Australian Government

Department of Health

NATIONAL PHN GUIDANCE

INITIAL ASSESSMENT AND REFERRAL FOR MENTAL HEALTHCARE

Version		
Number	**Date**	**Notes**
0.1	2 Nov 2018	Released for consultation with PHNs
1.0	11 Mar 2019	Release Version
1.01	12 Apr 2019	Minor correction to Decision Support Tool Logic graphics on pages 70-74, to indicate a rating of 2 on D1 (Symptom Severity and Distress) where D2, D3 or D4 = 2 or above are assigned to Level 3 or above care (previously suggested Level 4 or above)
1.02	30 Aug 2019	Revisions to Guidance and Appendix 1 Glossary to: - provide additional clarity about non-suicidal self-injurious behaviour (Domain 2 – Risk of harm) - include thresholds for the Edinburgh Postnatal Depression Scale (EPDS) (Domain 1 – Symptom severity and distress) - make minor adjustments to wording to improve clarity - accessibility improvements
1.03	17 Dec 2019	Revisions to Glossary to remove thresholds on standard assessment tools from rating points within Domain 1 and Domain 3. Thresholds for standard assessment tools are now included are included in Appendix 3. Threshold scores used for each standard assessment tool have been reviewed to reflect best available evidence. Prevalence estimates in Background chapter updated to 2018 population

FOREWORD

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

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

Stage 3

During this stage of the project, the Department of Health will develop and disseminate an *Initial Assessment and Referral in Stepped Care Systems Resource Toolkit*. The *Toolkit* will include:

- A brief implementation guide for PHNs
- Additional decision support flowcharts to guide specific components of the initial assessment
- A series of spotlight reports on best practice models (national and international)
- Tools to extend the clinical governance advice provided in the Draft National Guidance
- Exemplars using the consumer journey and referrer lens of how the National Guidance can be adapted to different regional and service delivery contexts
- Other resources viewed as useful by the Expert Advisory Group, Steering Committee and the broader PHN network

Stage 4

The Department of Health will facilitate an Implementation Review to examine the validity and utility of the National Guidance. The methodology used for Implementation Review is currently being developed.

ACKNOWLEDGMENTS

The Department of Health would like to acknowledge the efforts and contributions of a number of people who dedicated significant time and expertise to developing this Guidance.

The Project Steering Committee provided strategic oversight and valuable insight in to the expectations and requirements of PHNs. Members included:

Member	Position, Organisation
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Mr Bill Buckingham	Technical Advisor (Mental Health), Department of Health
Ms Jenni Campbell	National Project Manager

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

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SECTION 1- INTRODUCTION

OVERVIEW

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

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

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

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

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

In a stepped care approach, a person presenting to the health system is **matched** to the least intensive level of care that most suits their current treatment need, considering the balance between intended benefits and potential risks. A secondary and key feature of stepped care is

ongoing outcome and experience measurement to provide close to real-time feedback on outcomes allowing treatment intensity to be adjusted (stepping up or stepping down) as necessary. To achieve this, an initial assessment is required. This is undertaken in partnership with the individual in order to determine **suitable and appropriate treatment** choices/options.

Stepped care is in the early phases of implementation in Australia. PHNs have been tasked with operationalising stepped care, and it is recognised that the system is new and evolving.

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

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

Without a consistent national approach, PHNs (and their commissioned providers and referrers) will inevitably assess and assign levels of care inconsistently, resulting in discrepancies in the type of care provided across PHN regions, for similar clinical presentations. This Guidance has been developed to support nationally consistent evidence-informed initial assessment and referral processes and will be refined as new evidence emerges.

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

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

OVERVIEW OF INITIAL ASSESSMENT GUIDANCE

The Guidance includes relevant background information (section 1), information about initial assessment domains (section 2), a consistent description of the levels of care (section 3), advice about progress monitoring (section 4) and information about clinical governance expectations (section 5).

Figure 1: Overview of Guidance

1	INTRODUCTION
2	INITIAL ASSESSMENT DOMAINS
3	LEVELS OF CARE
4	PROGRESS MONITORING
5	CLINICAL GOVERNANCE

SCOPE

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

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- Intake teams responsible for undertaking initial assessments which may involve making recommendations on the level of care required
- Commissioned providers responsible for undertaking initial assessments and/or recommending the level of care required
- PHNs or commissioned provider implementing systems for the initial assessment and referral of individuals seeking help.

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

Issues this Guidance seeks to address

This Guidance has been developed to provide:

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

Issues that are not covered

The Guidance does not provide:

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

Whilst this Guidance refers to the critical interface between primary mental health care and acute, tertiary and specialist secondary settings, this Guidance is not intended to be applied within acute or specialist mental health care settings.

Target population

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

- Children and young people

- Aboriginal and Torres Strait Islander Peoples
- People from culturally and linguistically diverse backgrounds
- And people with multi-morbidities (including development disorders and intellectual disability).

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

Expectations of PHNs

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

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

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

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

Clinical Judgement

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

BACKGROUND

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

PREVALENCE OF MENTAL ILLNESS AND COMMUNITY NEED

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

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

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

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

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

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[1] Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing 2007: Summary of Results, ABS cat. no. 4326.0, Canberra, ABS.
[2] Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015), The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra, Department of Health.

Figure 2 summarises the estimated prevalence, graded according to levels of need.
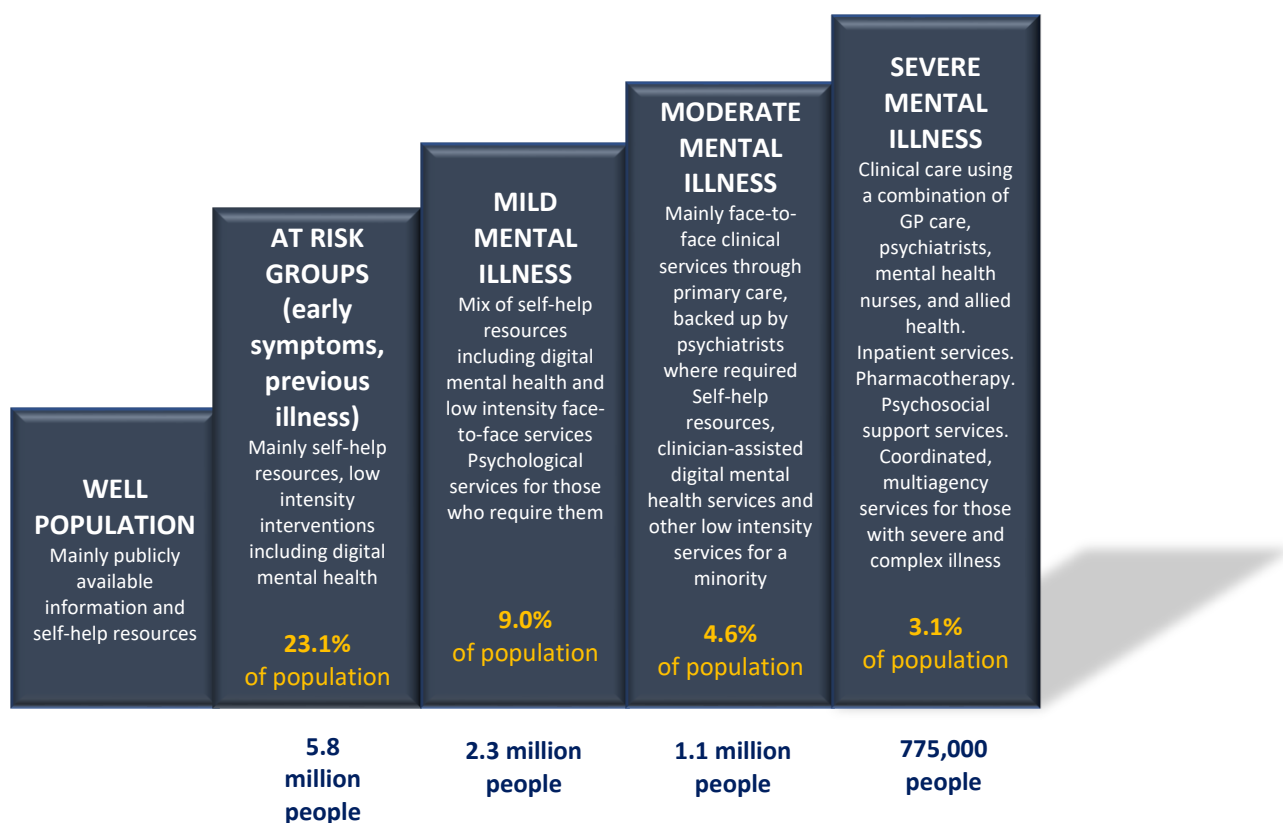
Figure 2: Estimated prevalence of mental health conditions and stepped care levels of need based on severity

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

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

THE PRIMARY MENTAL HEALTH CARE LANDSCAPE

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

Medicare and the MBS Better Access initiative[3]

The Medicare Benefits Schedule system is a universal system that provides Commonwealth-subsidised treatment for selected mental health services provided by GPs, psychiatrists, psychologists and eligible social workers and occupational therapists. The Better Access Initiative, introduced in November 2006, substantially expanded the role of Medicare in mental health service provision, and aims to increase access for people with a clinically diagnosable mental disorder to evidence-based treatment.

In 2017-18, 2.5 million Australians (10.5% of the population) received Medicare-subsidised mental health services using mental health specific MBS item numbers. The vast majority consulted their GP (2.1 million people), with also 1.2 million people seeing a psychologist or other allied health provider. A total of 400,000 people consulted a psychiatrist. Many individuals consulted more than one of these professionals.

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

Primary Health Network commissioned services

PHNs are responsible for commissioning a range of services across the stepped care spectrum. PHN commissioned services were provided to approximately 190,000 individuals in 2017-18, a relatively small fraction of those seen under Medicare arrangements but targeted to meet different needs, described below.

Low Intensity Services

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

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

Psychological therapies

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

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

Coordinated care for people with severe mental health conditions

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

Commissioned services for children and young people, including headspace

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

In 2017-18, an estimated 88,000 young people accessed a headspace centre.

Services for young people with severe mental illness

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

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

Aboriginal and Torres Strait Islander Mental Health Services

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

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

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

Suicide Prevention

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

Digital Mental Health Interventions

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

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

- **beyondblue:** beyondblue's telephone support service engages a team of mental health professionals to provide free, immediate, short-term counselling, advice and referrals to anyone in Australia via telephone and email and web chat. In 2016-17 there were **161,797** people who contacted the telephone support service, and **700,000** people accessed the online peer support forum.

- **MindSpot:** the MindSpot clinic is a telephone and online service for Australian adults experiencing symptoms of anxiety or depression. The service provides screening, assessment and treatment. The MindSpot Clinic has **20,000+** registrations each year.

- **eheadspace:** the eheadspace service provides online and telephone support to young people, parents, families and peers. In 2016-17 eheadspace serviced over **30,000** young people, providing 63,000 sessions of service.

- **ReachOut**- ReachOut is an online platform providing information, advice and services to young people and their families. In 2015-16, the ReachOut Next Step digital application was utilised by **4500** people per month, on average.

- **MoodGYM and eCouch**- MoodGYM is a cognitive behavioural therapy (CBT) based intervention designed to prevent or reduce symptoms of anxiety and depression. MoodGYM has **36,834** unique visitors per month, on average.

- **Lifeline-** Lifeline provides 24-hour crisis support and suicide prevention services. Lifeline receives an average of **60,000** calls per month, on average.

THE ROLE OF THE SPECIALIST ACUTE AND COMMUNITY MENTAL HEALTH SYSTEM

Specialist acute and community mental health services delivered primarily through state and territory funding, together with private hospitals, provide the most intensive mental healthcare.

These services usually include intensive team-based specialist assessment and intervention with involvement from a range of different types of mental health professionals, including case managers, psychiatrists, social workers, mental health nurses, occupational therapists, psychologists and other workers. Specialist mental health services include treatment and care provided in bed-based settings, including acute psychiatric units, step -up/down facilities and rehabilitation units.

Nationally, specialised state and territory mental health services see approximately 1.8 percent of the population annually, or 430,000 people[4]. Their predominant focus is on those with severe and more complex conditions.

HIGH LEVEL VIEW OF HOW CURRENT DEMAND IS MET BY THE PRIMARY MENTAL HEALTH CARE SYSTEM

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

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

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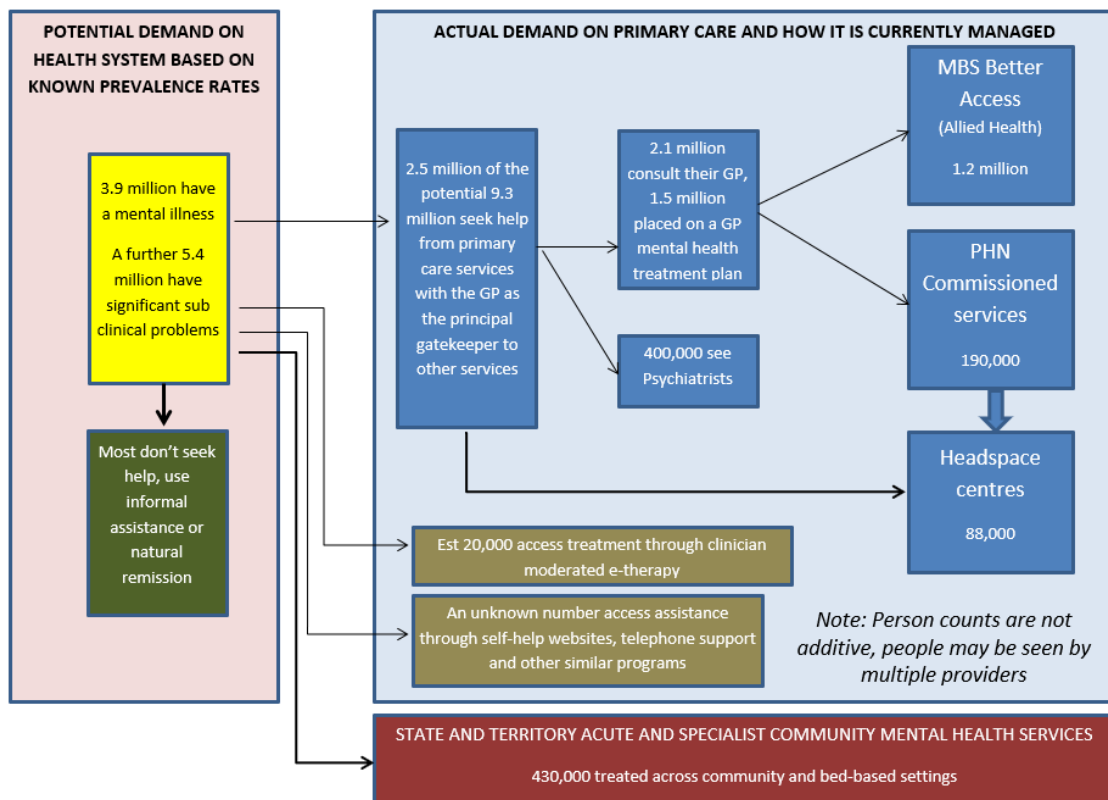
[4] SCRGSP (Steering Committee for the Review of Government Service Provision) 2018, *Report on Government Services 2018*, Productivity Commission, Canberra.

DEVELOPMENT OF THE GUIDANCE

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

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

The Department of Health also drew from information contained within the National Mental Health Services Planning Framework (NMHSPF).

PHN SUMMARY REPORT

The PHN Summary Report has been made available to PHNs via SharePoint. The Summary Report is informed by a national survey of PHNs. The survey took the form of a structured interview with pre-determined questions designed to elicit consistent information from across the network. The national survey was conducted via telephone.

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

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

Below is a summary of the key findings and recommendations.

Intake and referral mechanism

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

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

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

Role of referrers

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

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

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

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

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

Centralised decision-making

In some PHN regions, the referrer is not making the decision about the level of care or service recommendation, rather the PHN (or a commissioned provider) has responsibility for determining the level of care and referral pathway. For these PHNs, GPs and referrers are often able to make specific requests, however the final decision rests with the central intake team or commissioned provider.

Standard assessment tools

At the time of the survey, the majority of PHNs (21) had not yet introduced a region wide standard assessment tool and identified this as a priority area of work. Several PHNs have commenced development work in partnership with universities or other partners.

A small number of PHNs (5) have implemented a region wide standard assessment tool.

Describing levels of care

6 PHNs have described with detail the different levels of care. Of the PHNs who have described the different levels of care and applied intervention recommendations, there is significant variation regarding these descriptions and subsequent recommendations. In describing different levels of care, many PHNs recommended consistency with the *NMHSPF* – which most PHNs will be actively

using. In addition, several PHNs described how a consistent description of different levels of care could help inform the development or review of mental health related HealthPathways.

Survey findings also indicated that PHNs are seeking to describe various levels of care across the care continuum, alongside recommendations regarding service type and intensity (including secondary and specialist services and non-PHN commissioned services).

Commonly, PHNs are actively contemplating application of the NMHSPF, and queried the potential to align this guidance with the NMHSPF. A few PHNs also suggested matching the National Guidance with Medicare item numbers.

Step up/down

At the time of the survey, very few (n=7) PHNs have a step up/down protocol in place. Many PHNs indicated that escalation (or "step up") protocols were in place, to guide referral in to secondary specialist and acute mental health services only. In addition, many PHNs reflected that step up/down is occurring infrequently. The reasons provided included:

- Developing pathways and/or agreements across separate and multiple providers (slow progress linked to PHN resources and capacity).
- Limited acceptability of low intensity services leading to a reluctance to using these as treatments of choice.
- Clinician 'holding' a consumer for fear of disrupting the therapeutic alliance and care continuity, suggesting a reluctance to end an episode of care and refer to another more appropriate service.
- Problems with the fee for service model (in some commissioned programs) where funding is based on volume of services provided and therefore a transfer of care to a different intensity service may lead to decreased funding for the commissioned provider.

LITERATURE REVIEW

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

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

The following list highlights some of the common features of stepped care initial assessment and referral systems:

- The role of the GP appears to be critical as a gatekeeper/referral source.
- Effective engagement with the consumer at the point of assessment is a necessary precursor.

- Assessment is linked to evidence-based treatment recommendations and many systems provide referrers with specific advice on the type of intervention likely to benefit the individual consumer.
- In relation to assessment processes, there seems to be two areas of focus: (i) clinical symptomatology and the degree to which the individual meets criteria on specific tools, and (ii) indicators of functioning.
- The risks of suicide, self-harm and harm to others were highlighted as key issues for consideration in several stepped care systems.
- There is overwhelmingly a lack of quality control or clinical governance procedures that have been reported in the literature or descriptions of programs.
- Many systems are supported by technological infrastructure (including online screeners, electronic referral, electronic outcome recording and measurement).
- In some systems (e.g., NHS), the formal guidelines (e.g., NICE guidelines) are reinforced by professional bodies, who often produce their own complementary guides, tools, training and resources for their members.
- There is a trend towards single entry points, with decision making (regarding service type and intensity).
  resting with clinicians in a centralised intake team, rather than referrers.
- Policy and Guidance documents include a focus on preserving consumer choice and preference, and support strategies aligned with supported decision-making.

The following key points from the literature review were made based upon the limited available evidence:

- A focus on risks such as suicide/self-harm/ harm to others needs to be built in to all mechanisms from the first point of contact for screening/assessment and monitored throughout the steps of the intervention process.
- Clear and realistic processes for transitions between steps need to be prioritised. This will include practicalities around steps up or down as well as steps within steps. It requires effective clinical management processes around points of review, routine outcome monitoring, decision making and consumer engagement.
- Guiding principles, quality control and clinical governance processes and procedures need to be a priority given the range of complexity of the individual groups' needs.
- Initial assessment processes should be used to match individuals' needs with the most appropriate step for intervention. These assessments need to be sensitive to risks, comorbidity, age, gender and culture as well as the consumer's preferences, current circumstances and context.
- Given the lack of available evidence and the variable quality of the existing evidence, consideration could be given to undertaking research to inform ongoing development and implementation of assessment and referral within the Australian primary care mental health stepped care model.

GUIDING PRINCIPLES

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

1. Supported decision-making to support consumer choice

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

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

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

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

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

3. Accessible care options

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

4. Responsive and flexible

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

5. Effective clinical governance

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

6. Safe services

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

SECTION 2- INITIAL ASSESSMENT DOMAINS

An initial assessment is used to gather information from the referrer and consumer to guide decisions about the most appropriate next steps (e.g., intervention, further assessment). PHNs must be confident that an effective initial assessment is undertaken to match the consumer with the most appropriate level of care. For this context, the initial assessment is focussed on information gathering to assign a level of care and **is not** seeking to make a diagnosis or replace a comprehensive mental health assessment.[5]

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

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

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

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

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

- Non-clinical staff are adequately trained in mental health assessment and referral skills

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

- Suitably qualified and experienced mental health clinicians oversee decision-making by non-clinical staff. Key decision-making points during the IAR process include:
  - decisions about the rating on each of the domains and
  - the decision about an assignment of a level of care.
- Non-clinical staff have immediate access to supervision from a suitably qualified and experienced clinician (e.g., when-ever it is needed, via telephone or onsite supervision).

PRACTICE POINT

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

OVERVIEW OF ASSESSMENT DOMAINS AND RELATIONSHIP TO LEVELS OF CARE

The initial assessment process recommended in this Guidance identifies eight domains that should be assessed when determining the next steps in the referral and treatment process for a person referred to a PHN commissioned mental health service. The eight domains fall into two categories:

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

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

PRACTICE POINT

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

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

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

This version of the guidance includes an untested example for future review that aims to unravel the complexity by:

- Providing a guide to assessing severity of problems on each of the eight domains. This is presented as a rating glossary at Appendix 1, including a hierarchical ranking of factors relevant to each domain to guide judgements about problem severity.

- Detailing the logic and steps in a decision support tool format of how assessment on each of the domains, and interaction between them, could be used to inform decisions about assigning an individual to a level of care. This is provided at Appendix 2.

The resources in Appendix 1 and 2 have been developed in consultation with the Expert Advisory Group (EAG) established to guide this work. The EAG provided extensive advice on the project and the resources draw on both their clinical expert views and available evidence. At this stage of development of the national project, the resources provided at Appendices 1 and 2 are offered as examples that require testing in the field and will be subject to refinement based on experience in their use.

DOMAIN 1 – SYMPTOM SEVERITY AND DISTRESS (PRIMARY DOMAIN)

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

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

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

DOMAIN 2 – RISK OF HARM (PRIMARY DOMAIN)

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

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

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

PRACTICE POINT

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

DOMAIN 3 – FUNCTIONING (PRIMARY DOMAIN)

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

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

DOMAIN 4 – IMPACT OF CO-EXISTING CONDITIONS (PRIMARY DOMAIN)

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

Assessment of an individual on this domain should consider:

- substance use/misuse and the associated impact on the individual

- physical health condition and the associated impact on the individual where they have a concurrent mental health condition
- intellectual disability or cognitive impairment

DOMAIN 5 – TREATMENT AND RECOVERY HISTORY (CONTEXTUAL DOMAIN)

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

Assessment of an individual on this domain should consider:

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

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

DOMAIN 6 – SOCIAL AND ENVIRONMENTAL STRESSORS (CONTEXTUAL DOMAIN)

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

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

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

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

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- legal issues

DOMAIN 7- FAMILY AND OTHER SUPPORTS (CONEXTUAL DOMAIN)

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

DOMAIN 8- ENGAGEMENT AND MOTIVATION (CONTEXTUAL DOMAIN)

This initial assessment domain should explore the person's understanding of the mental health condition and their willingness to engage in or accept treatment.
Assessment of an individual on this domain should include:

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

USING THE GLOSSARY TO RATE THE INITIAL ASSESSMENT DOMAINS

Appendix 1 provides an example (to be tested) of how the domains can be rated, using a scoring system that grades each domain on a 5-point scale of severity, where:

0 = No problem

1 = Mild problem

2 = Moderate problem

3 = Severe problem

4 = Very severe problem

Specific criteria are outlined for assessing each domain, designed to serve as a checklist of factors to consider when judging the extent to which a problem is present. The rating scale and glossary has been prepared as an example of how the domains can be rated for future trial in the field, noting that it may be used in variable ways across the PHN network. A snapshot of the summary rating scale is shown in Figure 4.

Figure 4: Summary rating form for assessing domains (see Appendix 1)

INITIAL ASSESSMENT SUMMARY SHEET

PRIMARY ASSESSMENT DOMAINS

DOMAIN 1: Symptom severity and distress

0. No problem

1. Mild or sub-diagnostic

2. Moderate

3. Severe

4. Very severe

Initial Assessment Rating [ ]

DOMAIN 2: Risk of harm

0. No identified risk

1. Low risk of harm

2. Moderate risk of harm

3. High risk of harm

4. Very high risk of harm

Initial Assessment Rating [ ]

DOMAIN 3: Functioning

0. No problems

1. Mild impact

2. Moderate impact

3. Severe impact

4. Very severe to extreme impact

Initial Assessment Rating [ ]

DOMAIN 4: Impact of co-existing conditions

0. No problems

1. Minor impact

2. Moderate impact

3. Severe impact

4. Very severe impact

Initial Assessment Rating [ ]

CONTEXTUAL DOMAINS

DOMAIN 5: Treatment and recovery history

0. No prior treatment history

1. Full recovery with previous treatment

2. Moderate recovery with previous treatment

3. Minor recovery with previous treatment

4. Negligible recovery with previous treatment

Initial Assessment Rating [ ]

DOMAIN 6: Social and environmental stressors

0. No problem

1. Mildly stressful

2. Moderately stressful

3. Highly stressful

4. Extremely stressful

Initial Assessment Rating [ ]

DOMAIN 7: Family and other supports

0. Highly supported

1. Well supported

2. Limited supports

3. Minimal supports

4. No supports

Initial Assessment Rating [ ]

DOMAIN 8: Engagement and motivation

0. Optimal

1. Positive

2. Limited

3. Minimal

4. Disengaged

Initial Assessment Rating [ ]

SECTION 3- LEVELS OF CARE

This section provides a description of the different levels of care. The information gathered through the initial assessment (Section 2) is used to assign a level of care and inform a referral decision. The levels of care are not intended to replace individualised assessment and care - rather to provide information to guide decision making.

PRACTICE POINT- A NOTE ABOUT CONSUMER CHOICE AND PREFERENCE

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

Supported decision-making strategies for initial assessment and referral:

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

For more information and advice about supported decision-making visit: http://healthtalkaustralia.org/mental-health-and-supported-decision-making/ and for resources specifically for carers, visit: http://healthtalkaustralia.org/mental-health-carers-experiences/

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

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

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

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

Five levels of care are described, as summarised in Figure 5 below.

Figure 5: Schematic representation of levels of care

Primary mental health care falls into Levels 1 to 4.

- Level 1 (self-management) is suggested for those with relatively minor problems on the Primary Domains. Contraindications to Level 1 care include problems with engagement/motivation (because these will work against any referral to self-management

strategies) and severe problems in treatment/recovery history or very severe environmental stressors.

- Level 2 (low intensity interventions) is targeted at people with mild problems in the primary domains, where these do not present in the context of significant problems on the contextual domains. Level 2 may also be suitable for people with moderate symptoms, but this is dependent on extent of presenting problems on other primary and contextual domains.

- Level 3 (moderate intensity interventions) is targeted at people with mild to moderate symptoms/distress where these present in the context of significant problems on other domains. Level 3 is also proposed as suitable for management of severe symptoms where no significant problems are present on other primary domains.

- Level 4 (high intensity interventions) is targeted to individuals with severe symptoms/distress, where these occur in the context of significant other problems (up to severe levels). Level 4 is not suitable for people with severe symptoms who present with very severe problems on either risk or functioning. Individuals referred with this array of presenting problems are suggested as best referred to Level 5 care.

REFERRAL CRITERIA TO LEVELS OF CARE

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

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

Appendix 2 provides an untested Decision Support Tool that is based on the interaction of initial assessment ratings made using the Domains Glossary described in Appendix 1. This shows a proposed logic for referral decisions based on initial assessments that will need to be reviewed and tested by PHNs in the field.

LEVEL 1 (SELF MANAGEMENT)

Definition: services at this level of care are designed to prevent the onset of illness and are mostly focussed on supporting the person to self-manage any distress or symptoms. This level of care generally involves evidence-based digital therapies and other forms of self-help. A summary of the evidence based digital mental health therapies and self-help services is available through the Head to Health website.

Care environment: services are easily accessible and available online, via telephone or in the community. Services may also be available in integrated settings (for example- within schools, workplaces and general practice).

Core clinical services:

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

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

Other clinical interventions that may be required:

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

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

Referral criteria:

A person suitable for this level of care typically has no risk of harm, is usually experiencing mild symptoms and/or no distress/low levels of distress- which may be in response to recent psycho-social stressors. Symptoms have typically been present for a short period of time. The individual is generally functioning well and should be motivated to pursue self-management options. People experiencing a lack of motivation/engagement should not be referred to this level of care because these problems will work against involvement in self-management strategies. Additionally, Level 1 care is unlikely to be suitable for those with severe problems in their treatment/recovery history or very severe environmental stressors – each of these would usually trigger a referral to Level 3 care.

Using the Initial Assessment Rating Glossary to support decision making

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

Mild or no problems on all Primary Domains (Symptoms, Risk, Functioning and Co-existing Conditions, all scores ≤ 1) **AND**

> o No significant problems on Treatment and Recovery History, Social and Environmental Stressors and Engagement and Motivation (all scores ≤ 1), **OR**

- o Moderate problems on <u>Treatment and Recovery History</u> (score ≤ 2) but with good <u>Engagement and Motivation</u> (score ≤ 1), **OR**

- o High <u>Social and Environmental Stressors</u> (score ≤ 3) but with good <u>Engagement and Motivation</u> (score ≤ 1).

LEVEL 2 (LOW INTENSITY SERVICES)

Definition: Low intensity services are designed to be accessed quickly (without the need for a formal referral e.g., through a third-party service or provider), easily (through a range of modalities including face to face, group work, telephone and digital interventions) and typically involve few or short sessions.

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

Core clinical services:

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

Other clinical interventions that may be required:

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

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

Referral criteria:

A person suitable for this level of care typically has minimal or no risk factors, is usually experiencing mild symptoms/low levels of distress, and where present, this is likely to be in response to a stressful environment. Symptoms have typically been present for a short period of time (less than 6 months but this may vary). The individual is generally functioning well but may have problems with motivation or engagement that contraindicate a referral to Level 1 care. Where the person has experienced previous treatment for a previous episode, they are likely to have had a moderate or better recovery.

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

Using the Initial Assessment Rating Glossary to support decision making:

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

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

    - moderate problems on Treatment and Recovery History (score ≤ 2) and limited Engagement and Motivation (score ≥ 2), **OR**

- o high <u>Social and Environmental Stressors</u> (score ≤ 3) and limited <u>Engagement and Motivation</u> (score ≥ 2)

  OR

- Mild <u>Symptoms and Distress</u> (score = 1) in the context of moderate <u>Co-existing Conditions</u> (score =2)

  OR

- Moderate <u>Symptoms and Distress</u> (score = 2) but no significant problems indicated by <u>Risk of Harm</u>, <u>Functioning</u> or <u>Co-existing Conditions</u> (all scores ≤ 1).

LEVEL 3 (MODERATE INTENSITY SERVICES)

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

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

Core clinical services:

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

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

Other clinical interventions that may be required:

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

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

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

Referral criteria:

A person requiring this level of care is likely to be experiencing mild to moderate symptoms/distress (that would meet criteria for a diagnosis). Symptoms have typically been present for 6 months or more (but this may vary). Initial assessment would usually indicate complexity on risk, functioning or multimorbidity but not at very severe levels, which should trigger consideration of a referral to Level 5. People experiencing severe symptoms with mild or no problems associated with Risk, Functioning and Co-existing Conditions are usually suitable for this level of care.

Using the Initial Assessment Rating Glossary to support decision making:

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

- Mild or lesser problems on all Primary Domains (Symptoms and Distress, Risk of Harm, Functioning, Co-existing Conditions, all scores ≤ 1) but with indications of significant problems in relation to Treatment and Recovery History (score ≥ 3) or high Social and Environmental Stressors (scores ≥ 4) **OR**

- Mild or lesser Symptoms and Distress (score ≤ 1) but with complexity indicated by significant problems on Risk of Harm or Functioning (scores ≥ 2) or Co-existing Conditions (score ≥ 2) **OR**

- Moderate <u>Symptoms and Distress</u> (score = 2) with associated moderate or higher problems on any other Primary Domain (<u>Risk of Harm</u>, <u>Functioning</u>, <u>Co-existing Conditions</u>, scores ≥ 2) **OR**

- Severe <u>Symptoms and Distress </u>(score = 3) but problems on all other Primary Domain (<u>Risk of Harm</u>, <u>Functioning</u>, <u>Co-existing Conditions</u>) are mild or less (all scores ≤ 1).

* Individuals with a rating of 3 or higher on Symptoms may be accommodated at this level, only where ALL other primary assessment domains are rated as 1 or less

LEVEL 4 (HIGH INTENSITY SERVICES)

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

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

Core clinical services:

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

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

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

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

Referral criteria:

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

Using the Initial Assessment Rating Glossary to support decision making:

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

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

LEVEL 5 (ACUTE AND SPECIALIST COMMUNITY MENTAL HEALTH SERVICES)

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

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

Core clinical services:

For this level of care, the person is likely to benefit from psychiatric assessment and care, crisis management, and therapeutic interventions using assertive engagement strategies provided by a multi-disciplinary specialist team with outreach capability. Care should be provided in close collaboration with General Practice.

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

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

Referral criteria:

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

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

Using the Initial Assessment Rating Glossary to support decision making:

Individuals suited to this level of care may have:

- Very severe problems (score = 4) on one or more of <u>Symptom Severity and Distress</u>, <u>Risk of Harm</u> and <u>Functioning</u> domains **OR**
- Severe Symptoms (score = 3) in the context of moderate to severe problems in one or more other Primary Domains (<u>Risk of Harm, Functioning, Co-existing Conditions</u>, score 2 or 3) with associated severe or higher problems in one or more Contextual Domains (<u>Treatment and Recovery History</u>, <u>Social and Environmental Stressors</u>, <u>Family and Other Supports</u>, <u>Engagement/Motivation, score 3 or 4</u>)

SECTION 4- PROGRESS MONITORING

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

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

Who should monitor progress?

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

How should progress monitoring occur?

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

PRACTICE POINT

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

How often should progress monitoring occur?

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

When should a STEP-UP be considered?

A STEP-UP should be considered when:

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

PRACTICE POINT

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

When should a STEP-DOWN be considered?

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

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

PRACTICE POINT

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

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

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

SECTION 5- CLINICAL GOVERNANCE

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

> *Your Organisation must establish and maintain appropriate clinical governance and quality assurance arrangements for all components of the Activity and with a particular focus on the services commissioned. Building on the requirements of the PHN Grant Programme Guidelines (1.3 PHN Governance Arrangements) this must include:*
>
>   *i.   Ensuring a high-quality standard of services which is supported by appropriate quality assurance processes.*
>   *ii.   Ensuring the workforce is practicing within their area of qualification and competence.*
>   *iii.   Ensuring appropriate clinical supervision arrangements are in place.*
>   *iv.   Ensuring appropriate risk assessment and management procedures are in place.*
>   *v.   Establishing and maintaining appropriate consumer feedback procedures, including complaint handling procedures.*
>   *vi.   Ensuring appropriate crisis support mechanisms are in place to provide information to patients on how to access other services in a crisis situation, noting it is not the role of the PHN to provide or commission this type of service.*
>   *vii.   Ensuring transition pathways are in place that allow consumers to seamlessly move to an appropriate alternate service should their circumstances change.*
>
> *Your organisation is required to ensure that services are consistent with the National Standards for Mental Health Services 2010 and any other relevant standards, such as the National Practice Standards for the Mental Health Workforce 2013*

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

> *PHN Mental Health Guidance*
>
> *PHNs need to ensure minimum standards are met and that clinical governance arrangements are in place. Clinical supervision channels should also be ensured in all commissioned services as a quality assurance mechanism.*
>
> *Duty of care provisions need to be established to ensure consumers accessing commissioned services are provided with information about how to access other services in a crisis situation or when the level of service offered by the commissioned service no longer matches their presenting need. Service providers must appropriately screen for risk, routinely monitor and track a consumer's progress and support consumers to move to more appropriate services if required.*

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

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

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

Table 1: Clinical Governance

PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
Requirement: Initial assessment and referral practices are resulting in optimal alignment of clinical need and treatment need (NSMHS-10.3.3)		
The PHN should establish system-level and contract-level monitoring processes that provide an indication of whether initial assessment and referral practices are resulting in an effective alignment of clinical need with treatment need. The PHN must define performance measures relating to alignment of clinical need with treatment need. PHNs should consider undertaking an analysis of effectiveness including: - proportion of consumers seeking access to higher intensity interventions after initial match to a lower intensity service or seeking access to lower intensity service after initial match to a higher intensity intervention - local data indicating consumer flow between providers/service types - proportion of consumers who experience positive recovery outcomes (e.g., reduction in distress, improved functioning) - proportion of consumers who have a positive experience of initial assessment and referral	The provider must establish initial assessment and referral practices which effectively match clinical need with treatment need and ensure referral decisions result in the consumer gaining access to evidence based and recommended interventions that are matched to their presenting clinical need. Clinical decision making must be documented and auditable.	The Provider should regularly audit compliance with the National Guidance and decision support tools and undertake remedial action in instances of non-compliance

PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
Requirement: The consumer has a choice of the services available and their preferences are understood and supported (NSMHS 10.4)		
The PHN provides current and up to date information about available services mapped against the levels of care and makes this information available for initial assessment and referral purposes. In doing so, PHNs should aim to be clear about the scope of the services available.	Providers must be informed about the range of interventions available at each level and offer a choice of interventions available within the broader community to consumers during the initial assessment and referral process. Providers must seek to understand and accommodate the economic, practical, cultural and personal circumstances that may limit a consumer's willingness or ability to participate in some interventions.	Providers should adopt a supported decision-making approach to initial assessment and referral.
Requirement: Initial assessment and referral processes minimise burden on the consumer (NSMHS- 10.3.5)		
The PHN should work with commissioned providers and other stakeholders to examine opportunities for integrated initial assessment and referral processes aiming to minimise the likelihood of the consumer needing to undergo duplicate and/or unnecessary assessments.	The provider, with the consent of the consumer, must ensure all information collected during the initial assessment is made available to the service provider securely.	Where possible, information sourced through previous initial assessments and other relevant treatment information should be made available to streamline the process and support the consumer to share information that is new or has changed. PHN has a process to conduct audits on referrals to examine quality of referrals coming in

PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
		and information sent on to service providers.
Requirement: Identification and management of risk of suicide, harm to self, to others and from others during initial assessment and referral		
The PHN must ensure that contract specifications clearly define requirements for managing risk in initial assessment and referral decision making and processes to mitigate those risks. The PHN must define performance measures relating to safety. These measures should be included in provider contracts and/or service models. Service models and related contract specifications must clearly articulate the reporting and auditing responsibilities of providers.	The provider must ensure that appropriate processes for assessing and managing consumer risk are in place and monitored (NSMHS 2.3). The provider must have in place a process for facilitating rapid identification of risk (including suicide risk, risk of self-harm, risk of harm to others and risk of harm from others) and processes that maintain consumer safety during referral to specialist and/or emergency services- this includes ensuring the timeliness of any recommended intervention matches the risks associated with suicide, harm to self, harm to others and harm from others. Where a consumer who is at risk of suicide or self-harm, or who has a changing risk profile, is required to wait for a service, the provider must work with the consumer and significant others (including carers and family) to develop a safety plan and facilitate a supported referral for additional services and supports. The provider must ensure consumers (and significant others) have information about 24-hour services	The provider should monitor the appropriate use of escalation processes, including failure to act (National Standards for MHS- Standards 9.4.1, 9.4.2).

PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
	available in the event of a crisis (National Standards for MHS- Standard 10.2.3). The provider must have in place a documented policy and/or established process and an appropriate mechanism to escalate care and arrange emergency assistance	
Requirement: Identification and management of adverse events, complaints and incidents (NSMHS 1.16)		
Contracts with commissioned providers must clearly outline the expectations and processes for reporting adverse events, critical incidents and serious complaints associated with initial assessment and referral. The PHN must have in place a documented process for reviewing all adverse events, critical incidents and serious complaints arising from initial assessment, referral and all other relevant intake processes. The PHN should undertake an analysis of incident trends associated with initial assessment and referral to determine system-level and process-level flaws and work with providers and stakeholders (e.g., referrers) to undertake quality improvement activities.	The provider must have in place a process for recording and reporting adverse events, incidents and complaints arising from initial assessment and referral practices. The provider must make clear and promote the process for reviewing and reporting adverse events, incidents and complaints.	Serious or critical incidents and complaints associated with initial assessment and referral should be subject to a root cause analysis (RCA) with the process being overseen by the CEO, board and/or clinical governance committee- the results should be reported to the PHN.

PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
Requirement: Staff undertaking initial assessment and referral must have the requisite skills and experience (NSMHS- 10.4.2)		
Service models and related contract specifications must clearly articulate workforce requirements, training and orientation expectations and intended scope of practice for staff undertaking initial assessment and referral (PHNs need to be confident that there is sufficient coverage within initial assessment and referral systems to ensure that demand for initial assessment is met and that waiting times are minimised). The PHN must define a process through which compliance with these specifications are monitored (e.g., through provider activity reports, audits etc) and how non-compliance will be managed by the PHN.	The provider must employ or contract appropriately qualified and experienced staff and have systems in place for verifying and maintaining qualifications and registrations. At a minimum initial assessment must be undertaken by a clinician who is competent to perform a mental health assessment. This may include: - GPs - Psychologists and other mental health professionals - Psychiatrists - Credentialed mental health nurses or registered nurses who have completed additional training in mental health assessment and referral skills and have access to mental health focussed supervision. There may be instances where non-clinical staff may be required to undertake the initial assessment. This is suitable only where: • Non-clinical staff have immediate access to supervision from a suitably qualified mental health professional. • Non-clinical staff are provided with formal and evidence-based training in mental health assessment and referral skills.	

PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
	• Decision-making by non-clinical staff is overseen by a suitably qualified mental health professional. The provider must be confident that there is sufficient coverage within initial assessment and referral systems to ensure that demand for initial assessment is met and that waiting times are minimised. The provider must define a scope of practice for employed or contracted staff involved in initial assessment and referral. The scope of practice must outline the extent and limits of practice permitted across differing roles (e.g., clinical versus non-clinical roles). The provider must have in place a system to regularly review the scope of practice (National Safety and Quality Health Service Standards 1.23). The provider must define a process through which compliance with scope of practice will be monitored and how non-compliance will be managed.	
Requirement: Staff responsible for initial assessment and referral must have access to training and supervision		
The PHN must ensure that contract specifications clearly define training and supervision requirements and expectations of staff employed or contracted by providers.	The provider must have in place a professional development policy and procedure outlining the professional development activity and supervision	

PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
Funding models should make available an appropriate proportion of the overall budget to ensure providers are able to fund the necessary training and supervision requirements. If permitting employment/ contracting of non-clinical staff, funding models should factor in the time required and cost involved in ensuring initial training and skill development has been undertaken.	requirements of staff involved in initial assessment and referral. This includes competency-based training in: - mental health assessment - undertaking a risk assessment (including risk of suicide, self-harm, harm to others and harm from others) - supporting consumers in crisis. This also includes orientation in: - Mental health services within the region and an understanding of where each service is positioned across the stepped care continuum. - Local health and social care pathways and referral processes. - evidence based digital interventions - local crisis or emergency services when referring individuals for immediate support.	
Requirement: Initial assessment and referral systems result in efficient use of available resources		
PHNs should establish mechanisms for monitoring the use of services to detect patterns indicating under-use (e.g., low intensity) and overuse of other interventions (e.g., psychological therapies). The PHN must be prepared to work with providers to take corrective action if this is occurring. This should be closely monitored	The provider must operate the initial assessment and referral system in a way that delivers fidelity with the stepped care concepts and therefore a person presenting to the mental health system is matched to the level of care that most suits their current need.	

PHN RESPONSIBILITIES (COMMISSIONING ROLE)	MANDATORY REQUIREMENTS- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL	OTHER BEST PRACTICE ACTIVITIES- PROVIDER RESPONSIBLE FOR INITIAL ASSESSMENT AND REFERRAL
during implementation and/or introduction of new service models. The PHN may need to consider redesigning components of the initial assessment and referral system if service use is not consistent with estimated service demand. PHNs should establish requirements for communication and promotion of new models of service delivery- particularly those services which are poorly understood or have low levels of acceptability.	The provider must regularly review and analyse service utilisation data, this may involve: - regular review of the MDS against established KPIs - an audit including a review of initial assessment results and subsequent referral decisions The provider must undertake corrective action if there is an indication of that service use is not consistent with estimated service demand. Corrective action may include: - Additional training and/or supervision for staff undertaking initial assessment and referral. - Information and education for referrers. - Providing feedback to clinicians on variation in practice and health outcomes. - Support clinicians to engage in a review of their practice and referral decisions.	

APPENDIX 1- GLOSSARY FOR RATING THE ASSESSMENT DOMAINS

This Appendix provides a guide to assessing severity of problems on each of the eight domains (the Glossary). The Glossary includes a hierarchical ranking of factors relevant to each domain to guide judgements about problem severity.

The Glossary provides an example (to be tested) of how the domains can be rated, using a scoring system that grades each domain on a 5-point scale of severity, where:

> 0 = No problem
>
> 1 = Mild problem
>
> 2 = Moderate problem
>
> 3 = Severe problem
>
> 4 = Very severe problem

Specific criteria are outlined for assessing each domain, designed to serve as a checklist of factors to consider when judging the extent to which a problem is present. The rating scale and glossary has been prepared as an example of how the domains can be rated for future trial in the field, noting that it may be used in variable ways across the PHN network. A snapshot of the summary rating scale is shown in Figure 4.

GENERAL INSTRUCTIONS FOR RATING THE DOMAINS

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

OVERARCHING RULES AND GUIDE TO RATINGS

- Within each domain, if more than one descriptor applies to the consumer, the descriptor with the highest rating should be selected.
  - Example one: if 3-b, and 3-c apply, but 4-a is also present, the rating selected is 4.
  - Example two: if 2-a and 2-b apply, but 3-c is also present, the rating selected is 3.
- Unless stated otherwise, rate the person's current situation, defined as their most typical over the past month. This recognises that personal and social circumstances can change.
- Use all available information in making your rating. This may include clinical interview and information gathered from the person's family, referrers or other informants.
- While terms vary, the rating scale for each domain follows the general format:
  - 0 = No problem
  - 1 = Mild problem

- 2 = Moderate problem
- 3 = Severe problem
- 4 = Very severe problem

- The coding of ratings as numerals not intended to imply that an overall composite score can be used for making decisions about the person's service needs. The numbers should be regarded as just shorthand for summarising severity.

- Guidance is given for each domain on examples of problems that should be considered for specific ratings (the 'descriptors'). Consider these as examples only rather than an exhaustive list of all factors relevant to the domain. Therefore, at times, referring to the underlying rating format may be helpful.

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

- This tool should not be used without clinical oversight.

- It should not be used as a screening tool because it cannot be used without some form of personalised assessment.

PRIMARY ASSESSMENT VS CONTEXTUAL DOMAINS

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

INITIAL ASSESSMENT SUMMARY SHEET

PRIMARY ASSESSMENT DOMAINS

DOMAIN 1: Symptom severity and distress

0. No problem

1. Mild or sub-diagnostic

2. Moderate

3. Severe

4. Very severe

Initial Assessment Rating ☐

DOMAIN 2: Risk of harm

0. No identified risk

1. Low risk of harm

2. Moderate risk of harm

3. High risk of harm

4. Very high risk of harm

Initial Assessment Rating ☐

DOMAIN 3: Functioning

0. No problems

1. Mild impact

2. Moderate impact

3. Severe impact

4. Very severe to extreme impact

Initial Assessment Rating ☐

DOMAIN 4: Impact of co-existing conditions

0. No problems

1. Minor impact

2. Moderate impact

3. Severe impact

4. Very severe impact

Initial Assessment Rating ☐

CONTEXTUAL DOMAINS

DOMAIN 5: Treatment and recovery history

0. No prior treatment history

1. Full recovery with previous treatment

2. Moderate recovery with previous treatment

3. Minor recovery with previous treatment

4. Negligible recovery with previous treatment

Initial Assessment Rating ☐

DOMAIN 6: Social and environmental stressors

0. No problem

1. Mildly stressful

2. Moderately stressful

3. Highly stressful

4. Extremely stressful

Initial Assessment Rating ☐

DOMAIN 7: Family and other supports

0. Highly supported

1. Well supported

2. Limited supports

3. Minimal supports

4. No supports

Initial Assessment Rating ☐

DOMAIN 8: Engagement and motivation

0. Optimal

1. Positive

2. Limited

3. Minimal

4. Disengaged

Initial Assessment Rating ☐

DOMAIN 1 - SYMPTOM SEVERITY AND DISTRESS (Primary Domain)

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

Assessment of an individual on this domain should consider:

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

0= No problem in this domain – no descriptors apply

1= Mild or sub diagnostic

a) Currently experiencing some, but not all, of the symptoms associated with an anxiety disorder (e.g., symptoms like excessive worry, difficulty concentrating) or depressive disorder (e.g., symptoms like sadness, irritability, exhaustion, disrupted sleep, anger) that have <u>typically</u> been present for less than 6 months (but this may vary). Current symptoms at a level that would likely result in a diagnosis or associated with a mild level of distress.

b) Currently experiencing mild distress.

c) Currently experiencing symptoms (described above) at sub-diagnostic level but risk of escalating.

2= Moderate

a) Currently experiencing symptoms indicative of an anxiety disorder (e.g., excessive worry, panic, racing mind, difficulty concentrating) or depressive disorder (e.g., excessive sadness, irritability, exhaustion, disrupted sleep, loss of interest and pleasure) that have typically been present for more than 6 months (but this may vary) but symptoms may be of more recent origin. Symptoms are at a level that would likely meet diagnostic criteria, and/or are associated with a moderate to high level of distress.

b) Currently experiencing moderate to high levels of distress.

c) History of a diagnosed mental health condition that has not responded to treatment, with continuing symptoms and moderate to high levels of distress.

3= Severe

a) A history of significant and ongoing symptoms indicative of a severe mental illness (e.g., hallucinations, paranoia, disordered thinking, extreme mood variation, delusions, extreme avoidant behaviour) but the symptoms are mostly well managed or are re-appearing and at risk of escalation without ongoing assistance.

b) Other mental health condition that is associated with high to very high levels of distress.

c) Recent onset of symptoms indicative of a severe mental illness and/or the person is experiencing high to very high levels of distress.

d) Has been admitted to hospital for a mental health condition in previous 12 months.

4= Very severe

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

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

c) Other long-term mental health condition presenting in the context of significant complexity that requires multiple agency involvement.

DOMAIN 2 – RISK OF HARM (Primary Domain)

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

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

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

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

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

0= No problem in this domain – no descriptors apply

1= Low risk of harm

a) No current suicidal ideation but may have experienced ideation in the past (with no previous intent, plan or attempts).
b) May have engaged in behaviours in the past that posed a risk to others but no current or recent instances
c) Occasional non-suicidal self-injurious acts in the recent past and not requiring surgical treatment

2= Moderate risk of harm

a) Current suicidal ideation, without plan or intent. But may have had intent, plans or attempts in the past unrelated to current episode or current life stressors.
b) Current or recent behaviours that pose a non-life-threatening risk to self or others
c) Frequent non-suicidal self-injurious acts in the recent past and not requiring surgical treatment

3= High risk of harm

a) Current suicidal ideation with intent and history of suicidal attempts. No plan or strong reluctance to carry out plan, strong protective factors and a commitment to engage in a safety plan including involvement of family, significant others and services.
b) Current or recent life-threatening self-harm or dangerous behaviours to self or others.
c) Clearly compromised self-care ability to the extent that indirect or unintentional harm to self is likely. This includes indirect harm to self- associated with conditions such as anorexia nervosa.
d) Frequent non-suicidal self-injurious acts in the recent past and requiring surgical treatment

4= Very high risk of harm

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

DOMAIN 3 - FUNCTIONING (Primary Domain)

An initial assessment should consider functional impairment caused by or exacerbated by the mental health condition. While other types of disabilities may play a role in determining what types of

support services may be required, they should generally not be considered in determining mental health intervention intensity within a stepped care continuum.

Assessment of an individual on this domain should consider:

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

0= No problem in this domain – no descriptors apply

1= Mild

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

2= Moderate

a) Functioning is impaired in more than one of their usual roles including work, social, parenting and family, education, to the extent that they are unable to meet the requirements of those roles on average 1 to 2 days per month.
b) The person experiences occasional difficulties with basic activities of daily living but without threat to health.

3= Severe

a) Significant difficulties with functioning, resulting in disruption to many areas of the person's life (e.g., work, education, interpersonal relationships, self-care) but the person can function independently with adequate treatment and community support.
b) The person experiences difficulties with basic self-care (hygiene, eating, appearance) on a frequent, consistent basis but without threat to health.

4= Very severe

a) Profound difficulties with functioning, resulting in major disruption to virtually all areas of the person's life (e.g., unable to work or participate in education, withdrawal from interpersonal relationships).
b) Mental health condition contributes to severe and persistent self-neglect that poses a threat to health.

DOMAIN 4 – IMPACT OF CO-EXISTING CONDITIONS (Primary Domain)

Increasingly, individuals are experiencing and managing multi-morbidity (coexistence of multiple conditions including chronic disease). An initial assessment should specifically examine the presence of other concurrent health conditions that contribute to (or have the potential to contribute to)

increased severity of mental health problems and/or compromises the person's ability to participate in the recommended treatment.

Assessment of an individual on this domain should consider:

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

0= No problem in this domain – no descriptors apply

1= Minor impact

a) Occasional episodes of substance misuse but any recent episodes are limited, are not currently causing any concerns and do not impact on the concurrent mental health condition of the person.

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

2= Moderate impact

a) Ongoing or episodic substance abuse impacting on, or with the potential to impact on, the concurrent mental health condition of the person or ability to participate in treatment.

b) Physical health condition present and impacting significantly on the mental health condition of the person or their ability to participate in treatment.

3= Severe impact

a) Substance use occurs at a level that poses a threat to health or represents a barrier to mental health related recovery.

b) Physical health condition present and require intensive medical monitoring and are seriously affecting the mental health of the person (e.g., worsened symptoms, heightened distress).

c) Intellectual disability or cognitive impairment that impacts significantly on the mental health condition and impedes the person's ability to participate in treatment

4= Very severe impact

a) Severe substance use disorder with inability to limit use without specialist AOD intervention, in the context of a concurrent mental health condition.

b) Significant physical health conditions exist which are poorly managed or life threatening, and in the context of a concurrent mental health condition.

c) Severe intellectual disability or severe cognitive impairment that impacts significantly on the mental health condition and impedes the person's ability to participate in treatment

DOMAIN 5 - TREATMENT AND RECOVERY HISTORY (Contextual Domain)

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

Assessment of an individual on this domain should consider:

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

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

0= No prior treatment history

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

1= Full recovery with previous treatment

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

2= Moderate recovery with previous treatment

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

3= Minor recovery with previous treatment

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

4= Negligible recovery with previous treatment

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

DOMAIN 6 – SOCIAL AND ENVIRONMENTAL STRESSORS (Contextual Domain)

This initial assessment domain should consider how the person's environment might contribute to the onset or maintenance of a mental health condition. Significant situational or social complexities can lead to increased condition severity and/or compromise ability to participate in the recommended treatment. Unresolved situational or social complexities can limit the likely benefit of treatment. Furthermore, understanding the complexities experienced by the individual (with carer/support person perspectives if available), may alter the type of service offered, or indicate that additional service referrals may be required (e.g., a referral to an emergency housing provider).

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

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

0= No problem in this domain – no descriptors apply

1= Mildly stressful environment

a) Person experiences their environment as mildly stressful.

2= Moderately stressful environment

a) Person experiences their environment as moderately stressful.

3= Highly stressful environment

a) Person experiences their environment as highly stressful.

4= Extremely stressful environment

a) Person experiences their environment as extremely stressful.

DOMAIN 7- FAMILY AND OTHER SUPPORTS (Contextual Domain)

This initial assessment domain should consider whether informal supports are present and their potential to contribute to recovery. A lack of supports might contribute to the onset or maintenance

of the mental health condition and/or compromise ability to participate in the recommended treatment.

0= Highly supported

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

1= Well supported

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

2= Limited supports

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

3= Minimal supports

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

4= No supports

    a) No useful sources of support are available.

DOMAIN 8- ENGAGEMENT AND MOTIVATION (Contextual Domain)

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

Assessment of an individual on this domain should include:

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

0= Optimal

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

1= Positive

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

2= Limited

   a) Limited understanding or confusion about condition and impacts.

   b) Unlikely to access supports without prompting and encouragement.

   c) Limited interest in taking an active role in managing condition.

3= Minimal

   a) Rarely accepts reality of condition but may acknowledge associated situational difficulties.

   b) No ability or interest in managing the condition.

   c) Some reluctance to accept supports, does not use resources available.

4= Disengaged

   a) No awareness or understanding of the condition and impacts.

   b) Actively avoids managing the condition.

   c) Deliberately avoids potentially useful and available supports.

APPENDIX 2- DECISION SUPPORT TOOL

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

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

Assessment on the eight domains detailed in Appendix 1 provides the starting point. The next step is to define levels of care, based on different levels of resource intensity. Section 3 of the guidance outlines the proposed schema for conceptualising resource intensity, based on five levels of care. The model is offered as a practical approach to guide thinking about referral options rather than a picture-perfect reflection of the mental health service system.

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

An individual's presenting problems on each domain can interact in different ways. As an example, a person presenting with mild to moderate symptoms (Domain 1) but no significant problems on any of the contextual domains (Domains 5-8) is likely to require a different level of care from a person with mild to moderate symptoms but extensive social and environmental stressors or a history of poor response to previous treatment. The challenge for referral decision making is portrayed in Figure 6.

Figure 6: Mapping assessments on 8 interactive domains to 5 levels of care
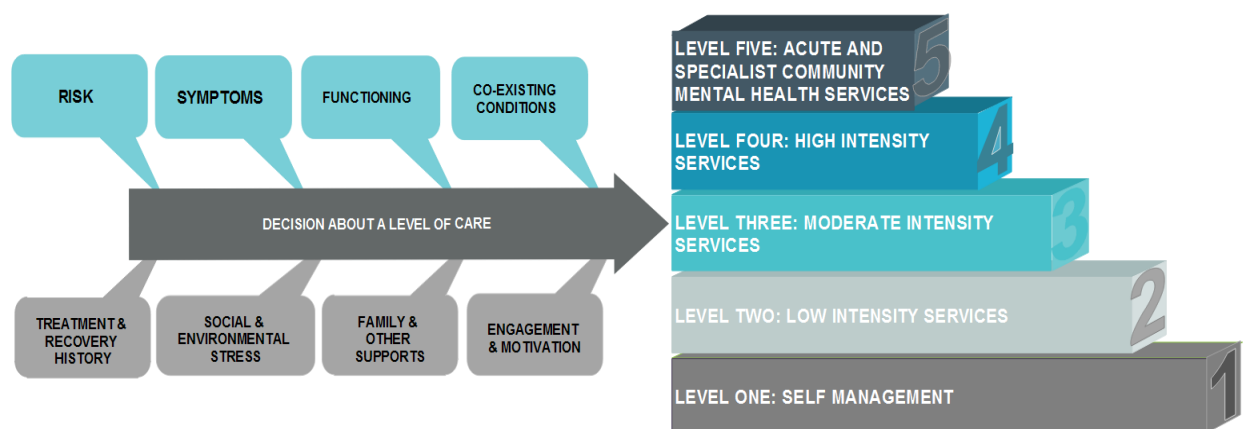
DEVELOPMENT OF A DECISION SUPPORT TOOL

The next stages of the National Assessment and Referral project will examine options for the development of a software tool that assists decision making based on initial assessments made using the rating approach outlined in Section 2 and 3, and Appendix 1 (the Glossary). The aim will be to simplify the process to guide decision making, whereby ratings made on the domains can be quickly converted to a recommended level of care.

There are two important caveats to this planned work:
- Any development work will only proceed subject to consultation feedback from PHNs about the overall approach outlined in this Guidance, and the content of the domains.
- Development of software tool will be to support and not replace clinical judgement, nor over-ride consideration of consumer choice and preferences.

DECISION SUPPORT TOOL LOGIC

Figure 7 summarises the proposed logic that could underpin the decision support tool. It shows how ratings of the domains using the glossary scoring guide provided in Appendix 1, and interactions between the domains, can potentially be applied to guide referral decisions.

Figure 7: Decision support tool logic for mapping assessment on domains to levels of care
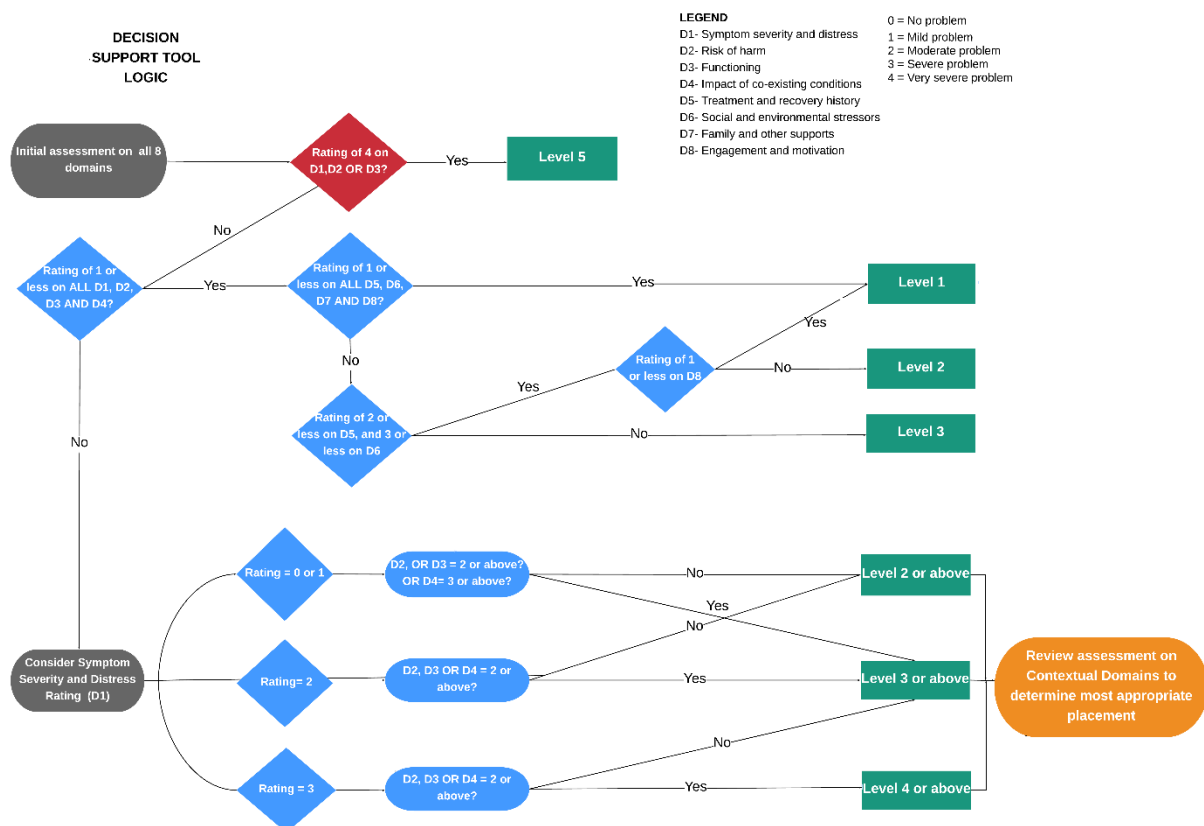
A STEP THROUGH OF THE LOGIC

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

The **top layer of the decision support tool is shown in the yellow section below** – 'red flag' items are identified that would usually warrant referral to acute and specialist community mental health services (largely state and territory services). These include very severe ratings on symptoms, risk and functioning domains. 'Red flag' items act as independent criteria that automatically place a client in a specific level of care, regardless of what their assessment is on other domains.
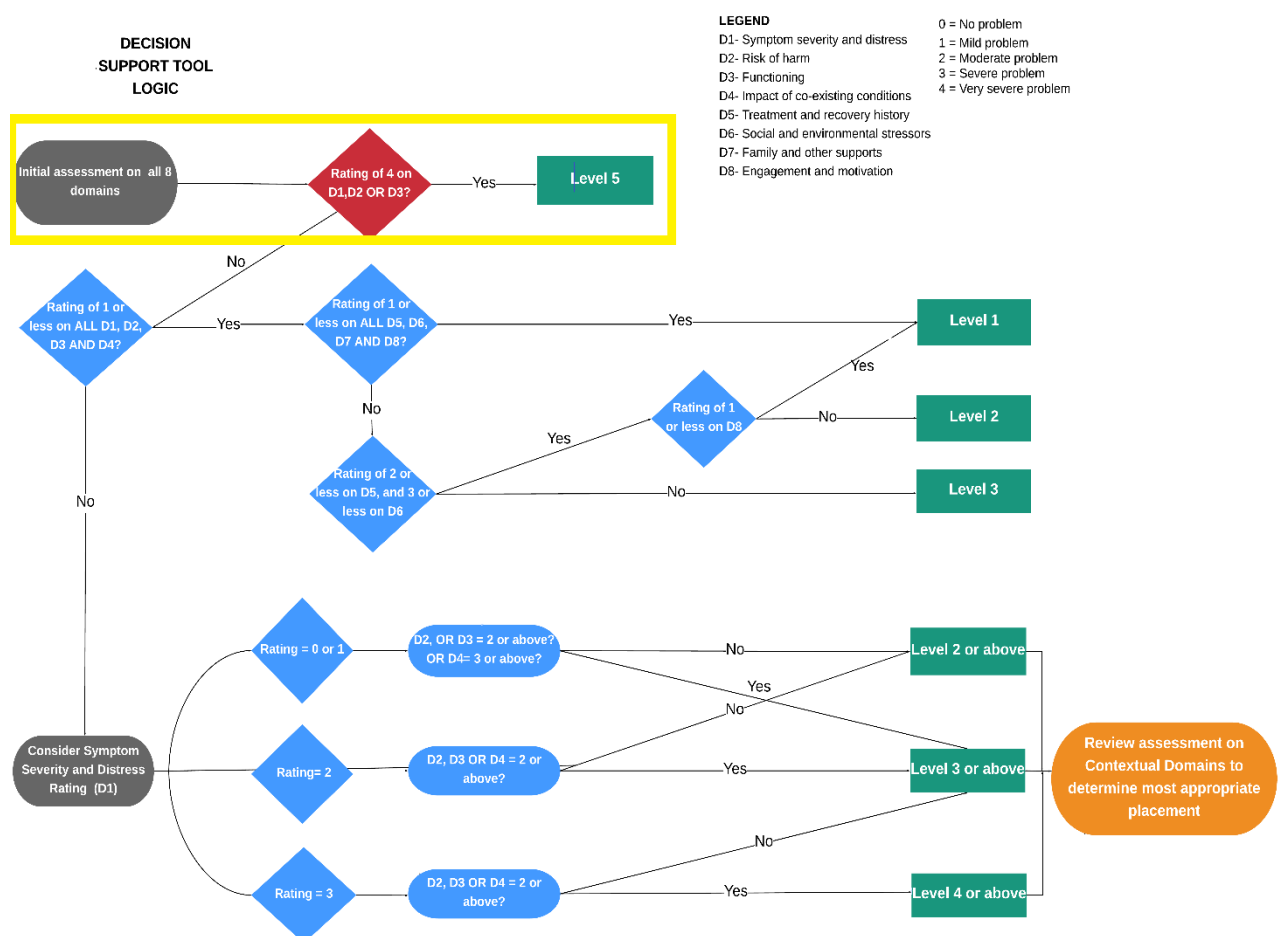
The middle layer in the decision support tool targets people with relatively minor problems on primary domains, who are shown in the yellow bordered area below.

DECISION
SUPPORT TOOL
LOGIC

LEGEND
D1- Symptom severity and distress
D2- Risk of harm
D3- Functioning
D4- Impact of co-existing conditions
D5- Treatment and recovery history
D6- Social and environmental stressors
D7- Family and other supports
D8- Engagement and motivation

0 = No problem
1 = Mild problem
2 = Moderate problem
3 = Severe problem
4 = Very severe problem
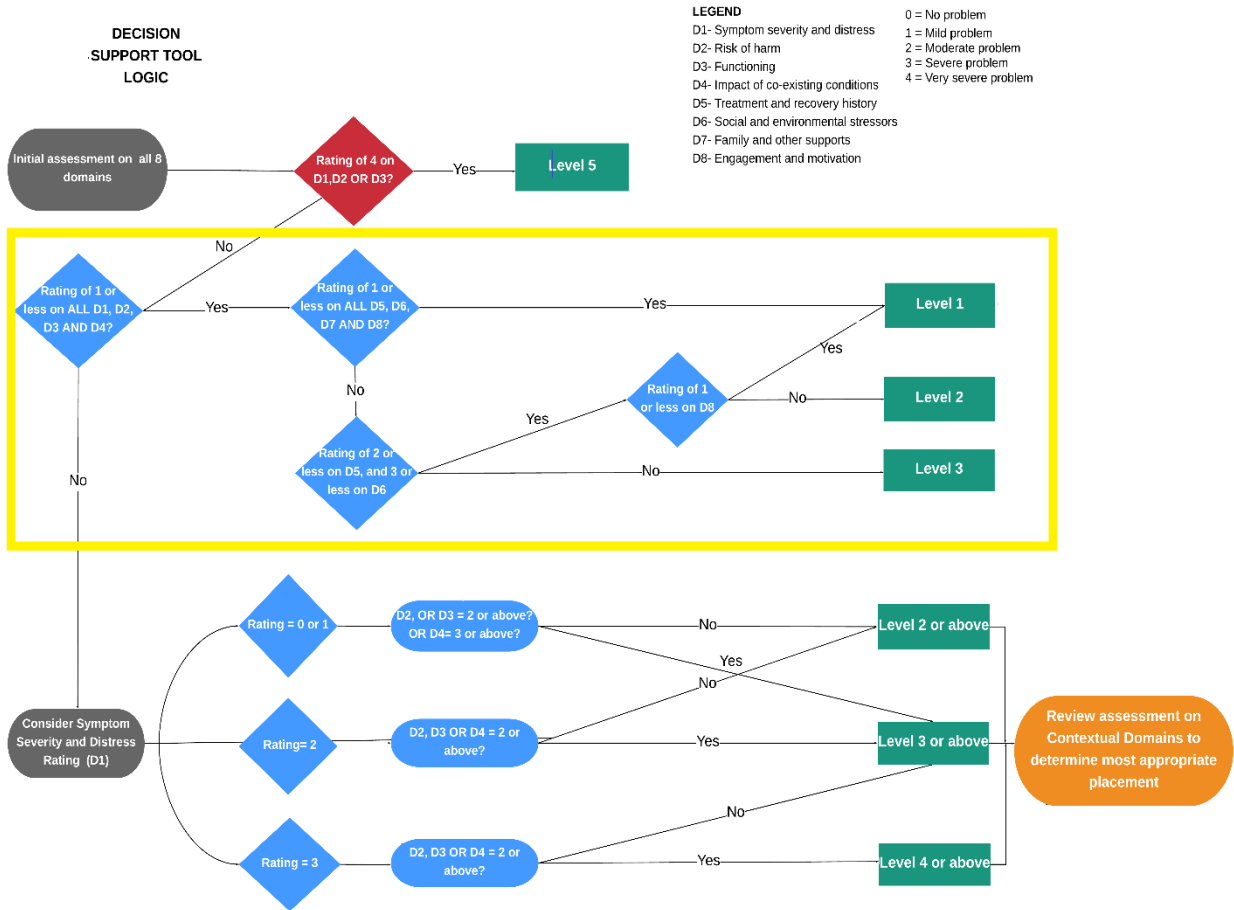
Decisions about this group are guided using treatment history (D5) and other contextual domains, into (mostly) Level 1 or 2 care.

All other client presentations are shown at the bottom layer of the decision support tool, shown below in the yellow bordered area below.

DECISION SUPPORT TOOL LOGIC

Initial assessment on all 8 domains

Rating of 4 on D1,D2 OR D3? — Yes → Level 5

No

Rating of 1 or less on ALL D1, D2, D3 AND D4? — Yes → Rating of 1 or less on ALL D5, D6, D7 AND D8? — Yes → Level 1

No

Rating of 2 or less on D5, and 3 or less on D6 — Yes → Rating of 1 or less on D8 — Yes → Level 1

Rating of 1 or less on D8 — No → Level 2

Rating of 2 or less on D5, and 3 or less on D6 — No → Level 3

No

Consider Symptom Severity and Distress Rating (D1)

Rating = 0 or 1 → D2, OR D3 = 2 or above? OR D4= 3 or above? — No → Level 2 or above

D2, OR D3 = 2 or above? OR D4= 3 or above? — Yes → Level 3 or above

Rating= 2 → D2, D3 OR D4 = 2 or above? — No → Level 2 or above

D2, D3 OR D4 = 2 or above? — Yes → Level 3 or above

Rating = 3 → D2, D3 OR D4 = 2 or above? — No → Level 3 or above

D2, D3 OR D4 = 2 or above? — Yes → Level 4 or above

Review assessment on Contextual Domains to determine most appropriate placement

There is considerable complexity in this potentially large group. Client presentations in this group are classified initially based on symptom/distress severity, then on the presence of other complexity in the other primary domains. This group are then allocated to levels based on contextual domains which are (as yet) unmapped. Most of this group are expected to be referred to Level 3 or above, where a comprehensive assessment would be undertaken.

DECISION SUPPORT TOOL LOGIC

LEGEND
D1- Symptom severity and distress
D2- Risk of harm
D3- Functioning
D4- Impact of co-existing conditions
D5- Treatment and recovery history
D6- Social and environmental stressors
D7- Family and other supports
D8- Engagement and motivation

0 = No problem
1 = Mild problem
2 = Moderate problem
3 = Severe problem
4 = Very severe problem

Initial assessment on all 8 domains

Rating of 4 on D1,D2 OR D3? — Yes — Level 5

No

Rating of 1 or less on ALL D1, D2, D3 AND D4? — Yes — Rating of 1 or less on ALL D5, D6, D7 AND D8? — Yes — Level 1

No

Rating of 2 or less on D5, and 3 or less on D6 — Yes — Rating of 1 or less on D8 — Yes — Level 1

Rating of 1 or less on D8 — No — Level 2

No — Level 3

No

Consider Symptom Severity and Distress Rating (D1)

Rating = 0 or 1 — D2, OR D3 = 2 or above? OR D4= 3 or above? — No — Level 2 or above

Yes

Rating= 2 — D2, D3 OR D4 = 2 or above? — No / Yes — Level 3 or above

Rating = 3 — D2, D3 OR D4 = 2 or above? — No — Level 3 or above

Yes — Level 4 or above

Review assessment on Contextual Domains to determine most appropriate placement

73
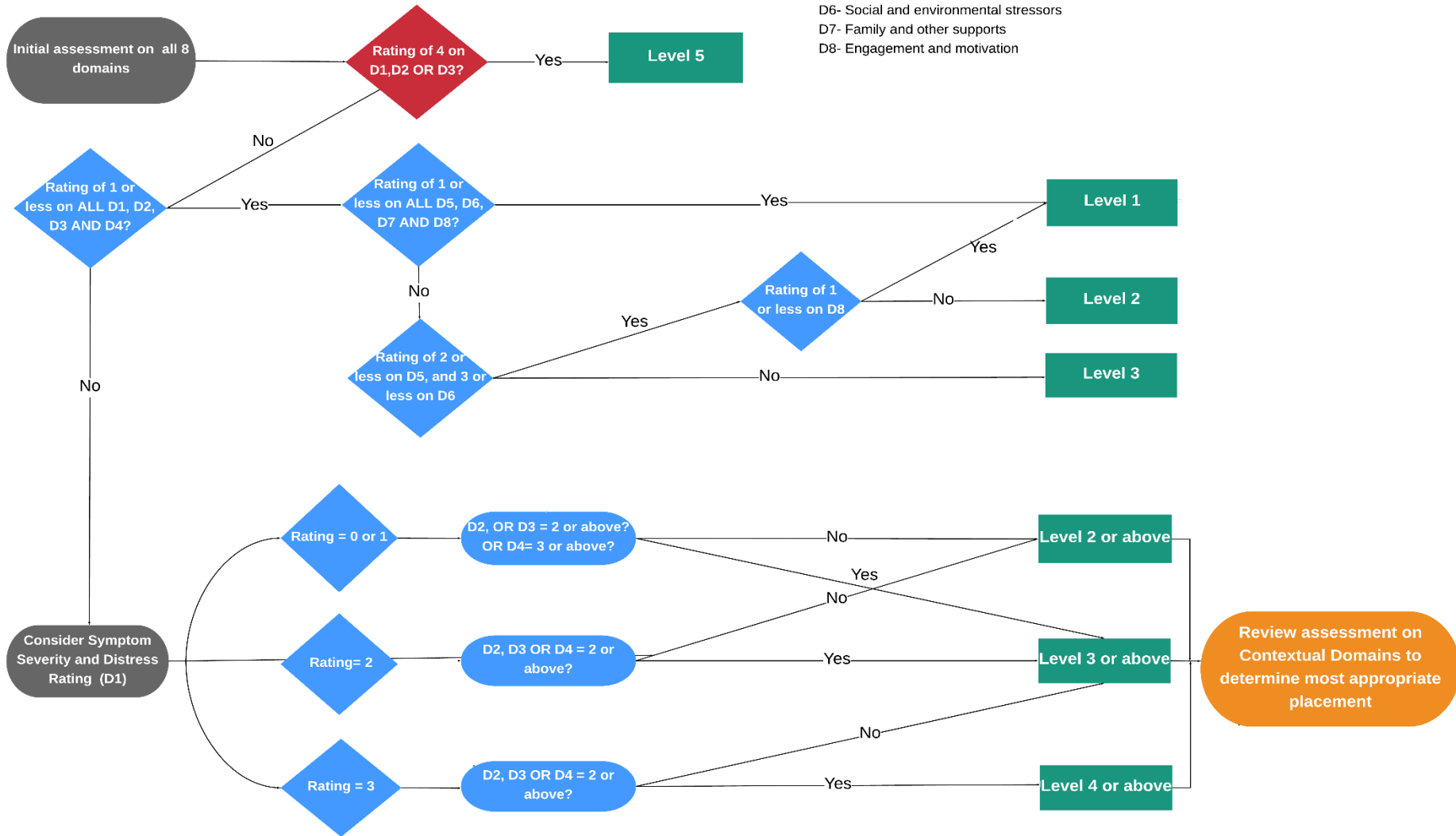
APPENDIX 3- INTERPRETING STANDARD ASSESSMENT TOOLS TO GUIDE ASSESSMENTS ON DOMAIN 1 AND DOMAIN 3

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

PRACTICE POINT

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

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

Kessler-10+ (K10+)

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

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

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

It is essential to note that these thresholds are based the distribution of K10 scores in the **general population**, derived from general household surveys, and **do not reflect clinical samples** – that is, people who present for assistance with mental health problems. In general, people presenting for

help have significantly increased K10 scores compared with the general population. For example, based on PMHC MDS data, 84% of clients receiving mental health services commissioned by PHNs have K10 scores in the High or Very High categories (Score 22+) compared with 13% of the general population; 58% report distress in the Very High (score 30+) range compared with 4% of the general population. These findings highlight that the K10 scores when used alone should not be interpreted as aligning directly with Domain 1 rating levels (e.g., a rating of 4 'Very severe' on Domain 1 is not simply equivalent to a K10 score of 30+). Remember that the K10+ identifies **non-specific** distress and that high levels might be attributable to factors other than mental health problems.

Kessler 5 (K5)

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

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

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

Patient Health Questionnaire 9 (PHQ-9)

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

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

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

Generalised Anxiety Disorder Scale- GAD-7

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

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

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

Edinburgh Postnatal Depression Scale (EPDS)

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

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

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

Work and Social Adjustment Scale (WSAS)

The Work and Social Adjustment Scale (WSAS) is a measure of functional impairment pertaining to work and social functioning. WSAS is a 5-item self-report scale.

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

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

END