Australian Government

TRAINING FACILITATOR MANUAL

Initial assessment and referral for mental healthcare

Acknowledgements

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Contents

Introduction

The Initial Assessment and Referral (IAR) for Mental Healthcare Guidance and Decision Support Tool assists general practitioners and clinicians in recommending a level of care for a person seeking mental health support. Each level of care is based on the least intensive and least intrusive evidence-based intervention that will lead to the most significant gain.

The IAR is an initiative of the Australian Department of Health. IAR brings together information from various sources, including Australian and international evidence and advice from a range of leading experts. The IAR is designed to assist the various parties involved in the assessment and referral process, including:

- General Practitioners (GP) and other clinicians seeking to determine a level of care that is the least intensive and least intrusive evidence-based intervention that will lead to the most significant gain, and
- Service providers and intake teams responsible for undertaking initial assessments, which may involve making recommendations on the level of care required.

Training overview

In the 2021-22 Budget, the Australian Government announced a $2.3 billion investment in mental health through the National Mental Health and Suicide Prevention Plan (the plan) to lead landmark reform. The plan includes $34.2 million to expand and implement the Initial Assessment and Referral (IAR) tool in primary care settings. As part of this funding, Primary Health Networks (PHNs) have received funding for an IAR Training and Support Officer (IAR TSO) to support General Practitioners (GPs) and staff in their network to learn about, use and embed the IAR in clinical practice.

As part of this work, IAR TSOs will deliver the National IAR training to GPs and other clinicians in Adult Mental Health Centres, General Practices, Aboriginal Medical Services, commissioned providers, and in the future, Child Head to Health Centres, Residential Aged Care Facilities, and Local Hospital Networks.

The National IAR training consists of two workshops, summarised in Table 1. The first workshop is pre-recorded and available online, the second workshop will be delivered by TSOs.

Table 1 – Overview of IAR training

Workshop	Content	Description
One	• Introduction and learning outcomes • IAR background • Initial Assessment Domains • Levels of care • Introduction to the Decision Support Tool	A pre-recorded webinar that participants access and view online. Workshop One runs for 30 minutes and is a pre-requisite for enrolment in Workshop Two.

Two	• Using the Decision Support Tool
	• Practical Activity
	  ◦ Large-Group Activity – Scenario (Adults)
	  ◦ Small-Group Activity – Scenario (Adults)
	• Discussion and reflection from groups
	• Check-in, supported decision making, care preferences, care type
	• Overview of adaptations for different population groups
		A workshop hosted locally that participants participate in online or in-person. Workshop Two runs for 90 minutes. Completion of Workshop One in the six months prior to attending Workshop Two is a pre-requisite.

Audience

The IAR Train the Trainer Facilitator Manual has been developed for Training and Support Officers (TSOs) engaged by Primary Health Networks (PHNs) and other personnel assisting PHNs in delivering the National IAR training (e.g., local GP champion). The IAR TSO role aims to coordinate and drive the implementation of the National IAR Guidance at the regional level.

Train the Trainer requirements

To be an IAR trainer, the following requirements must be met:

- Complete the Train the Trainer package (including 2 x 3-hour workshops with the National Project Manager).
- Participate in a minimum of 1 training observation session (observing the National Project Manager facilitate training). Trainers are encouraged to attend as many observation sessions as they would like.
- Facilitate a minimum of 1 observed training session (observed by the National Project Manager).
- Participate in monthly TSO meetings.
- Participate in national IAR webinars.
- Future training relating to version developments and adaptations.

Mandatory reading

- National IAR Guidance
- IAR Snapshot
- IAR Implementation Toolkit
- Recovery-Oriented Language Guide
- National Communication Charter Language Guide
- TSO PHN program guidance

How this training has been developed

This training has been designed using the 4MAT cycle. The 4MAT cycle incorporates experience, reflection, conceptualisation, action, and integration as essential processes for learning (McCarthy, 2000). 4MAT is a cycle that focuses on dynamic and engaging learning. The role of the facilitator changes as the workshop progresses- with the first two elements of the workshop being focused on engaging in dialogue and discussion. The second two elements are focused on the learners applying the Decision Support Tool in real-life contexts and reflecting on their practical experience.

4MAT incorporates four considerations:

- Why – personal meaning and motivation to engage with the content.
- What – acquisition of new knowledge and concepts.
- How – practical application of new knowledge and concepts.
- If – Synthesis and extension of new knowledge and concepts.

The 4MAT considerations as applied to the IAR training are presented in Table 1.

Table 1: 4MAT and IAR training

WHY Personal relevance	**WHAT** Concepts	**HOW** Hands-on learning	**IF** Reflect, integrate, and extend
IAR Background	IAR domains and levels of care	Applying the Decision Support Tool	Group reflection and discussion
This content takes learners through the IAR development journey – including the rationale for the project and the relevance to the sector. This content also focuses on how IAR was developed, building	This content introduces learners to the IAR initial assessment domains and levels of care. This content also includes a high-level introduction to the Decision Support Tool.	This content introduces a scenario for learners to work through with the trainer and then in small groups. Learners review the scenario and use the Decision Support Tool to suggest an appropriate rating for each domain and	This content introduces a complex scenario for learners to work through together in small groups. Learners review the scenario and use the Decision Support Tool to suggest an appropriate rating for each domain and review the recommended level of care.

WHY Personal relevance	WHAT Concepts	HOW Hands-on learning	IF Reflect, integrate, and extend
confidence in the process amongst users.		review the recommended level of care.	

PART 1 – Facilitation

National IAR Training coordination

Promotion and marketing

Healthcare professionals working in service delivery roles typically plan their calendars and schedules well in advance. Therefore, to maximise attendance, the promotion of the workshop should begin a minimum of six weeks in advance of the scheduled date.

Payment is available through PHNs for General Practitioners who complete the IAR training (workshops one and two). Participation in workshop one is a mandatory prerequisite for participation in workshop two. This information should be communicated with GPs as part of the marketing and communication approach.

A sample training flyer is included in Appendix 1.

Training group size

There is no minimum or maximum group size for Workshop One.

Workshop Two involves active peer learning and discussion through practical application of the IAR-DST using established scenarios. A minimum of four training participants optimises this experience.

Workshop Two involves small group work during the practical activities. Therefore, 24 is the maximum number of participants in each workshop per facilitator. This group size allows the facilitator to have 3-4 small groups per workshop. This maximum number of small groups is vital as the facilitator needs to have the time to check in with and support each group as they complete the practical activities. Where a co-facilitator is involved, the maximum workshop number can increase depending on the comfort of the facilitators.

Registration

Registration is mandatory for all IAR training.

- For national online training (workshop 1), registration is required, and a record of all registrations is stored centrally and made available to each PHN.
- Registration is required for local training (workshop 2), and the PHN records all registrations. TSOs are responsible for ensuring that participants have successfully completed workshop 1in the six months before attending workshop 2. Participants who completed workshop 1 more than six months previously must view the recording again.

A sample registration form is included in Appendix 2.

Note - Workshop One is a pre-recorded video that participants access online. Workshop One runs for 30 minutes. Completion of Workshop One is mandatory before the commencement of Workshop Two. This requirement must be communicated to participants interested in attending Workshop Two. TSOs must check that registrants for Workshop Two have completed Workshop One. A list of all registrants who have completed Workshop One is available by checking the PHN class report on the National IAR Training Portal.

Physical learning environments

If hosting the training in a physical learning environment, considerations for the training include:

- Accessibility of the venue (e.g., parking, access, directions/signage)
- The required risk or hazard assessments (including emergency evacuation briefing for participants)
- Number of chairs and tables available for participants
- Adequate lighting
- Access to toilets
- Available heating and cooling
- Checking equipment to project the workshop slides
- Printing the workshop slides and scenarios
- Access to computers, laptops, or devices to utilise the IAR-DST online

Housekeeping requirements

Trainers communicate the following expectation and housekeeping requirements:

- Complete an acknowledgement of country at the commencement of each workshop.
- Complete an acknowledgement of lived experience at the commencement of each workshop.
- Complete the notice about emotional safety.
- Complete the notice about confidentiality.
- Advise participants that all slides and links to resources will be sent to participants after the workshop.
- Advise participants that there are two evaluation opportunities. The Training Experience survey will assess participant satisfaction, and the Training Outcomes survey will evaluate outcomes from the training and use of the IAR-DST.

Acknowledgements

An acknowledgement of country is a sign of respect to the traditional and continuing Custodians and can be given by any Aboriginal or non-Aboriginal person.

- *'I begin today by acknowledging the <insert name of people here (e.g., Ngunnawal)> people, Traditional Custodians of the land on which we meet today and pay my respects to their Elders past and present. I extend that respect to Aboriginal and Torres Strait Islander peoples here today. I also acknowledge the Traditional Custodians of the various lands on which you all work today and the Aboriginal and Torres Strait Islander people participating in this meeting/webinar.'*

A recognition of lived experience reinforces the centrality of people who experience mental health issues and those who provide care and support.

- *'I recognise people with lived experience of mental health issues and recovery and the experience of people who have been carers, families, or supporters. I acknowledge the people with lived experience who share their views, knowledge and expertise, and stories to help shape our work.'*

A notice about the emotional safety of participants reminds participants that the nature of the subjects (mental health, distress, and suicide) being discussed in the workshops may impact their emotional wellbeing and encourages all participants to seek help and support where needed.

- *'The content of the workshop today is focused on mental health. We will explore a range of topics, including psychological distress, suicide, and risk of harm. All participants are reminded that support is available should any content impact your emotional well-being or safety. If you are unsure who to contact, visit www.headtohealth.gov.au or call Lifeline on 13 11 14.'*

A statement about confidentiality and the rights/responsibilities of participants:

- *'As we share reflections about our own practice experiences, all participants are reminded to carefully protect the privacy and confidentiality of the people we work with. Participants are also asked not to share or disclose training discussions with others beyond the training today.'*

Virtual learning environments

It is important to prepare carefully when planning to deliver content via an online platform (e.g., Zoom). Trainers should:

- Provide the participants with the training agenda and resources (e.g., slides and scenarios) before the workshop.
- Consider engaging a co-facilitator to manage and respond to the chat box and support small group activities.
- Seek assistance from an information technology officer (if available) to attend the workshop (or parts of the workshop) to troubleshoot and assist with any technical difficulties.
- When setting the agenda, allow time for breaks, stretches and interactivity so participants stay engaged – a 5-minute comfort break is usually sufficient.
- Be familiar with the online platform you are choosing to use. Most disruptions due to technical challenges can be avoided through adequate preparation and familiarity with the platform. Be familiar with critical functions of the platform (e.g., sharing a screen, closing a shared screen, muting participants, running a poll, using the chat box).
- Encourage participants to log in 5-minutes early.

- Deliver the training from a quiet, uninterrupted location with good lighting, internet connection, headset, and speakers.
- Encourage the use of the chat box function for questions and comments. The chat box is a crucial resource.
- Use the breakout room function for the practical activity. Be familiar with opening and closing the breakout rooms, moving in and out of the breakout rooms, and communicating with participants using the chat box while in the breakout rooms.

Trainers communicate the following expectation and housekeeping requirements:

- Participants must leave their video on to assess and optimise engagement and learning- all participants should be made aware of this as a condition of participation (and payment) before registration.
- Encourage participants to mute their microphones unless speaking for audio quality purposes.
- Encourage the use of the chat box for questions that arise during presentations.
- If recording the workshop, ensure participants are aware and consent to the recording and its intended uses. TSOs must check their responsibilities under the Privacy Act if intending to record the workshop, and if required send notices in advance to participants.
- Complete an acknowledgement of country at the commencement of each workshop.
- Complete a recognition of lived experience at the commencement of each workshop.
- Complete the notice about emotional safety.
- Complete the notice about confidentiality.
- Advise participants that all slides and links to resources will be sent to participants after the workshop.
- Advise participants that there are two evaluation opportunities. The Training Experience survey will assess participant satisfaction, and the Training Outcomes survey will evaluate outcomes from the training and use of the IAR-DST.

Assessment

All training participants are required to complete a series of multiple-choice questions. Whilst there is no pass or fail, participants are required to answer all questions.

- National online training – multiple choice questions are displayed at the conclusion of the training. The participant is told of their selected answer is correct. If the selected response is not correct, the correct answer is displayed. Failing to answer all questions after viewing the national online training, will lead the system to record the participants attempt as “incomplete.”
- Physical learning environment - multiple-choice questions should be printed and included on a piece of paper for participants to return during the break between workshop 1 and workshop 2 for review by the trainer. The trainer reinforces the correct responses. Individual scores are not recorded.
- Virtual learning environment – multiple-choice questions can be displayed as a poll using most online platforms. The trainer reinforces the correct responses. Individual scores are not recorded.

Certification

A certificate is provided to all participants who complete all IAR training content.

- For local training, certificates will need to be supplied by the training organiser (typically, the PHN).
- For national online training, certificates will be automatically sent to participants on completion.

A sample certificate is included in Appendix 3.

Workshop follow-up

A workshop follow-up email is sent to all training participants following completion of the IAR training.

- The training organiser sends the follow-up email (typically the PHN) for local training. The follow-up email includes the workshop slides and links to any relevant regional/local resources that stakeholders might be interested in.
- The follow-up email is sent automatically for national online training and includes the workshop slides and links to national resources (including the IAR Guidance and Decision Support Tool).

A follow-up email is included in Appendix 4.

Evaluation – experience of training survey

There is a standard evaluation process for all IAR training for assessing participant satisfaction with training. Participants who complete workshop 1 online using the pre-recorded training video will automatically receive a survey link after the training. Training organisers must share a survey link with all participants attending local training (workshop 1 or 2). A record of all experience of training survey responses is stored centrally and made available to each PHN.

PHNs and other training organisers can request to add questions to the survey for locally delivered training (e.g., seeking participant feedback on local implementation activities or local support required). The survey assessing satisfaction with training is sent with a follow-up email to all participants immediately after the conclusion of the training workshop. The evaluation questions are included in Appendix 5.

Evaluation – training outcomes survey

There is a standard evaluation process for all IAR training for assessing post-training outcomes. The training outcome survey examines:

- Use (including frequency) of the Initial Assessment and Referral Decision Support Tool (IAR-DST) since the training.
- Face validity of the IAR-DST in accurately estimating the level of care the person is likely to require.
- The comprehensiveness and appropriateness of the IAR-DST.
- The value of using the IAR-DST.
- Feedback on how the IAR-DST could be improved.
- Feedback on how local implementation could be improved.

Training organisers must share a survey link with all participants attending local training. A record of all responses to the training outcomes survey is stored centrally and made available to each PHN.

PHNs and other training organisers can add to the questions for locally delivered training (e.g., seeking participant feedback on local implementation activities or local support required). The survey assessing training outcomes is sent with the follow-up email to all participants 3 months after the conclusion of the training workshop. The evaluation questions are included in Appendix 6.

Resources

The resources you will need to facilitate IAR Workshop Two may include:

- Attendee name stickers
- Sign-on sheet (confirming the attendance of registered participants)
- Projector / HDMI cable for PowerPoint presentation
- Post-it notes, markers, whiteboard, or flip pad
- Copies of the National IAR Guidance, IAR snapshot, presentation slides and scenarios for face-to-face workshops

Facilitator skills

Creating a positive learning environment

Several qualities and skills are essential for creating a comfortable and safe learning space where participants feel comfortable sharing their ideas and opinions and learning new knowledge. They are:

1. Building an atmosphere of trust by setting clear group rules and expectations and encouraging curiosity (e.g., no right or wrong answers).
2. Showing empathy for the participants and their experiences.
3. Be warm and genuine in how you relate to the participants.
4. Demonstrating and modelling confidence in the participants and yourself.
5. Being confident in your knowledge whilst also bringing out knowledge in others (e.g., not always having the answers but asking the group for their thoughts).
6. Showing enthusiasm for the topic.
7. Demonstrate respect for the participants and for what you are teaching.

You should reflect on these qualities and where you feel your strengths and opportunities for improvement lie. No matter how experienced you are at delivering training and education, every workshop should provide you with an opportunity for reflection and improvement.

Subject matter expertise

In delivering IAR training, there are several specific skills and knowledge pre-requisites that are also important:

- Appreciating and understanding the inter-disciplinary perspectives and experiences and facilitating respectful inter-disciplinary discussions.
- Knowledge of specific population groups' unique experiences and needs (children, adolescents, older adults).
- Knowledge of and a commitment to cultural awareness and safety.
- Knowledge of the regional, state, and national mental health system resources and services.
- Knowledge of the history of IAR development and the policy surrounding it.

Preparation

If you are under-prepared, you are more likely to be put on the spot by participant questions, uncertain about responses, or provide incorrect information. Make sure you take the time to prepare, especially when you first start delivering content. Being prepared will improve your confidence which will be evident to participants and assist you in engaging with them. Prepare by:

- Participating actively in the Train the Trainer workshops.
- Participating in observed and observation training sessions.
- Being familiar with the Decision Support Tool and how it works.
- Being familiar with the implementation priorities and activities of your PHN region.
- Participating actively in monthly TSO meetings.
- Reaching out to the National Project Manager for assistance and support if required.

Giving feedback

As participants work with the content for the first time, participants will require feedback on the appropriate use of the IAR Guidance and the Decision Support Tool. Providing feedback is a powerful learning activity and should be incorporated into every workshop. Because the participants work in small groups to complete the scenarios, feedback might also come from fellow participants.

As participants might not be used to or comfortable with receiving feedback, it is vital to establish the expectation of feedback at the commencement of the practical activities.

Facilitator Tip

The workshop today will involve us all being a little vulnerable as we apply a scenario that we are not familiar with to a decision support tool that we might not have used before, alongside colleagues we might not have met before. The aim of this activity is not to be right/correct but to explore and learn about the tool and how it works. Along the way, you might hear feedback about using the tool from a fellow training participant or me. You also might like to give feedback. Working in small groups with people from various backgrounds and experiences represents an excellent opportunity to extend our knowledge of the tool and its uses.

Language

Language is powerful and can potentially shape individuals' positive and negative training experiences. All IAR trainers must familiarise themselves with the Recovery Oriented Language Guide (Second Ed.) by the Mental Health Coordinating Council (MHCC).

Specific Guidance regarding communication about suicide is available through the National Communications Charter. The Charter is a resource and uniting document to guide the way people in the mental health and suicide prevention sectors, Government, business, and community members talk about mental health and suicide prevention. All IAR trainers must familiarise themselves with the National Communication Charter Language Guide.

PART 2 – IAR Clinical Training

Policy commitments

As part of the 2021-22 Budget, the Australian Government announced $34.2 million to expand and implement the Initial Assessment and Referral (IAR) tool in primary care settings to support General Practitioners, allied health professionals and referrers to determine a consistent level of care for a person presenting for mental health assistance, using a holistic decision support tool.

The Department of Health has also embarked on a development process for specific population groups, including:

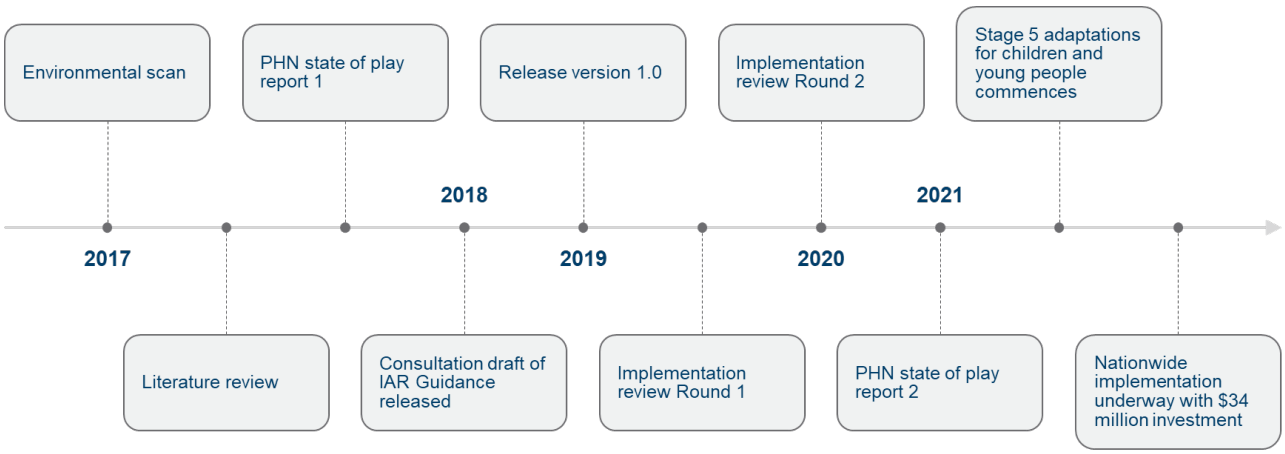
- Children (5-11)
- Adolescents (12-17)
- Adults (18-65)
- Older adults (65+)
- Aboriginal and Torres Strait Islander Peoples
- Culturally and linguistically diverse people
- Veterans
- People with co-occurring conditions (including intellectual disability)

Development process and timeline

In 2017, the Australian Department of Health commenced the development of the Initial Assessment and Referral for Mental Healthcare Guidance. As depicted in graphic 1, there were several key development processes undertaken:

1. The development of an environmental scan.
2. The development of a literature review.
3. A PHN state of play survey to examine current approaches to initial assessment and referral.
4. The production and release of the IAR Guidance in consultation form to elicit feedback from the PHN network regarding content.
5. The release of versions 1.0 – 1.5 between 2019 and 2021.
6. Implementation review with PHNs 2019-2021 to inform implementation processes and enablers for national implementation.
7. The production and release of the IAR Guidance for children (5-11) and adolescents (12-17) to elicit feedback from the sector regarding content.
8. An investment by the Australian Government in national implementation.

Graphic 1 – IAR Development Timeline



Assisting the Department of Health with developing the IAR Guidance is an Expert Advisory Group (EAG). The EAG is comprised of lived experience representatives nominated by the National Mental Health

Consumer and Carer Forum, representatives from the relevant colleges and peak bodies, universities, and industry representatives, including:

- The Royal Australian College of General Practitioners (RACGP)
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- The Australian College of Mental Health Nurses (ACMHN)
- The Australian Psychological Society (APS)
- The Australian Association of Social Workers (AASW)
- The Australian College of Rural and Remote Medicine (ACRRM)
- Mental Health Australia
- University of Melbourne
- University of Queensland
- Black Dog Institute
- MindSpot
- PHN representatives.

Working groups for specific populations groups have been (and will continue to be) established to build in additional clinical expertise for specific populations. For example, the working groups for children and adolescents included specific clinical expertise from RACGP, RANZCP, the Murdoch Children's Research Institute, headspace National and Orygen.

Facilitator Tip

Understanding the background and development process for the IAR Guidance is vital in building users' confidence. Given the tool is used across sectors and disciplines, sharing information about the extensive, cross-discipline, and trans-sector approach to development and consultation is essential.

Workshop One

Workshop One is a pre-recorded webinar that participants access and view online. Workshop One runs for 30 minutes. Completion of Workshop One is mandatory before the commencement of Workshop Two. This requirement must be communicated with participants interested in attending Workshop Two.

PHNs can run Workshop One locally if preferred, and all TSOs will be trained to deliver Workshop One content.

Workshop One Overview

Time		Content	Resources
	2 minutes	Introduction and learning outcomes	Pre-recorded video Slides
	6 minutes	IAR background	Pre-recorded video Slides 1-3
	8 minutes	Initial Assessment Domains	Pre-recorded video Slide 4
	5 minutes	Levels of care	Pre-recorded video Slide 5
	7 minutes	Introduction to the Decision Support Tool	Pre-recorded video Slide 6

	2 minutes	Evaluation and next steps	Follow up email Slide 7

Workshop One Facilitator Notes

Slide 1 – Stepped care and IAR

There are two critical elements of a stepped care approach to mental health service delivery.

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

The IAR Guidance focuses on the initial response to requests for mental health assistance in primary care settings. There were several challenges with stepped care in Australia before the IAR initiative. These challenges are summarised in Slide 1.

Facilitator Tip

Some participants might feel like they already have a good sense of the level of care the individual needs without using the IAR-DST and therefore wonder about the tool's value. In addition to being a valuable tool for estimating/confirming the level of care required, the IAR Guidance and the IAR-DST are being implemented nationwide and sector-wide. Commonwealth mental health funded services will be required to use the tool where appropriate. With their agreement, states and territory mental health services will also begin using the tool. When implemented on a large scale, we create an environment with a shared framework, standardisation, and a shared language from which to work. Consistently documenting and communicating about service needs is enabled through the individual and collective use of a commonly understood and evidence-based decision support framework.

Slide 2 – Objectives of IAR

- A person seeking mental health assistance has their experiences understood in the context of holistic assessment domains (the **8 domains**). The 8 domains help to distil essential assessment information and amplify key signals (e.g., red flags) that are critical for decision making.
- A person's treatment needs, and recovery goals are understood and matched to a service type and intensity based on the least intensive and least intrusive evidence-based intervention that will lead to the most significant gain (the **5 levels of care**).
- Bring together the assessment results rather than replace (or require additional) existing clinical assessment scales and processes.
- To minimise the risks that arise through under-servicing (poor outcomes) and over-servicing (unnecessary burden of care for the individual).
- To guide clinical judgement and inform discussions with the consumer about choice and preferences.

Facilitator Tip

Focusing training participants on the person-centred objectives of the IAR Guidance is essential to onboarding and building acceptability of the Guidance and its use.

Under-servicing is a well-understood risk. Where a person experiences under-servicing, they are unlikely to receive sufficient support to achieve therapeutic benefit from the intervention, prevent deterioration, and reduce the risk of harm (if present).

Over-servicing is not so well understood regarding the burden of treatment an individual may experience. As the resource or service burdens accumulate, some people are overwhelmed, drop out of care, or have a poor care experience.

The focus on improved individual outcomes and experience is central to IAR's importance. There is an economic argument for IAR – there are finite resources available, and careful assignment of the resources

means those who require them are more likely to have access to them. However, this is a secondary objective and typically the least important to training participants, whose focus is delivering therapeutic assessment and services to individuals.

Slide 3 – Why use the IAR-DST

In addition to the overall program objectives, sharing other benefits with training participants may help clarify why this policy commitment is so important.

All Commonwealth funded mental health services will progressively begin using the IAR-DST. State and territory mental health services will also begin using or exploring the use of the tool.

- Widespread use of the IAR-DST improves the awareness of and transparency about how decisions relating to referral appropriateness are made – reducing the frustration that occurs with referrals not being accepted by service providers.
- A standardised tool like IAR helps referrers communicate initial assessment and referral information consistently and articulate treatment needs using language commonly understood across the sector.
- Appropriate use of the IAR-DST may minimise the risks and liabilities associated with under-estimating a person's treatment needs. The IAR-DST does not replace the user's capacity to make individualised clinical decisions based on the consumer/patient's particular circumstances.

Slide 4 – When to use IAR

The IAR-DST is used to help explore and inform an individual's treatment needs requiring mental health assistance and the intensity of the resource or service likely to be required.

The IAR-DST is typically used alongside or after an assessment. There are many uses of the IAR-DST. For example:

- General Practitioners (GP) may use the IAR-DST after a mental health treatment planning process when making a resource recommendation or service referral.
- Service providers and intake teams may use the IAR-DST following an initial assessment to determine the intensity of the response required from their or another service.
- An acute or specialist mental health service may use the IAR-DST following a triage assessment to determine suitable options for onwards referral (if acute or specialist care is not required).

Typical use examples and benefits are outlined in the table below.

Referrer led	Referrers and intake teams working together	Intake of provider	Local Hospital Networks
Use of IAR-DST by a clinician familiar with the person (e.g., GP) may improve the completeness and the accuracy of the information used to rate the IAR-DST.	Referrer completes the IAR-DST. Intake then confirms the level of care and navigates the referral to a service that is compatible with the indicated level of care or recommends an alternative service option for consideration.	Use of the IAR-DST to confirm the appropriateness of the referral. Use of the IAR-DST to determine initial intensity of service provision (e.g., frequency, duration, and type of care) to be provided by service.	Following the triage process and clinical risk assessment, if person does not require acute and specialist interventions within Level 5 (e.g., to determine appropriate care intensity in primary mental healthcare setting) for onwards referrals.

Early use of IAR-DST in the care journey may decrease the likelihood of inappropriate referrals and the burden of the assessment process on the consumer.	Intake teams providing remote support to referrers to use the IAR-DST.	Use of IAR-DST within a service where the service accepts provisional and informal referrals (e.g., referrals from non-health providers, self, and family) or no previous assessment has been undertaken, or referral information is limited.	When considering discharge from Level 5 to primary mental healthcare (e.g., to determine the appropriate care intensity in primary mental healthcare setting).

Slide 5 – What IAR is not

IAR is not a new assessment tool

IAR is not a new assessment instrument. Existing evidence-based, developmentally appropriate, and contextually appropriate assessment instruments (e.g., the HEADSS assessment in a headspace Centre, a social and emotional well-being assessment in an Aboriginal Medical Centre) are still used for intake and assessment. IAR is not an assessment instrument. IAR is a decision aid.

The expectation is that the clinician has already undertaken a clinical assessment utilising their assessment tools and capabilities. The domains reflect areas that are covered in a typical mental health assessment. The domains also prompt areas for further exploration if the clinician has not sufficiently assessed a particular area of importance.

IAR is not prognostic or predictive

IAR is used at a point in time. That point is when a person seeks or requires mental health assistance. Users consider what has been 'typical' for the person over the past 30 days. The IAR-DST prompts users to look back further than 30 days where it is critical to do so (e.g., lifetime experience of suicide attempts and previous mental health treatment history). IAR does not predict the course of the condition or treatment outcome.

Not diagnostic

The IAR-DST does not require that the person has a diagnosis (the tool refers to symptoms and distress – not diagnostic labels). Nor is the IAR-DST designed to formulate a diagnosis.

Not a treatment planning tool

The IAR-DST is used to estimate the intensity of the mental health resource or service required. The IAR-DST is not a treatment planning tool.

Not a replacement for clinical judgement and decision-making

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.

Slide 6 – Initial Assessment Domains

There are eight initial domains (see Graphic 2) that should be assessed when determining the next steps in the referral process for a person referred to a mental health service. The eight domains fall into two categories:

- *Primary Assessment Domains (Domains 1 to 4):* These cover Symptoms Severity and Distress, Risk of Harm, Functioning and Impact of Co-existing Conditions. Primary Assessment Domains represent the essential areas for an initial assessment that directly affect decisions about the level of care.
- *Contextual Domains (Domains 5 to 8):* These cover Treatment and Recovery History (Service Use and Response History in the child and adolescent versions), Social and Environmental Stressors, Family and Other Supports and Engagement and Motivation. Assessment on these domains provides essential context to moderate decisions indicated by the primary domains.

Initial assessment should consider the person's current situation on all eight domains. Each domain looks at specific factors relevant to making decisions about a level of care that is suitable for the person's mental

health treatment 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 a person referred for care.

Domain 1 Symptom severity and distress	Current symptoms and duration, level of distress, experience of mental illness, symptom trajectory	Previous treatment (including specialist or health inpatient treatment) Current engagement in treatment Response to past or current treatment	**Domain 5** Treatment and recovery history
Domain 2 Risk of harm	Past or current suicidal ideation or attempts, past or current self-harm, severe symptoms posing a risk to self or others, severe risk arising from self-neglect	Life circumstances such as signficant transitions, trauma, harm from others, interpersonal or social difficulties, performance related pressure, difficulty having basic needs met, illness, legal issues	**Domain 6** Social and environmental stressors
Domain 3 Functioning	Ability to fulfil usual roles/ responsibilities Impact on or disruption to areas of life Capacity for self-care	Presence of informal supports and their potential to contribute to recovery.	**Domain 7** Family and other supports
Domain 4 Impact of co-existing conditions	Substance use/misuse Physical health condition Intellectual disability/ cognitive impairment	The individual's understanding of the symptoms, condition, impact ability and capacity to manage the condition motivation to access the necessary supports	**Domain 8** Engagement and motivation

Resource

The initial assessment domains across IAR versions are mostly consistent. However, there are some key differences to be familiar with as a TSO. These differences are summarised in ***Slide Pack Four – Summary of approach to and outcomes from version development.*** Slide Pack Four is not for sharing with participants during the workshop but might be helpful to share as part of the post-workshop follow-up email.

Slide 7 – Levels of Care

The levels of care are designed around what resource is delivered and the amount of resources delivered rather than who and how the resources are delivered.

Resource intensity

The levels of care are differentiated based on the intensity of the resource or service provision associated with each level of care. The levels of care are focused on mental health resources or service intensity. They have no relationship to other types of resources or service intensity (e.g., the intensity of alcohol or other drug treatment the person might require).

Trans-diagnostic

The levels of care are trans-diagnostic (e.g., a person does not have to have a particular diagnosis to access a level of care). For instance, a person with schizophrenia in a non-acute phase of their illness may benefit from a low-intensity intervention focused on a recovery or treatment goal (e.g., sleep hygiene focused online education). Whilst the levels of care are trans-diagnostic, learners must be aware that some resources and services have a diagnostic focus or related eligibility criteria.

Whilst the trans-diagnostic nature of the IAR-DST and levels of care have been celebrated, it is important to acknowledge that a diagnosis might be necessary for other purposes (e.g., optimising care planning, considering pharmacotherapy, etc.

Mode of service delivery

A resource or service might be delivered online, via the telephone, in written form or face to face at any level of care. The levels of care are not differentiated based on how care is provided.

Who is delivering services?

The levels of care are not differentiated based on who is providing care. Whilst some disciplines and service types are more commonly associated with a particular level of care (e.g., psychiatry is more commonly associated with specialist and acute care), it is the intensity of what is provided rather than who is providing the care, that is important. Some disciplines are associated with and have a vital role at all levels of care (e.g., General Practitioners).

Level of Care 1 Self Management 6.4 million people	Level of Care 2 Low Intensity 1.2 million people	Level of Care 3 Moderate Intensity 1.6 million people	Level of Care 4 High Intensity 400,000 people	Level of Care 5 Acute and Specialist 350,000 people
Typically no risk of harm, experiencing mild symptoms and/or no /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 have high levels of motivation and engagement.	Typically minimal or no risk factors, 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). Generally functioning well but may have problems with motivation or engagement. Moderate or better recovery from previous treatment	Likely mild to moderate symptoms/distress (meeting criteria for a diagnosis). Symptoms have typically been present for 6 months or more (but this may vary). Likely complexity on risk, functioning or co-existing conditions but not at very severe levels. Also suitable for people experiencing severe symptoms with mild or no problems associated with Risk, Functioning and Co-existing Conditions	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.	A person requiring this level of care usually has significant symptoms and problems in functioning independently across multiple or most everyday roles 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.
Evidence based digital interventions and other forms of self-help	Services that can be accessed quickly & easily and include group work, phone & online interventions and involve few or short sessions	Moderate intensity, structured and reasonably frequent interventions (e.g., psychological interventions)	Periods of intensive intervention, typically inc. multi-disciplinary support, psychological interventions, psychiatric interventions and care coordination	Specialist assessment and intensive interventions (typically state/territory mental health services) with involvement from a range of mental health professionals

Australian Department of Health, National Initial Asssessment and Referral for Mental Healthcare Guidance, 2019

The Department of Health drew from information contained within the National Mental Health Services Planning Framework (NMHSPF) to estimate how many people could benefit from treatment at each level of care in an optimal stepped care approach to service delivery. The modelling examined the total population with a potential need, including those with diagnosable mental illness and those with sub-threshold or at-risk problems. This equates to 10 million people, or roughly 40% of the population, as described in the Guidance. The outcome of the modelling provides indicative estimates of how mental health needs in the population are spread across the five defined levels of care:

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

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

Slide 8 – The IAR-DST

Sitting behind the assessment domains is an algorithm that leads to a recommended level of care. The algorithm does not add up the ratings. Each rating on each domain stands alone to inform the recommended level of care. There are 496,000 rating combinations that inform the recommendation.

The Department of Health has automated the algorithm and developed a digital IAR-DST (https://iar-dst.online/#/). Users do not require a login or a password.

1. Show participants the domains. Rate each domain using the drop-down box.

2. Remind users not to rate without first referring to the rating guide for each domain.
3. Show participants the rating guides.
4. Enter a rating for all eight domains.
5. Point out the auto-generated level of care.
6. Show participants the content in the “read more about this level of care.”
7. Show participants the option of downloading a rating report.

Resource

The Decision Support Tool Logic is explained in more detail in ***Slide Pack Three – Decision Support Tool Logic.*** IAR trainers should be familiar with the logic in preparation for questions that participants might have about how the logic works. Slide Pack Three is not for sharing with participants during the workshop but might be helpful to share as part of the post-workshop follow-up email.

Facilitator Tip

Key enablers for utilisation of the IAR-DST are the integration of the IAR-DST into system workflows and information management systems (e.g., GP software).

The Australian Department of Health has funded Logicly to make available the code library and test data set for the digital-DST. All enquiries about accessing the code library and test data set are sent to: support@logicly.com.au

Additionally, the Australian Department of Health is working with GP software vendors for the national implementation of the digital IAR-DST within GP practice software. More information will be shared as soon as it is available.

In the meantime, the digital IAR-DST is available online, is free of charge, and users do not require a username or login to access the tool - https://iar-dst.online/#/

Training facilitators can also touch on using the IAR in already existing e-referral forms (if applicable to their region), noting that not all practices will have access to these forms. The focus should be on the GPs using the online tool.

The potential for integrating the IAR-DST across online and digital platforms is significant. Training facilitators should acknowledge that there are likely to be multiple platforms in which the tool is embedded. Whilst the platform might vary, the tool remains unchanged.

Slide 9 – Evaluation and next steps

All participants will receive a follow-up email with a copy of the slides, links to key resources, a link to the training evaluation survey and a workshop certificate.

Remind participants to enrol in Workshop Two. Workshop Two focuses on teaching participants how to apply the IAR-DST.

Workshop Two

Workshop Two focuses on the National Guidance and applying the Decision Support Tool. Workshop Two runs for 90 minutes. Should PHNs wish to provide updates about regional implementation activities, additional time should be allowed for this.

Workshop Two Overview

Time		Content	Resources
	5 minutes	Introduction, housekeeping, and learning outcomes	Name tags Slides Group discussion
	5 minutes	Refresh – key content from Workshop One	Slides 1-3
	10 minutes	Using the Decision Support Tool	Slides 4-8
	5 minutes	Introduce Practical Activity	Vignette and instructions
	5 minutes	Large Group Activity – Scenario (Adults)	Slide 9 Group activity
	25 minutes	Small-Group Activity – Scenario (Adults)	Slide 10 Group activity
	10 minutes	Discussion and reflection from groups	Slides 11-12 Group discussion
	10 minutes	Check-in, supported decision making, care preferences, care type	Slides 13-16
	10 minutes	Overview of adaptations for different population groups	Slides 17-18
	To be determined locally.	If the PHN would like to update participants about local implementation activities, include them here.	To be developed locally.
	5 minutes	Questions, evaluation, and conclusion	Slides 19-20 Completion of evaluation Certificate handout

Workshop Two Facilitator Notes

Slides 1-3 – Refresher

A quick refresh of critical content from Workshop One. Remind participants:

- Domain summary: the 8 initial assessment domains are divided into primary and contextual categories. Each domain has a rating scale, where users indicate the severity of any problems experienced relevant to the domain.
- Level of care summary – five levels of care, differentiated by the amount and intensity of the resources available at each level.
- Digital IAR-DST – the digital IAR-DST automates the decision logic, generating a recommended level of care based on the user ratings. The recommended level of care is then considered using clinical judgement and supported decision-making strategies.

Slide 4 – The Glossary Example from Domain 4

Each initial assessment domain has a glossary called a 'rating guide.' The rating guide supports the user in identifying an appropriate rating for the person. A glossary is essential to provide the reference point for promoting consistency between users and is critical for training.

It defines the 'rules' for making ratings and outlines factors to be considered for selecting a rating on each domain. These are presented as a hierarchical checklist to guide judgements about problem severity. Slide 4 displays an example of the rating guide for Domain 4 – co-existing issues.

Slide 5 – The rating scale

Each rating guide has a rating scale. The rating scale for each domain quantifies severity using a 5-point scale, ranging from 0 to 4. Higher ratings indicate increased severity of the problem and point to the possible need for higher (more intensive) levels of care.

The scale uses the following generic descriptors:

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

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

Slide 6 – Selecting a rating

If more than one descriptor applies to the consumer within each domain, 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.

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.

Slide 7 – Do not rate if uncertain

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.

The clinician should build certainty to rate with confidence (e.g., through additional questions or administering a standard assessment tool), seeking additional clinical input, or referring for a comprehensive assessment.

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

Slide 8 – Whose perspective?

Users of the rating guides can consider all available information in selecting a rating. This may include clinical interviews and information gathered from the person, their family, referrers, or informal supports.

Slide 9 – Large Group Activity

Participants remain in one room and rate the first domain together. The facilitator:

1. Reads the entire scenario to participants (provide a printout in advance or share on a shared screen).
2. Opens the rating guide for Domain 1, asking participants to read the rating guide and (when prompted) add their rating to the zoom poll.
3. Displays the zoom poll to the group.
4. Calls on a participant to reflect on why they selected their rating. If some people have chosen a different rating from the majority, ask one person to explain why they selected the rating they did. Ask the person to be specific (e.g., which descriptor they felt applied?).
5. Invites questions about the process.

Resource

The standard scenarios to use during the workshop are in Appendices 7, 8 and 9.

Note – with a General Practitioner audience, a scenario involving more complexity is strongly recommended (e.g., Leah, William, Jessica).

Slide 10 – Small group activity

Participants work in small groups (of 4-8) to rate the remainder of the scenario, working through Domain 2 to Domain 8 until a recommended level of care is generated.

1. Ensure participants can access the scenario independently during the small group activity. Participants will need to be able to refer to key content.
2. Advise participants that they have 25 minutes for the activity. Participants will need to spend most of their time on the primary domains (the rating guides are lengthier).
3. Ask participants to work together to determine a rating – talking their decision-making process through.
4. Ensure participants are aware that the aim of the activity is not to agree with each other and reach a consensus rating. Participants should maturely discuss differences in their selected ratings.
5. If the training is being held virtually, ensure participants know how to reach you if they need assistance in the breakout room (most platforms have a “call for help” option).
6. Visit each of the groups/rooms at least once to check in, offer support, and document key discussion points.
7. Visit each of the groups/rooms before the small group activity ends to collect the ratings from each group. These ratings are recorded on a slide. The ratings are shared with the whole group once the activity has finished.
8. Ask each group to nominate a spokesperson to provide feedback on the experience.

There are 25 minutes for this activity, so you must manage time well and regularly remind participants of the remaining time.

Participant instructions

Rate each domain by referring to the rating guide

Use the IAR-DST to work out the recommended level of care

What is your practitioner determined level of care?

What more would you want to know about the person?

Slide 11 – Group ratings

Once the activity has finished, share the compiled ratings with the group. Ask the spokesperson from each group to:

- Share the practitioner determined level of care and whether there was agreement/disagreement amongst the group. Was the practitioner determined level of care consistent with the DST recommended level of care? If not, why not?
- Share any challenges or observations the group had.

Slide 12 – Rating patterns

Select the rating slide for the vignette on which the group has focused. Delete the others. Comment on the similarities between the ratings today and the usual pattern of ratings for the vignette.

Resource

The rating patterns for all adult scenarios are included in Slide Pack Two. Keep the rating slide for the scenario you are using for the workshop. Delete the ratings for the scenarios you are not using during the workshop.

Slide 13 – Check-in / Check back (follow up and review)*

- A check-in is a plan to reach out to a person following the initial assessment proactively.
- A check back strongly encourages the person to check back in if there are any concerns, questions, or changes.

A follow-up check-in helps ensure that the intervention commenced as planned and determine if the recommended information, resources, or services are being utilised and perceived as helpful. In the initial stages of treatment, it may be too early to determine clinical benefit; however, early signs of clinical deterioration or worsening are possible and should be checked.

A check-in or check back is essential if:

- The person is recommended to access Level 1 (self-management) resources.
- There is volatility observed during the initial assessment (e.g., multiple changes occurring in the person's environment).

** General Practitioners refer to this as follow up (check-in) and review (check back). Be mindful of using terminology that audiences are familiar with (e.g., follow up and review if training GPs).*

Facilitator Tip

Training participants commonly express frustration about the difficulties in locating and accessing services aligned with the recommended level of care, reflecting on the service gaps within their local service system. Both consumers and referrers shared these frustrations during the Implementation Review (undertaken by the University of Melbourne). In these situations, service availability and waiting times can become the driver for referral decision making, irrespective of the outcome of using the IAR-DST. It is important to acknowledge these frustrations.

There are many drivers of service gaps – high demand, workforce shortages etc. IAR might address some of these pressures (e.g., improved utilisation and optimisation of self-management and low-intensity interventions may alleviate pressure on moderate-intensity interventions). Once referrals are flowing in a way that is underpinned by IAR, referral demand and service gaps are likely to be easier to detect and validate.

In the meantime, IAR-DST users are encouraged to use available services and consider multiple referrals (e.g., bundling services in a care team approach) where there is no single service capable of providing the level of care a person might require. If selecting a lower level of care than is indicated, IAR-DST users are encouraged to use the check-in/check-back approach and regularly monitor the person's response to the selected level of care.

Slide 14 – Supported Decision Making

The IAR-DST provides a recommended level of care. The recommended level of care is then considered in partnership with the consumer, and a final decision about the next steps in the referral journey is made collaboratively. 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 strongly prefer 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). This can often be resolved using supported decision-making strategies.

The strategies outlined for participants include:

- Ensure the consumer is provided with information using their **preferred way of receiving information** (e.g., written/verbal/visual, English/other languages, with/without a support person).
- Ensure the consumer is provided with a list of recommended intervention options (including no intervention) and **encourage them to contribute their options, ideas, solutions, and expectations** (e.g., 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, the potential impact on symptoms) as well as the pros and cons of no intervention.
- 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 consumer's decision, acknowledging that other options can be explored in the future if this decision does not work out.

Slide 15 – Care preferences

When making a resource recommendation or referral decision at any level of care, consider the circumstances of the person and the appropriateness of resources and services options, such as:

- readiness of the person
- the priorities of the person
- cost
- location
- availability of in-language, interpreter, and translator services
- digital literacy of the person
- the availability of technology (e.g., internet connection, telephone)
- the practical and emotional support needs of the person.

Slide 16 – Type of care considerations

The levels of care are differentiated by the intensity of the resources and services provided. IAR-DST users must still be mindful that they need to consider the type of care within each level of care. These are:

- Culturally appropriate and safe services (such as social and emotional well-being services available through Aboriginal Community Controlled Health Organisations),
- Age-appropriate services,
- Services-specific to the person's diagnosis (where applicable), such as evidence-based dialectical behavioural therapy for borderline personality disorder,
- Specialist sexuality and gender diversity resources and services,
- If the person has multiple service needs, consider integrated services and service models.
- Services that incorporate social and environmental supports (e.g., specialist family violence services).

Slide 17-18 – Overview of adaptations for different population groups

The Department of Health has also embarked on a development process for specific population groups, including:

- Children (5-11)
- Adolescents (12-17)
- Adults (18-65)
- Older adults (65+)
- Aboriginal and Torres Strait Islander Peoples
- Culturally and linguistically diverse people
- Veterans
- People with co-occurring conditions (including intellectual disability)

The adaptations incorporated into the child and adolescent versions are captured on slides 17-18.

Facilitator Tip

The IAR adaptations have commenced with a lifespan approach (children, adolescents, adults, and older adults). Whilst the IAR Guidance uses age to indicate the overall appropriateness of each tool, the final

decision about the most appropriate version is based on the clinical judgment of the user, taking into account contextual and developmental considerations.

Slide 19 – Evaluation and next steps

Training organisers must send participants a follow-up email with a copy of the slides, links to key resources, a link to the experience of training survey, and a workshop certificate.

The training outcomes survey focused on outcomes from the training and use of the IAR-DST, should be sent to participants three months after completion of workshop 2.

Facilitator Tip

Encourage participants to continue practising with the IAR-DST and extend their practice to a mix of scenarios for people experiencing a variety of mental health presentations. To enable this additional practice, the participant resources for Workshop Two include all 11 scenarios (five adult scenarios, three adolescent scenarios, and three child scenarios) and the rating profile for some scenarios for comparison purposes.

Appendix 1 – Sample Training flyer

Training – Initial Assessment and Referral (IAR) for Mental Healthcare

Background

The National IAR Guidance and IAR-DST were developed by the Australian Department of Health and is designed to provide:

- Advice relating to initial assessment and intake (the eight domains).
- A description of evidence-based services by level of intensity (the five levels of care).
- Criteria to assist with matching an individual to a level of care that is most likely to meet the individual's treatment needs and recovery goals (the IAR-DST).

The workshops

The training will focus on:

1. Introduction to IAR and the development of the National Guidance.
2. Orientation to the domains, levels of care, and decision support tool.
3. Clinical judgement and supported decision-making.
4. Application of the IAR in assessment and intake settings (practical activity using a scenario).

The learning outcomes are:

- Participants are familiar with the principles underpinning the national approach to stepped care.
- Participants have an awareness of and confidence in the IAR development process.
- Participants can apply the IAR Guidance in practice settings, using the domains and the decision support tool to generate a recommended level of care.
- Participants understand the levels of care and can determine regional services matched against the levels of care.
- Participants understand the principles related to clinical decision making and consumer choice and can practice following these principles using supported decision-making strategies.

There are two workshops that participants are required to complete.

Workshop One is a pre-recorded training video that participants can access independently and at a day/time that is convenient. Workshop One focuses on an introduction and orientation to stepped care, the initial assessment and referral process, and the decision support tool. The video training is 30 minutes in length. Participants must complete Workshop One before registering for Workshop Two.

Workshop Two is a live practice community where participants engage in practical activity focusing on applying the IAR decision support tool to the prepared scenario.

Workshop #	Time and Date	Scenario	Location/Link
1	Anytime	N/A	Workshop One is accessed online by visiting: LMS webpage URL.
2	Insert day, date, time	Select scenario	Insert address or link

For more information about this training, contact:

Insert Name

Insert Email

Insert Telephone Number

Appendix 2 – Sample Registration Form

First name	
Surname	
Email address	
Telephone contact	
Organisation	
Position title	
Accessibility requirements	
Specific requests	
Dietary requirements (if applicable)	
Declaration	By submitting this form, I declare that I have completed Workshop One via the National IAR Training Portal or by attending a locally facilitated workshop.

Appendix 3 – Sample certificate

Certificate of Attendance

Presented to

<Full Name>

for participating in

<Professional Development Session Name>

Total duration: <hours>

Completed on: <insert date>

Signed:

<Trainer Name>

<Trainer Organisation>

Appendix 4 – Workshop follow up email.

Dear training participants,

Many thanks for your time today for the IAR training workshop. Please find attached the slides.

You have been sent a link to an anonymous online survey about your training experience today. It would be fantastic if you could take 2-3 minutes to complete the survey.

Here are some important links for you:

1. The link to the National IAR Guidance: https://www.health.gov.au/resources/publications/primary-health-networks-phn-mental-health-care-guidance-initial-assessment-and-referral-for-mental-health-care
2. The link to the online Decision Support Tool: https://iar-dst.online/#/
3. *Include content relevant to local implementation activities.*

Many thanks

Appendix 5 – Training evaluation survey

The purpose of the experience of training survey is to assess participant satisfaction with the training.

After each pre-recorded workshop 1 session, a national experience of training survey is automatically sent to all training participants.

PHNs that deliver a live version of workshops 1 or 2 locally are responsible for distributing the experience of training survey to participants following the workshop.

The survey is anonymous, and the results are available to the Australian Department of Health. A report with survey outcomes is available to each PHN and compared to national benchmarks.

The experience of training survey includes the following questions:

1. The content was organised and easy to follow (strongly agree, agree, disagree, strongly disagree)
2. The time allocated to the training was sufficient (strongly agree, agree, disagree, strongly disagree)
3. The training improved my understanding of the National Initial Assessment and Referral Project (strongly agree, agree, disagree, strongly disagree)
4. The training improved my knowledge of how to apply the decision support tool (strongly agree, agree, disagree, strongly disagree)
5. It was helpful to see the online Decision Support Tool and how it can be used in practice (strongly agree, agree, disagree, strongly disagree)
6. The Initial Assessment and Referral (IAR) tool will help support improved decision-making for referral across mental health services (strongly agree, agree, disagree, strongly disagree)
7. Using the Initial Assessment and Referral (IAR) tool is likely to be a valuable use of my time (strongly agree, agree, disagree, strongly disagree)
8. It was clear how to get in touch with a representative about the project (strongly agree, agree, disagree, strongly disagree)
9. You are welcome to leave any thoughts or comments regarding your overall impression of the National Initial Assessment and Referral Guidance here (open text box)
10. Please let us know if there is any way we can improve the training (open text box)
11. Finally, please tell us a little about yourself (tick all that apply) (open text box)
    - Lived experience representative (consumer)
    - Lived experience representative (carer)
    - Peer Worker
    - General Practitioner
    - Nurse (including Mental Health Nurse)
    - Psychiatrist
    - Psychologist
    - Social Worker
    - PHN Clinician
    - PHN Administrator (e.g., Manager/Team Leader)
    - Local Hospital Network Administrator
    - Local Hospital Network Clinician
    - Service Provider Clinician
    - Service Provider Administrator (e.g., Manager/Team Leader)
    - Other (please specify)

Appendix 6 – Training outcomes survey

The purpose of the training outcomes survey is to evaluate outcomes from the training and use of the IAR-DST.

PHNs should distribute the training outcomes survey to workshop 2 participants three months after their workshop 2 session.

The surveys are anonymous, and the results are available to the Australian Department of Health. A report is available to each PHN and can be compared to national benchmarks.

The training outcomes survey includes the following questions:

- Since the workshop, I have used the Initial Assessment and Referral Decision Support Tool (IAR-DST) (not at all, several times, monthly, weekly, daily)
- I am finding the IAR-DST accurately estimates the level of mental healthcare service intensity the person is likely to require (strongly agree, agree, disagree, strongly disagree)
- The Initial Assessment Domains are helping me consider all the factors relevant to informing a decision about mental healthcare service intensity (strongly agree, agree, disagree, strongly disagree)
- Using the IAR-DST is a valuable use of my time (strongly agree, agree, disagree, strongly disagree)
- The IAR-DST could be improved by: (open comment)
- Local implementation could be improved by: (open comment)

Appendix 7 – Training Scenarios – Adults

JESSICA

Link to online DST- https://iar-dst.online/#/

A maternal health nurse sends a referral letter to the intake team for mental health intervention. Jessica is 25 years of age and has just had her second baby, now 3.5 months old. As part of the universal screening recommended by the State Health Service, Jessica had completed the Edinburgh Postnatal Depression Scale. The score was 16. As per the local Health Pathway, the maternal health nurse refers Jessica to the intake team. The intake team arrange a telephone appointment for an initial assessment.

Domain 1 – Symptom severity and distress

Jessica recalled getting the "baby blues" with her first baby and was assisted at the time by her GP, with good recovery. Jessica says that she started "feeling teary" a few days after the birth of her second child; at first, she brushed it off, but the "teary feeling" persisted. Jessica reports feeling tearful and crying most days. When asked, Jessica reports she is not sleeping well -but she says that this is mainly because the baby wakes several times a night for feeding. Jessica reports not feeling connected to her new baby and not having time for her toddler. Jessica says she feels like she is a failure as a mother and has no energy.

Domain 2 – Risk of harm

Jessica tells the intake worker that she has no suicidal ideation and reports no history of suicide ideation or attempts. Jessica tells the intake worker that she is not self-harming and has no history of self-harm. Jessica reported that she has had no thoughts of harming her child or baby. The intake worker assesses Jessica as having normal thought-form and no perceptual disturbance.

Domain 3 – Functioning

Jessica tells the intake worker that she hasn't been cooking or cleaning as much. She says she has been looking after her partner and her children but hasn't been looking after herself properly (not showering as often and skipping meals).

Domain 4 – Impact of co-existing conditions

Jessica tells the intake worker that she has had mastitis several times. Jessica indicates a solid commitment to breastfeeding but struggles with discomfort and pain. Jessica acknowledged that this is not helping her feel better.

Domain 5 – Treatment and recovery history

Jessica has not previously accessed a mental health service; however, she was assisted by her GP following the birth of her first baby, with good recovery.

Domain 6 – Social and environmental stressors

Jessica reports feeling overwhelmed by "the new baby period." Jessica tells the intake worker that she has less patience and less interest in intimacy. Jessica and her partner are fighting more often.

Domain 7 – Family and other supports

Jessica says she has a close family, but she does not feel comfortable disclosing her feelings for fear of being judged. Jessica has not disclosed how she feels to her partner but thinks she has noticed a change. Jessica said that she knows her family and partner would support her if she asked for help despite this.

Domain 8 – Engagement and motivation

Jessica reports a strong desire to feel better. She recognises that what is happening to her is a repeat of the experience she had after the birth of her first child and that she can get better with help. Jessica says she is worried about finding the time for treatment but knows it is important.

End

Domain	Rating	Concordance	Notes
Symptom severity and distress	2	70% of training participants give Jessica a rating of 2 on this domain. 30% of training participants give Jessica a rating of 1 on this domain.	Throughout the Guidance, 'soft thresholds' are used regarding metrics such as duration (e.g., "typically"). Jessica has been experiencing symptoms for less than six months, and therefore some participants select a 1. However, 2a applies as symptoms are likely to have reached a diagnostic threshold for perinatal depression. Jessica is likely to be experiencing moderate to high levels of distress; therefore, the correct rating is 2. Further certainty through administering a standard assessment tool (e.g., K10 or EPDS) might be appropriate to quantity the level of associated distress.
Risk of harm	0	90% of training participants give Jessica a rating of 0 on this domain. 10% of training participants give Jessica a rating of 1 on this domain.	No descriptors apply in this domain, and therefore the rating is 0.
Functioning	2	70% of training participants give Jessica a rating of 2 on this domain. 30% of training participants give Jessica a rating of 3 on this domain.	For a rating of 3a to apply, Jessica would need to require treatment and community supports to maintain independent functioning. Some participants select 3b due to the notes relating to Jessica not showering as often and skipping some meals. However, the appropriate rating is 2.
Co-existing issues	2	70% of training participants give Jessica a rating of 2 on this domain. 30% of training participants give Jessica a rating of 1 on this domain.	The link between Jessica's experience of mastitis and distress is not clear; however, most training participants select a rating of 2.
Treatment and recovery history	1	100% of training participants give Jessica a rating of 1 on this domain.	Jessica reports having experienced a good response to the mental health treatment provided through her general practitioner.
Social and environmental stressors	2	70% of training participants give Jessica a rating of 2 on this domain. 30% of training participants give Jessica a rating of 3 on this domain.	Rating this domain accurately depends on the person's perception of how stressful they experience their environment. This domain cannot be rated accurately without speaking directly to Jessica.
Family and other support	1	75% of training participants give Jessica a rating of 1 on this domain. 25% of training participants give Jessica a rating of 2 on this domain.	
Engagement and motivation	1	95% of training participants give Jessica a rating of 1 on this domain.	
Level of care	**3+** **2+**	**95% concordance** **5% concordance**	There are several services designed for parents in the perinatal period. This is an opportunity to talk to participants about type of care considerations. For instance, is there a local service that integrates psychological support alongside early parenting supports (e.g., sleep, settling, lactation, etc.)? Some low intensity and moderate intensity services specialise in perinatal mental health (e.g., national PANDA helpline).

JASON

Link to online DST - https://iar-dst.online/#/

Jason is a 33-year-old male who calls Central Intake and tells the clinician that he feels stressed because of a restructure at work. Much of the workforce in his section are expected to be let go. Jason lives with his wife and three children (aged 8, 9 and 12).

Domain 1 – Symptom severity and distress

Jason tells central intake that he has been experiencing some trouble sleeping some nights. Jason links the onset of the sleep difficulties with his challenges at work. Jason notes that he is more frustrated than usual (mostly at home) and states that he has been more impatient with the kids. Jason mentions that he is often distracted by what is happening at work and feels he cannot relax. This has been happening for around eight weeks. Jason tells the clinician he has never had mental health issues before. Jason is concerned that the impending work restructure will result in him losing his job, and he worries that he will not be able to pay the mortgage, bills, and support his young family. Otherwise, Jason still enjoys spending time with friends and family. The clinician administers the K10, and Jason has a score of 20.

Domain 2 – Risk of harm

When asked, Jason denies any suicidal ideation or self-harm. Jason tells the doctor he has never experienced suicidal ideation or self-harm. Jason has not ever had thoughts of hurting others. The clinician finds no evidence of current or past perceptual disturbance, delusions or thought disorder.

Domain 3 – Functioning

Jason reports being less effective at work but still attends work daily and is mostly productive. Jason also mentions that he is communicating less with his wife and children lately but fulfils his parenting responsibilities. Otherwise, Jason says he is functioning well.

Domain 4 – Impact of co-existing conditions

Jason drinks beer socially (4-5 beers once per week)- but reports he is drinking less now.

Domain 5 – Treatment and recovery history

Jason tells the clinician he has never previously accessed a mental health service. He tells the clinician he recently did an online test that told him to seek help or talk to his GP.

Domain 6 – Social and environmental stressors

Jason's current employment is at risk due to a company restructure. He is the primary income earner. Jason says that he finds it hard to stop worrying about losing his job.

Domain 7 – Family and other supports

Jason has a loving wife and parents who live locally and have been a great source of support.

Domain 8 – Engagement and motivation

Jason tells the clinician he would like to talk to someone outside the family about what is going on. Jason wants to learn how to cope with work-related stress and be prepared for the worst- being out of a job. Jason tells the clinician that money is an issue, and it would not be possible to fund treatment out of the little money left over after paying the bills. Jason has access to a car and can get to appointments but thinks it would be best to have appointments after work or on weekends not to have to take time off work.

End

Domain	Rating	Concordance	Notes
Symptom severity and distress	1	100% of training participants give Jason a rating of 1 on this domain.	The symptoms Jason is experiencing are likely to be in direct response to an environmental stressor, sub-diagnostic and short in duration. 1a applies to Jason. There are no descriptors at a higher rating point that apply.
Risk of harm	0	100% of training participants give Jason a rating of 0 on this domain.	No descriptors apply.
Functioning	1	100% of training participants give Jason a rating of 1 on this domain.	Jason reports diminished performance in a single functional domain (work) and possibly some diminished performance associated with caregiving responsibilities. However, this diminished performance is not associated with days out of role or adverse consequences.
Co-existing issues	0	90% of training participants give Jason a rating of 0 on this domain. 10% of training participants give Jason a rating of 0 on this domain.	Some participants are concerned about alcohol intake being above recommended limits, and therefore meeting criteria for “misuse” at 1a. However, many participants select a rating of 0 on this domain.
Treatment and recovery history	0	100% of training participants give Jason a rating of 1 on this domain.	
Social and environmental stressors	2	80% of training participants give Jason a rating of 2 on this domain. 20% of training participants give Jason a rating of 3 on this domain.	Without speaking with Jason, it is not possible to assign a rating with certainty.
Family and other support	0	90% of training participants give Jason a rating of 0 on this domain. 10% of training participants give Jason a rating of 1 on this domain.	
Engagement and motivation	0	90% of training participants give Jason a rating of 0 on this domain. 10% of training participants give Jason a rating of 1 on this domain.	
Level of care	**1**	**100% concordance**	Given the level of volatility associated with the stress in the environment (impending restructure at work), self-management with a check-in approach (level 1) or low intensity services (level 2) represents best practice and is often noted as the practitioner determined level of care by training participants. If the restructure results in a positive outcome for Jason, his mental well-being might quickly improve. If, however, the restructure leads to Jason losing his job, a higher intensity intervention (e.g., low intensity supports) might be warranted. See check-in approach and reinforce with participants.

LEAH

Link to online DST- https://iar-dst.online/#/

A GP sends a referral letter through to intake for Leah (aged 20). The intake clinician makes telephone contact and collects some additional information. The following information about Leah is captured from the referral letter and the clinician's contact with her.

Domain 1 – Symptom severity and distress

Leah reports low mood for the past seven months, with tearfulness, loss of enjoyment and persistent fatigue. Leah does not feel in control of the symptoms, and the GP noted that the symptoms are not improving. Leah has a history of anxiety and self-harm (skin cutting) since age 14. K10 score is 29. The K10 was completed by the GP and attached to the referral letter.

Domain 2 – Risk of harm

Leah has a history of self-harm (cutting) without suicidal ideation or intent since age 14. The GP notes that the cuts were examined and were superficial. Leah tells the intake clinician she has never required medical attention for previous cuts. Self-harming has increased in frequency and intensity in the last three weeks. The GP conducted a Mental State Exam (MSE) and ticked 'normal' on all boxes relating to cognition, thought process, thought content, perception, judgement, and orientation.

Domain 3 – Functioning

The intake clinician notes that Leah's mental health impacts her interest and commitment to university. Leah has been missing lectures and handing in assignments late. Leah does not like the online learning arrangements now in place. Leah is catching up with friends and has a roommate with who she gets along well. They go for a walk or bike ride.

Domain 4 – Impact of co-existing conditions

The GP notes that Leah disclosed that she occasionally uses ecstasy with friends, most weekends and only if she can afford it.

Domain 5 – Treatment and recovery history

When Leah was 15 years old, she accessed a headspace service and was prescribed medication (Lovan 20mg) by a GP and saw a youth counsellor. Leah reports that both the service and the medication helped to improve her low mood. However, her self-harm behaviour continued.

Domain 6 – Social and environmental stresses

The MHTP notes that Leah is uncertain about being in the right university course. Leah tells the intake clinician that she is experiencing course-related pressures (high study workload and exam stress). Leah also feels sad living so far away from her family.

Domain 7 – Family and other supports

Leah moved town to attend university eight months ago, and as a result, she is living away from her family for the first time. Leah says that the lack of physical presence and contact is difficult. Despite the distance, her family are loving and supportive, and they regularly speak on facetime.

Domain 8 – Engagement and motivation

The GP notes a strong desire and commitment to access services and support. GP notes that Leah is highly motivated and is keen to access a service as soon as possible. Leah tells the intake clinician she is not concerned about her self-harming and does not need help "trying to fix that." Leah "just wants help to feel happy again."

End

Domain	Rating	Concordance	Notes
Symptom severity and distress	2	90% of training participants give Leah a rating of 2 on this domain. 10% of training participants give Leah a rating of 3 on this domain.	Symptoms are at a level that would likely meet diagnostic criteria for an anxiety disorder or are associated with a moderate to a high level of distress. 2a applies.
Risk of harm	2	100% of training participants give Leah a rating of 2 on this domain.	2c applies. Leah reports frequent non-suicidal self-injurious acts in the recent past and does not require surgical treatment.
Functioning	2	60% of training participants give Leah a rating of 2 on this domain. 30% of training participants give Leah a rating of 1 on this domain. 10% of training participants give Leah a rating of 3 on this domain.	Leah is experiencing impaired functioning associated with the vocational domain to the extent that this leads to days out of role (2a). However, with low confidence, we attribute the absenteeism to mental health – given Leah has also expressed a concern that she is in the wrong university course and does not enjoy the online learning environment now in place. Participants should select 2 but acknowledge that it might be important to build certainty about the impairment associated with mental health issues in real-world practice. Leah does not require community support to maintain independent functioning (3a).
Co-existing issues	1	50% of training participants give Leah a rating of 1 on this domain. 50% of training participants give Leah a rating of 2 on this domain.	The impact of Leah using ecstasy is unclear; however, with the information contained in the scenario, there is no reported impact, and therefore, a rating of 1 is likely to be appropriate. However, as rating point 2 notes the "potential" to impact, training participants may appropriately select a 2. In real-world settings, building understanding about the impacts of ecstasy use from Leah's perspective might be important.
Treatment and recovery history	2	90% of training participants give Leah a rating of 2 on this domain. 10% of training participants give Leah a rating of 1 on this domain.	2a applies to Leah. Leah had previously sought help for an earlier episode(s) and achieved partial recovery with no need for ongoing intervention.
Social and environmental stressors	3	50% of training participants give Leah a rating of 3 on this domain. 25% of training participants give Leah a rating of 1 on this domain. 25% of training participants give Leah a rating of 2 on this domain.	Without speaking with Leah, it is not possible to assign a rating with certainty.
Family and other support	2	60% of training participants give Leah a rating of 2 on this domain. 20% of training participants give Leah a rating of 1 on this domain. 20% of training participants give Leah a rating of 0 on this domain.	
Engagement and motivation	1	80% of training participants give Leah a rating of 1 on this domain.	Leah's reluctance to talk about self-harm is a reason why most training participants select a 1, rather than 0.

		20% of training participants give Leah a rating of 0 on this domain.	
Level of care	**3+**	**95% concordance**	Consider age-appropriate service options.

WILLIAM

Link to online DST- https://iar-dst.online/#/

A GP sends a referral letter to Central Intake for William (aged 52). The intake clinician makes telephone contact and collects some additional information. The following information about William is captured from the referral letter and the clinician's contact with him. William has a diagnosis of schizophrenia and was referred by his GP after requesting anti-depressants.

Domain 1 – Symptom severity and distress

William tells the Intake Clinician that there is no point to anything, and he feels hopeless. He has felt "really down" lately and has been thinking about suicide. The GP included the K10 score in the referral paperwork, noting a score of 34.

Domain 2 – Risk of harm

The GP has included a risk assessment in the referral paperwork. The following information is available to the intake clinician.

- **Duration:** 4 months
- **Frequency:** The suicidal thoughts occur daily.
- **Plan:** No clear plan.
- **Lethal means:** No.
- **Previous attempts:** Nil attempts. Risk-taking behaviour.
- **Contributing factors:** Hopelessness.

The intake clinician's risk assessment confirms this information. William tells the clinician he does not want to die. But if he 'keeps feeling so bad,' he does not want to live either.

Domain 3 – Functioning

When asked, William tells the intake clinician that the house is messier and does not care about his looks. He cannot remember the last time he showered and sometimes goes days without eating. William says this is "definitely not" normal for him.

Domain 4 – Impact of co-existing conditions

William previously smoked marijuana but denies current or recent use. William is overweight and has ongoing dental problems. He cannot find a dentist that is affordable and reports pain. The GP notes that a complete physical health check has been arranged due to William's elevated risk of metabolic syndrome.

Domain 5 – Treatment and recovery history

William was previously supported through the Community Mental Health Team and the housing accommodation provider. William has been stable on clozapine and has not accessed any other services other than regular medication reviews for the past 13 years. William has 6-monthly medication reviews with a public psychiatrist and reports being happy taking the medication prescribed. William tells the intake clinician that he has always thought the Community Mental Health team were helpful. He likes his psychiatrist.

Domain 6 – Social and environmental stresses

William lives alone and was engaged in part-time employment. William was let go from his job when the pandemic hit- but tells the intake clinician he was about to quit anyway. William was working as a tech assistant at a local electronics store. William would like to open his own business offering computer repairs. William reports feeling lonely. William lives in an apartment complex but rarely talks to his neighbours, who he reports are not friendly. When the Covid-19 pandemic first hit, William says people got 'smilier.' But he tells the clinician everyone keeps a distance from each other now.

Domain 7 – Family and other supports

William's mother died two years ago, and William misses her deeply. William has a brother with who he is not in contact.

Domain 8 – Engagement and motivation

William has shown a commitment to treatment in the past and has a good understanding of his condition. William has been proactive about managing his condition in the past. William is 'open to any ideas.'

Domain	Rating	Concordance	Notes
Symptom severity and distress	2	70% of training participants give William a rating of 2 on this domain. 30% of training participants give William a rating of 3 on this domain.	Participants are encouraged to avoid diagnostic over-shadowing. William has a severe mental illness (schizophrenia); however, the current presentation is in the context of low mood, and this domain is rated based on the current point in time and what has been typical over the past 30 days for William. Therefore, 2a applies. Low mood is a negative symptom of schizophrenia and therefore a comprehensive psychological assessment is recommended. Participants might also note the existing engagement of a psychiatrists and opportunities for psychiatric review. K10 score of 34
Risk of harm	2	70% of training participants give William a rating of 2 on this domain. 30% of training participants give William a rating of 3 on this domain.	William has current suicidal ideation without plan or intent. 2a applies. More information about "risk taking behaviour" is required to rate this domain with certainty. Administering the K10 tool again, might also be helpful. Some participants select a rating of 3 due to descriptor 3c. Whilst William's basic self-care is compromised (eating and hygiene), it is unclear if this represents a risk of harm or threat to health – more information might assist.
Functioning	3	100% of training participants give William a rating of 3 on this domain.	3a applies to William.
Co-existing issues	3	60% of training participants give William a rating of 3 on this domain. 35% of training participants give William a rating of 2 on this domain. 5% of training participants give William a rating of 1 on this domain	Due to the multiple physical health issues (e.g., dental pain, concerns about metabolic disorder, overweight), participants are concerned that William requires intensive medical monitoring. Therefore, select 3b; however, more information is required to rate with certainty and therefore, discordance in this domain is expected.
Treatment and recovery history	2	95% of training participants give William a rating of 2 on this domain. 5% of training participants give William a rating of 3 on this domain.	William has previously received treatment for an earlier episode(s) and was able to achieve and maintain partial recovery with limited support. Therefore, 2a applies.
Social and environmental stressors	2	80% of training participants give William a rating of 2 on this domain. 20% of training participants give Jason a rating of 3 on this domain.	Without speaking with William, it is not possible to assign a rating with certainty.
Family and other support	4	70% of training participants give William a rating of 4 on this domain. 30% of training participants give William a rating of 3 on this domain.	
Engagement and motivation	1	70% of training participants give William a rating of 1 on this domain. 15% of training participants give William a rating of 0 on this domain.	

		15% of training participants give William a rating of 2 on this domain.	
Level of care	**3+**	**80% concordance**	It is important to note that low mood is a negative symptom of schizophrenia and therefore, this might warrant an earlier review by the psychiatrist.

ROBERT

Link to online decision support tool- https://iar-dst.online/#/

Robert (74) calls the intake team. Robert tells the clinician that his wife is making him call because he is 'not quite right.' Robert is reluctant to seek help; however, he explains to the intake clinician that his wife (Liz) plans to initiate a separation if he does not seek help soon. The intake clinician speaks with Robert, and then with his consent, speaks with Liz.

Domain 1 – Symptom severity and distress

Robert's wife reports that he is impatient and moody. Angry outbursts are over minor issues (spilling a drink). Other family members (adult children) have also experienced these angry outbursts. One son-in-law is refusing to have contact with him. Robert tells the clinician he is tearful 1-2 times a week, and it usually lasts most of the day. Liz tells the clinician that Robert 'doesn't get violent or anything.' When asked, Liz says it has been like this for approx. nine months and it is "just getting worse."

Domain 2 – Risk of harm

Liz tells the clinician that Robert has made comments like "I just don't want to be here anymore." When the intake clinician talks to Robert about these comments, he becomes defensive and denies feeling suicidal. Robert is a registered firearm owner.

Domain 3 – Functioning

Robert explains that he is the primary carer for his son who is in a wheelchair and says he has not been as active in caring for their son. Robert usually provides the bulk of the support, but his wife has been taking on more and more. Robert reports he has not been helping around the house or socialising as much over the past six months due to covid-19. He usually has a busy social life with a long-term group of friends. Their regular meeting place is the local pub.

Domain 4 – Impact of co-existing conditions

Robert has Type 1 diabetes, has previously had a heart attack (15 years ago) and is overweight. Robert has been trying to make some lifestyle changes. Robert is a daily drinker and has been for about 35 years. Robert was recently arrested for his second *driving under the influence* (DUI) offence and currently has a suspended license. His wife uses the term "drinking problem," which Robert objects to. Robert drank 3-4 beers daily, increasing his intake to 6-8 beers minimum when he drinks socially on weekends. Since the second DUI his wife has significantly restricted his access to beer, and Robert now has 1-2 wine and sodas an evening. He can no longer go to the pub, which has also led to decreased alcohol consumption.

Domain 5 – Treatment and recovery history

Robert has not sought nor accessed treatment previously.

Domain 6 – Social and environmental stressors

Liz was able to identify several stressors. Robert and his wife are the carers of an older son in a wheelchair. Liz says that their relationship is strained due to the drinking and anger. Their financial situation is poor, and despite having had long and well-paid careers, Robert's drinking and gambling have left them with no financial reserves. Robert however says that he is not worried about these issues and believes Liz is being dramatic.

Domain 7 – Family and other supports

Robert's wife said that she and the family would continue to support him as much as needed if he sought help. But otherwise, everyone is fast losing patience with his irritability and moodiness. Robert reports having great family support but tells the clinician that he feels like a burden on them at times.

Domain 8 – Engagement and motivation

Liz tells the intake clinician that Robert is very reluctant to access support and expresses a strong reluctance to make any meaningful changes in his life. Liz believes the ultimatum to end the marriage is the only thing that might work. Robert reports he will speak to someone "if I have to."

End

Domain	Rating	Concordance	Notes
Symptom severity and distress	2	100% of training participants give Robert a rating of 2 on this domain.	Symptoms are at a level that would likely meet diagnostic criteria or are associated with a moderate to high level of distress. 2a applies.
Risk of harm	2	70% of training participants give Robert a rating of 2 on this domain. 30% of training participants give Robert a rating of 3 on this domain.	It is difficult to rate this domain given the scenario has not included any information supplied directly by Robert. However, based on the reports from Liz, participants commonly select a rating of 2 based on Robert's age, tearfulness, low mood, agitation, outbursts, access to firearms and environmental stressors.
Functioning	2	80% of training participants give Robert a rating of 2 on this domain. 20% of training participants give Robert a rating of 3 on this domain.	Diminished performance in multiple functional domains (caregiving role, social role). Information from Liz indicates this is leading to days when Robert cannot fulfil his responsibilities within these functional domains, and therefore, 2a applies.
Co-existing issues	3	60% of training participants give Robert a rating of 3 on this domain. 40% of training participants give Robert a rating of 2 on this domain.	The relationship between alcohol use, physical health condition and Robert's mental health are unclear; however, a rating of 2-3 is likely to be appropriate based on the information provided in the scenario.
Treatment and recovery history	0	100% of training participants give Robert a rating of 0 on this domain.	
Social and environmental stressors	2	50% of training participants give Robert a rating of 2 on this domain. 50% of training participants give Robert a rating of 3 on this domain.	
Family and other support	2	60% of training participants give Robert a rating of 2 on this domain. 40% of training participants give Robert a rating of 1 on this domain.	
Engagement and motivation	3	60% of training participants give Robert a rating of 3 on this domain. 40% of training participants give Robert a rating of 4 on this domain.	
Level of care	**3+**	**100% concordance**	

Appendix 8 – Training Scenarios – Adolescents

BRANDON

Link to online DST- https://iar-dst.online/#/

Brandon is a 14-year-old adolescent from a small rural community.

Domain 1 – Symptom severity and distress

Brandon has been acting strangely for some time but has recently become snappy and verbally aggressive towards his family. Brandon has disturbed sleep and often paces the house at night, occasionally talking to himself. Brandon is quiet and mostly avoids eye contact with people he meets. These symptoms have worsened over six months, but his development has been relatively normal before this. He is not active at home with hobbies or interests.

Domain 2 – Risk of harm

Nil risks noted.

Domain 3 – Functioning

Brandon has never been confident in school; however, there are no noted changes in his academic performance. Socially, the school has noted the same recent concerns as his parents (withdrawn, limited eye contact, pacing at school and irritability with teachers). He is withdrawn from most peers, except for a couple of friends. Brandon also has recently shown lapses in his self-care, occasionally forgetting to shower or wear clean clothes to school.

Domain 4 – Impact of co-existing conditions

Brandon uses marijuana to try and 'chill out' - his few friends and their older brothers persuaded him to try marijuana for the first time at age 13. Since then, Brandon has consistently used marijuana with more heavy use (daily) over the past few months.

Domain 5 – Service use and response history

Nil history of seeking access to, or use of, services for a mental health issue.

Domain 6 – Social and environmental stressors

Brandon doesn't identify anything worrying him, but his parents report that the transition to high school was hard, and Brandon never really settled in. His parents report that he is often bullied and ridiculed by his school friends and believe that that is distressing him, although Brandon is reluctant to talk about it.

Domain 7 – Family and other supports

Brandon has very few supports beyond the immediate family, who are incredibly supportive and tolerant, despite his recent challenging behaviours. There are no connections with extended family.

Domain 8 – Engagement and motivation

Brandon's family are concerned and seeking assessment and support for their son. They have a limited understanding of what might be happening for Brandon but indicate a willingness to do whatever is required to help him. Brandon has not expressed any interest in getting help but is not likely to actively resist attending services.

MARLA

Link to online DST- https://iar-dst.online/#/

Marla is a 12-year-old girl living with her mother in a three-bedroom public housing complex in a large city. She has two brothers, aged six years and six months, respectively.

Domain 1 – Symptom severity and distress

Marla has trouble sleeping and usually ends up in her mother's bed at night. She often appears sad but brightens up when interacting with her baby brother. She appears disinterested in the toys and other activities. Marla makes minimal eye contact and refuses to stay without her mother present in the room, usually breaking into tears if left alone. Marla is extremely shy and stays close to her mother, often fussing over the baby. Her mother has become concerned about Marla's future and has approached her GP for advice on what to do.

Domain 2 - Risk of harm

Nil risk issues identified.

Domain 3 – Functioning

Marla has lost all interest in attending school and has been spending most of her time at home helping her mother with the baby. Previously, she had been described as a pleasant student and achieved average grades, with good physical health and normal developmental milestones. Marla's mother is concerned about her school refusal and admits her school attendance has also been patchy over the last 12 months. She has no friends.

Domain 4 – Impact of co-existing conditions

No co-existing conditions.

Domain 5 – Service use and response history

Nil history for Marla or her family.

Domain 6 – Social and environmental stressors

In the last 12 months, Marla has suffered the loss of her maternal grandmother, aged 54 years, through chronic illness, her father, aged 30 years, from an acute myocardial infarction and a male cousin aged 16 years from suicide. Her sister died three years ago from sudden infant death syndrome, aged 13 months. The housing estate on which Marla lives is a site where there are often violent attacks and a high prevalence of drug use.

Domain 7 – Family and other supports

An extensive family system supports Marla's family with several aunties and paternal grandparents, and there are often additional relatives staying in the home.

Domain 8 – Engagement and motivation

Marla's mum is nervous about engaging with services. Marla's mum has been happy to keep Marla at home rather than send her to school and is worried about the repercussions of this decision. Marla's mum is concerned that she might be in trouble with Family and Community Services and doesn't want Marla on their radar.

LUCY

Link to online DST- https://iar-dst.online/#/

Lucy is a 17-year-old high school student.

Domain 1 – Symptom severity and distress

Lucy reports feeling very anxious for the past seven months, with restlessness, 'feeling hyped up,' and worried about things outside of her control (e.g., the covid pandemic). Lucy is not sure if she has had a panic attack but reports experiencing feeling overwhelmed by panic on occasion, with trouble breathing. The symptoms are not improving.

Domain 2 – Risk of harm

Lucy has occasionally cut her arms but only superficially. She explained this as how she deals with elevated levels of stress. She says she has never contemplated taking her own life.

Domain 3 – Functioning

Lucy's mental health is impacting her interest and commitment to school. Lucy reports that she has missed several classes each week and handed in assignments late. Lucy reports that she does not like the online learning arrangements. She has a good friendship network and sees her friends regularly.

Domain 4 – Impact of co-existing conditions

Nil

Domain 5 – Service use and response history

Lucy received assistance from a psychologist during her childhood following a sexual assault. She remembers this as helping her a lot.

Domain 6 – Social and environmental stresses

Lucy is uncertain about continuing at school. Lucy is experiencing course-related pressures (high study workload and exam stress). Lucy would prefer to commence an apprenticeship in jewellery. Lucy has a history of childhood sexual assault from age 5-7 perpetrated by a neighbour.

Domain 7 – Family and other supports

Lucy's family is loving and supportive and are eager to see Lucy feel better.

Domain 8 – Engagement and motivation

Lucy has a strong desire and commitment to feel better. GP notes that Lucy is highly motivated and is keen to access a service as soon as possible.

Appendix 9 – Training Scenarios – Children

CHARLIE

Link to online DST- https://iar-dst.online/#/

Charlie is a 9-year-old boy who lives with his mother, Kate and father, Chris. Chris is a real estate agent, and Kate works part-time in administration. Charlie has no siblings.

Domain 1 – Symptom severity and distress

Kate (mum) is becoming worried about Charlie as she has noticed he has changed over the past couple of months. He doesn't seem himself, spending more time in his room or the shed with Rex's old things. Rex was the family dog who died of old age about three months ago. Kate has noticed Charlie has wet the bed on occasions over the past few months, something he has not done for years. She has not talked with him about this as he hides his wet pyjamas under his bed. He is increasingly getting into trouble at school for distracting the class or starting arguments. At home, he has started to shout at his parents over minor things and has temper outbursts where he throws things at them or smashes toys on the ground.

Domain 2 – Risk of harm

Nil identified risk.

Domain 3 – Functioning

At school, Charlie has typically been a below-average student. Still, his teachers have noticed that his performance in school tasks has deteriorated and is now far below his year level. He also displays some challenging behaviours (distracting the class, argumentative). Kate has met with the school upon their request; however, no clear explanation for the recent changes in Charlie's behaviour was identified. Kate's neighbour urges her to 'control' Charlie or diagnose him with ADHD.

Domain 4 – Impact of co-existing conditions

Charlie's parents recently discovered that he had drunk a small amount of alcohol in the park with a few older teenagers, but this seems to have been a 'one-off event.' The school has mentioned ADHD several times to Kate; however, she has not investigated this because Chris refuses to accept ADHD as an "actual" condition, believing that 'bad behaviours' can be 'sorted out' with discipline.

Domain 5 – Service use and response history

Nil history of seeking access to, nor use of, services for a mental health issue.

Domain 6 – Social and environmental stressors

Lately, Charlie has been hearing Chris scream at his mother at night-time. Chris says that Kate is 'useless' and 'stupid.' Charlie is worried his dad will hurt his mum because he has heard him threaten her.

Chris exerts a strong influence over the family in terms of the financial and social decisions, which can leave Charlie and Kate feeling like they don't have much say.

Domain 7 – Family and other supports

Charlie and his parents are estranged from the extended family. Kate has excellent support from the neighbours and the local church. Charlie has some neighbourhood friends that he enjoys riding bikes with. Charlie joins in Sunday school but reports not liking it. He says his mum helps him but feels intimidated by his father.

Domain 8 – Engagement and motivation

Kate is motivated to seek support for Charlie; however, Chris does not agree to a referral at all under any circumstances. Chris does not believe there is a problem and does not support Kate's concerns about Charlie's behaviours.

NOAH

Link to online DST- https://iar-dst.online/#/

Noah is a 9-year-old boy who lives at home with his mother (Amy), father (Ray), and 10-year-old sister (Jesse). Both parents have been unemployed for more than a year and live on basic government income support.

Domain 1 – Symptom severity and distress

Noah attends a support unit in a mainstream school. Due to his learning difficulties, Noah requires moderate support, instruction and prompting around aspects of daily living (personal care, social skills, and keeping safe). To communicate, Noah has traditionally used a combination of speech (simple, short sentences), some keyword signs, communication boards and books, facial expressions, body language, vocalisations, gestures, and eye contact. Since Noah was three years old, he and his parents have participated in speech therapy.

Noah's behaviours have become much more challenging for at least the last year. His parents find it difficult to settle him down to bed at night, and he wakes around 5 am. He hits, pinches, and scratches his sister and parents much more frequently, and his parents find it harder to help him calm down. He sometimes cries for extended periods during and after an aggressive incident. There have been a few incidents at school this year where Noah has pinched and pulled the hair of a couple of other students. Overall, Noah seems more irritable and easily distressed by various triggers. He doesn't seem to dance as much as he used to, he often has an angry or sad facial expression, and he seems restless (pacing).

Domain 2 – Risk of harm

Noah's teachers have told his parents that some of his behaviours pose a risk of harm to others. Charlie's sister fears his temper outbursts.

Domain 3 – Functioning

Since a very young age, he has communicated unmet needs through his behaviour. Frequent, uncontrollable meltdowns, non-compliance with reasonable requests, and physical aggression (hitting, pinching, pulling hair, scratching) towards his parents, sister, teachers, and paid carers have been challenging for caregivers. His family and support people were able to manage these with behaviour support strategies like managing his environment (for noise, temperature, and other triggers), developing predictable routines, working on communication between Noah and communication partners, and developing consistent responses to behaviours.

Over the past year, his teachers and family have also noted that he requires more one-to-one support, repeated instruction and prompting to complete activities as he becomes easily distracted or else restless.

Domain 4 – Impact of co-existing conditions

He has a moderate intellectual disability, and he takes medication for epilepsy and attention deficit hyperactivity disorder. He has lots of energy and is affectionate with people he likes, seeking lots of hugs and interaction. He loves dancing, swimming, and "playing tricks" on people to get a laugh out of them.

Domain 5 – Service use and response history

Noah has accessed behavioural supports through the school and accessed early intervention support services before starting school. After initial problems in his acceptance of the interventions, he adjusted well to the ongoing support offered. Noah has not accessed mental health services previously.

Domain 6 – Social and environmental stressors

Noah has not reported any worries or concerns to his parents or schoolteacher. He talks about his family not having enough money and their worries about being evicted from their rented house. The family often seeks help from welfare agencies to feed the children.

Domain 7 – Family and other supports

Noah's sister, Jesse, has developed some mental health difficulties (anxiety and tic disorder). She and her parents have been seeing a psychologist for support around these for about a year.

Both parents display warmth and care for Noah and Jesse but talk about feeling exhausted and overwhelmed. Amy experienced postnatal depression after the birth of both children. Although she returned to work part-time when Noah was 18 months old, it was challenging to juggle work with Noah's daily care needs while coordinating his support. She ceased work three years ago, and while both parents agree this

was necessary for them, their low income causes stress. Ray often looks for odd jobs but only obtained these occasionally. Most of their family live interstate, except for Amy's mother, who was once extremely helpful to the family but is ageing and developing health problems.

Domain 8 – Engagement and motivation

Both Amy and Ray advocate strongly for the school to arrange specific mental health supports for Noah. Amy would prefer additional services be introduced within the school environment, which reduces the burden on Amy and Ray to run Noah to appointments or be directly involved.

CRYSTAL

Link to online DST- https://iar-dst.online/#/

Domain 1 – Symptom severity and distress

Crystal is a five-year-old child who lives with her parents (Hayley and Lewis). Crystal is having tummy pains, and Hayley describes changes in Crystal's mood (described as "down" and "sadder") and explains that she has been unusually withdrawn over recent months. She has shown little interest in doing things that she previously enjoyed.

Domain 2 – Risk of harm

Nil risk of harm.

Domain 3 – Functioning

Crystal is in kindergarten, and her teacher is pleased with her schoolwork and behaviour in class, but Crystal's shyness impacts her ability to form friendships. Crystal typically hangs around the teacher on duty or sits on her own. She has met typical developmental milestones for her age.

Domain 4 – Impact of co-existing conditions

Crystal has good physical health and no co-existing issues.

Domain 5 – Service use and response history

Nil history of seeking access to, or use of, services for a mental health issue.

Domain 6 – Social and environmental stressors

Crystal's parents say they are both trying hard to be good parents, providing basic material support. Still, there are many obstacles in their way, including poverty, Lewis's drug addiction and Haley's frequent episodes of depression. Haley and Lewis have been arguing lately, and Crystal regularly witnesses this.

Domain 7 – Family and other supports

Crystal's parents have an extensive social network, few of whom would be considered productive and supportive. These networks are predominantly recreational and social activities in which the primary activity with Haley and Lewis is drinking and drug-taking.

Crystal is very fond of her class teacher and has several 'big' cousins whom she loves spending time with and being babysat.

Domain 8 – Engagement and motivation

While Haley and Lewis express interest in getting help for Crystal, they are ambivalent because it might bring attention to their lifestyle.

End