase in the rates of referrals across the stepped care continuum, particularly those areas that are presently under utilised
- An increase in the number of referrers utilising the tool
- An increase in consumer awareness and acceptance around receiving services across the stepped care continuum
- Positive feedback from IAR users
- Positive feedback from consumers that they did receive an appropriate level of care and the referral process was efficient
- Increased uptake of early intervention services lessening the burden of disease

What advice do you have for other PHNs considering a similar activity?

- Consider the implementation process carefully by working with a reference group
- Identify champions

- When introducing, go simple first. The Webinars by the National Project Manager are a great way to introduce the concept and follow up with relevant material. Do not provide them with the IAR guidance documents first!
- Allow time to hear concerns around clinical risk, reinforce that the IAR tool was based on evidence and confirm choice in everyone using the tool
- Make it simple- get the tool as close to the practice software as possible
- Explain the bigger picture around the Australians Government rationale of introducing a stepped care approach and then stitch in to your PHNs approach
- Provide regular support through one dedicated project officer
- Provision of consumer awareness strategies both on a local perspective but also DoH could consider a national awareness campaign

NORTH QUEENSLAND PHN EXEMPLAR

Describe the IAR process/activity implemented.

The implementation of a region-wide National Initial Assessment and Referral (NIAR) working party, consisting of contract managers for mental health across the three NQPHN regional offices, to collaborate in learnings to implement the NIAR with remote area service providers, and also review low intensity service provision across the remote NQPHN regions.

Why was this activity important to IAR implementation in your region?

The NQPHN region is diverse, and several remote areas (Cape York, Torres Strait, Etheridge/Croydon Shires, and Richmond/Flinders Shires) rely on visiting or fly-in fly-out mental health service delivery, with few services on the ground.

NQPHN participated in Round 1 of the implementation review of the NIAR and focused on three major activities:

1. The University of Melbourne research project testing of the domains and the decision support tool. This was undertaken with the external central intake service provider, Connect to Wellbeing (Neami National) who provide intake to the urban and regional areas of the Cairns and Hinterland, Townsville, and Mackay HHS areas. Connect to Wellbeing provides intake services to the mild-moderate and severe mental illness cohorts, as well as referral to appropriate community services outside of PHN funding, such as housing, alcohol and other drugs, and family support.
2. The University of Melbourne survey requesting feedback on the NIAR Guidance Material which was available to providers in the region over a one-month period.
3. Workshops conducted by the University of Melbourne with a group of 22 service providers in Cairns, five NQPHN staff, and seven consumer representatives. The workshop provided opportunities for participants to test the NIAR Guidance Material using case studies and the Decision Support Tool. Most attendees were from urban areas of the region.

Connect to Wellbeing manage initial assessment and referral for a range of stepped care programs, however the commissioning process for stepped care undertaken in 2018 recognised the unique needs of place-based (remote and Aboriginal and Torres Strait Islander services) and the necessity for them to undertake their own intake and referral rather than utilise the central intake system.

This project sought to enable understanding and use of the NIAR guidance material by place-based providers. The referral processes of the decision support tool also stimulated an interest in the availability of the levels of stepped care services available in the regions.

Generally, low intensity services were not available as a ‘step’ in the remote regions, so a concurrent process reviewed the stepped care models across place-based services with a view to progressing greater utilisation of existing internet-based low intensity services where appropriate and technologically possible (e.g. Head to Health), as well as investigating the need for a diverse stepped care model in the place-based services, incorporating low intensity provision.

How did you go about this activity? What were the steps? What resources were needed?

The steps taken included:

The NIAR guidance material was distributed to all stepped care intake and referrers, including the place-based providers, in early October 2019. Providers were advised of the NIAR workshops and survey to be undertaken in Cairns with the University of Melbourne in mid-November. Skype links were offered to those services unable to attend the workshop in person, and the University of Melbourne offered to do follow-up interviews with those unable to attend.

Of the 12 place-based providers funded by NQPHN, seven attended the workshop/completed the survey/had a follow-up interview.

Following establishment of the NIAR working party, contract managers reviewed the guidance material with the place-based services, ensuring compliance or modification of their existing intake protocols and procedures, and use of the decision support tool. The clinical governance requirements were also reviewed, with providers using a checklist developed from the draft NIAR toolkit.

Full implementation is still progressing and has not been finalised.

What were the enablers for the activity?

Provider knowledge of the NIAR guidance material.

Limited number of provider contracts – allowing for a manageable number for contract managers to work with.

What were the challenges for the activity?

The timelines for the initial NIAR implementation review were difficult. Final NIAR documents were not available for distribution until early October 2019, with workshops already under planning with the University of Melbourne in mid-November, with only a six-week lead.

Further implementation of the project in the region was impacted by COVID-19.

The project plan for NIAR implementation in the place-based services was agreed to by the NQPHN Executive Team in May 2020.

What would your PHN do differently?

Set more realistic timelines – the lead-in time for the Round 2 PHNs obviously had more time to prepare and follow-up.

Provide more resources, specifically a project officer appointed to the role.

What types of measures indicate success or otherwise?

The project plan for this activity has listed the following expected benefits and outcomes:

Service providers are provided with the tools and skills to be able to conduct in-depth assessments and refer clients to the appropriate level of care.

Consistency of assessments across the region and across programs.

Promotion of low intensity digital resources and mental health services could be enhanced by identifying synergies with internal projects and the possibility of promotion of shared:

- resources
- services
- education
- service delivery

Low intensity review is aligned to outcomes of the primary mental health care activity work plan and internal NQPHN investment and outcomes processes.

The review may also inform current thinking about the stepped care model and identify viable opportunities to expand the model to incorporate low intensity mental health services in the place-based services.

The key performance indicators are:

- Increase in the number of service providers utilising the NIAR as part of their standard intake procedure.
- Identification of access to, and knowledge of, low intensity services in the service provider's catchment area.
- Increase in options for low intensity service provision in the service provider's catchment area.

What advice do you have for other PHNs considering a similar activity?

Commence planning processes well in advance of the implementation period.

Appointment of a designated staff position to undertake the implementation across service providers and the PHN.

Appendix 1- Impressions of the IAR Guidance and IAR-DST

Reactions and responses to the IAR Guidance and DST are measured through the online anonymous survey available to participants who have participated in training. The question asked is:

Please provide thoughts or comments regarding your overall impression of the IAR Guidance and the IAR-DST.

As of February 2021, more than 1000 people across Australia have participated in IAR training by the National Project Team. Approximately 10% of participants have completed a post-training survey. All comments relating to the participants impression of the IAR-DST by participants have been included here.

It is clear, makes sense across clinical and management contexts, and recognises the individuality of each person and the fluid nature of mental health presentation.
It was straight forward to follow and easy to use
A really useful tool
Very excited to see this implemented
Thanks for the resources and for your really impressive and valuable workshop today – thoroughly enjoyed it
I wish we had the IAR when we began delivering services in XX catchment in early 2018!
Really useful and a good way of capturing such broad information and distil that down into something useable and useful.
The training was incredibly useful and informative.
What a Fantastic training session. Great work. It is great to see this tool and how it has evolved. It is finding its rightful place in our mental health landscape.
Fantastic training today, thank you
Thanks for the session- it was great and very informative!
Domain 6 is open to interpretation
It looked good, clear, concise way of measuring the presentation and providing recommendations to treatment, whilst still allowing for clinical judgement. I do not think it allows for age as a factor, but that is where clinical judgement can come into play.
I thought the training was well introduced and delivered, and that the tool has been well designed, including the link to the DST.
I was really impressed with the tool I particularly liked the scope to rate the tool as appropriate but refer client for comprehensive assessment where clinical judgement suggests this is appropriate, even if level is below 3. Many thanks - the presentation was very engaging and informative.
I think the Tool is a great way to standardise consistency across the sector and pave the way for comparative analysis in the future. Very useable and clear!
I think the tool is very useful and the Clinical mental health services could learn from this tool to enhance their decision making at triage and revise the state MHTS to reflect and align the categories with the IAR. Having only used it a few times it sounds great so far

Excellent presenter, vignette was on target with red herrings and enough details to pick up on as well
It is a fantastic tool. Very excited this has been implemented to the Head2Help intake service.
Really enjoyed the tool, thought it holistically captured an individual's profile.
The IAR and DST appear to be easy to use and appropriate across sectors - mental health and AOD
A very thorough tool that will assist greatly with providing a more tailored response to those experiencing ill mental health.
I worry that it might take precedence over good clinical judgement on occasions. I was really happy to see that this was addressed in the Workshop.
The IAR provides a great foundation to understand the levels and assessments needed for an individual. Although it standardizes the way to look at an assessment, it still leaves room for clinical judgement and further assessments. I look forward to being a part of this space.
The tool is very helpful for navigating the stepped care model and feeling supported in doing so.
Would be good if there was more training to professionals in all levels of step care. Increased awareness of PHN Stepped care and pathways needs to occur.
Very excited to see this implemented.
Looking forward to phase 2 and how responsive participants will be once they have used the guidance.
So far, looks pretty user friendly. the built-in ratings guide is great. I like the whole thinking behind the levels of care.
It looked good, clear, concise way of measuring the presentation and providing recommendations to treatment, whilst still allowing for clinical judgement. I don't think it allows for age as a factor, but that is where clinical judgement can come into play.

End