PMHC

Information System

Documentation centre

Help Documentation support

by PMHCIS Team

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1. Medicare Mental Health - Help Documentation

We acknowledge the traditional owners of the land on which we work and live. We pay our respects to their Elders past, present and emerging, and extend that respect to all Aboriginal and Torres Strait Islander people.

1.1 Foreword

Training videos - Introduction

Training videos - Documents and links

Medicare Mental Health centres operate throughout the Primary Health Network (PHN) Network, an Australian Government initiative.

Medicare Mental Health is a mental health service available funded by the Commonwealth government. The Medicare Mental Health phone line offers mental health service navigation for people unsure of where to seek appropriate services and supports for themselves, or a person they care for (e.g. G.P).

The Medicare Mental Health phone line is a free centralised phone number that prompts the caller to enter their postcode to be directed to the local intake for their Primary Health Network (PHN) catchment.

If appropriate, the caller will undertake an intake assessment, exploring their mental health history, risk, preferences and other factors which will indicate an appropriate level of care.

This care may be delivered by one of the Medicare Mental Health Hubs, from other PHN commissioned services, or external services such as digital mental health services (including those available through Medicare Mental Health), hospital-based care, Better Access, Community Managed Organisations, or specialist treatment options. The Medicare Mental Health service can support the person to access that care.

This document is to ensure consistency across the Medicare Mental Health intake points so that a consumer will experience the same intake approach, regardless of their first point of contact.

January 26, 2026 12:21:14

2. PMHCIS training videos

PMHCIS training videos links

Please use the following links to view the PMHCIS training videos stored on Vimeo.

1. Introduction This video is an introduction to the video training series.
2. Requesting access This video outlines how to request access to the PMHCIS, what to do when you first log in, the staging instance of the PMHCIS and first point of contact for support.
3. Logging in This video outlines the landing page of the PMHCIS and the incomplete contacts, incomplete referrals and to be actioned lists that are used to manage clients.
4. Documents and links This video outlines the key training and guidance resources and how to access them in the PMHCIS.
5. Feedback and support The video outlines how to provide feedback or request support for the PMHCIS.
6. Overview of the intake process This video outlines the intake process from contact, client, assessment to referral out.
7. Contacts This video outlines contact records, the mandatory fields required, checking for existing contacts, and adding documents and notes.
8. Clients This video outlines client records, the mandatory fields required and communication consent.
9. Referral This video outlines referral records, the mandatory fields required, the IAR-DST, risk assessment, notes, consent, tags, multiple referrals and sending referral outcomes.
10. Referral to MMHCs using the PMHCIS This video outlines the process for sharing referrals to MMHCs using the PMHCIS
11. Referral to other providers This video outlines the process for sharing referrals to other treatment service providers who do not have access to the PMHCIS.
12. Accepting referrals as an MMHC This video outlines the process for MMHCs using the PMHCIS to action and accept referrals they receive from the MMH phone service.
13. API out This video outlines the API out of the PMHCIS that supports integration with various treatment client management systems.
14. Follow up This video outlines the 7 day follow up function and process within the PMHCIS.
15. Reengaging This video outlines the suggested actions to support contacts and clients reengaging with the MMH service, including the options to abandon and merge records.
16. Landing page This video outlines the landing page, including the search functionality, landing page lists, follow up dates and notes and reports.
17. Other (organisation and template management) This video outlines managing organisations and IAR-DST and note templates.
18. User account management This video outlines how PHN admins can manage and create new user accounts.
19. PMHC-MDS upload This video outlines how PHN admins can download PMHC-MDS conformant intake data from the PMHCIS to upload to Logicly.
20. PowerBI reports This video outlines how to access the PowerBI reports that NWMPHN produces using the data collected in the PMHCIS.
21. Closing This video finalises the PMHCIS training video series.

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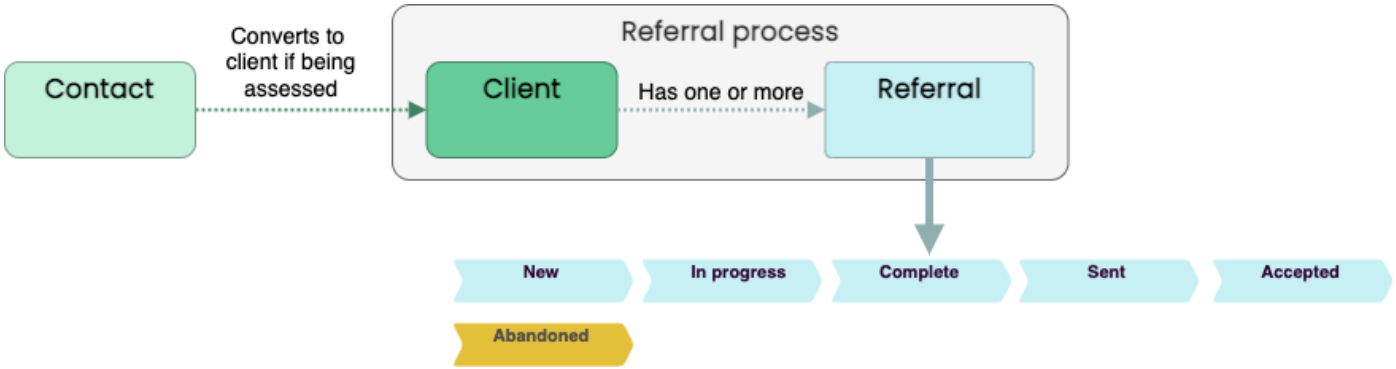
3. Overview of intake process

Training videos - Overview of Intake Process

As shown below, the consumer journey starts in the Intake Module with the creation of a **Contact** record. If the consumer requires assessment/referral, then their record is converted to a **Client**, and a **Referral** record is automatically created. **Contact**, **Client**, and **Referral** each has its own screen. The **IAR-DST** is done on the **Referral** screen.



Process overview

At any point in time, the **Referral** has a particular status. The status depends on the information that has been entered, until it is sufficient to be **Completed**. Once Completed, it can be **Sent** and **Accepted**. Once an assessment has started, sometimes a client may disengage for various reasons. When that happens, the Referral is closed off by being abandoned and is excluded from reporting. For more information about the referral timeline, refer to the Status of Referrals help page.

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4. System Access

Training videos - Requesting access

Training videos - Logging in

4.1 Log in

Open https://pmhcis.intake.org.au/, then log in with your email and password.

If you don't have access, have forgotten your password, or didn’t receive a password, contact your PHN Admin/Intake Manager.

You can also use the ‘Forgot Password’ link on the login page to reset your password.

To protect the confidentiality of clients it is important that you do not share your password with others, even colleagues within your organisation. If a colleague needs access, always refer them to your PHN Admin to request access.

4.2 Passwords

When your account is set up, you will be provided with a default password. When you first log in, you will be prompted to reset your password.

Your password should be a strong password that complies with your PHN/commissioning PHN’s password policy and is a minimum length of 10 characters. Your log in credentials should be stored securely, and you must not allow anyone else to log in using your credentials.

You can reset your password at any time by logging in and clicking on your name in the top right corner to access the Profile details screen, in which you can click the **Change password** button.

4.3 Multifactor Authentication

When you first log in, you will be prompted to set up multifactor authentication. This can be using an authenticator app (e.g. Microsoft Authenticator, Google Authenticator), SMS or email.

You can change this at any time by logging in and clicking on your name in the top right corner to access the Profile details screen, in which you can click the **2FA settings** button.

4.3.1 Staging/Training/Demo/Test access

The staging system is an exact replica of the main system, except that it has test client data. If you want to enter test data, conduct training, or do a demo, you must use the staging system, not the live system, to avoid contaminating the reporting and analysis with test data.

The link to staging is: https://pmhcis-staging.intake.org.au/. As above, contact your PHN Admin if you don't have access or your user account is inactive.

4.4 Log out

Go to the top-right corner of the landing page, click the [your name] menu item and click **Log out**.

As the system collects personal information about consumers, ensure that you log out whenever you are not actively using the system. Note that the system will automatically log you out after 3 hours.

4.5 Deactivation

Accounts are automatically deactivated if a user does not log in and access a consumer record within 90 days. Users will receive an automated warning 7 days before deactivation. If you receive this warning and do not log in, your PHN admin can reactivate your account.

4.6 Support

All requests for user account support should go to your PHN Admin/Intake Manager in the first instance before contacting pmhcis.support@nwmphn.org.au.

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5. Search

Training videos - Landing page

The main way to search is on the landing page when you log in.

Search

This searches on both Contacts and Clients. The fields it includes in the search are:

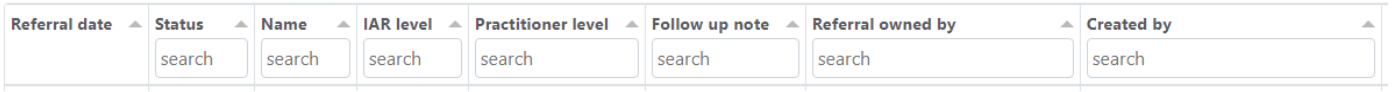
- Contact ID
- Client ID
- First name
- Preferred name
- Family name
- Date of birth
- Phone

*Note that the system **does not** search on Contact records that have been converted to a Client.*

When you see search results, Client records will display with **bold lettering**, and Contact records will display with *italicised lettering*.

Note if you are not in a clinician role (i.e. when you view records, you can't see identifying or sensitive information), then you will only be able to search on Contact ID or Client ID.

Another way to search is when you see lists of records. The screenshot below shows the columns for the **Incomplete Referrals** list. To search a column, click in the box with "search" inside it and then type a search term.



Incomplete Referrals columns

January 26, 2026 14:38:37

6. Contacts

Training videos - Contacts

6.1 Introduction

The first data entry point in the Intake System is to create a **Contact** record. A Contact record has information about the person who contacted the service, particularly the purpose of contacting. If an assessment is required, the Contact is then converted to a **Client** record.

For information about contacts created by the Medicare Mental Health national website see **Callback requests**.

6.2 Creating a contact

On the main page of the intake system is the **New Contact** button.

New Contact button

This displays a pop-up screen to collect the details about the contact.

Note: You don't have to record the consumer's details. The call may be on behalf of another person. The contact type should describe the person calling, not the person on whose behalf they are calling. This may need to be updated to the consumer's details if the contact is converted to a client record however.

6.3 Completing a contact

A Contact record will remain in the **Incomplete contacts** list on the main screen until it is completed. There are two ways to complete a Contact:

1. Open the Contact record, enter values in the Pathway, Contact type, Nature/purpose of contact and Outcome fields, and save the record. As soon as it's saved, it will disappear from the incomplete contacts list.
2. Convert to a Client (see next section below).

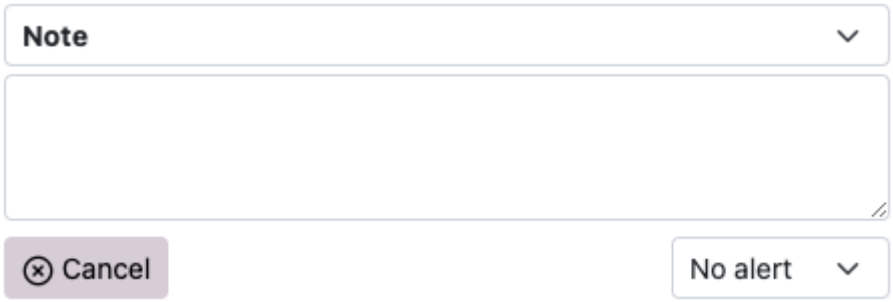
For those contacts who need information, require a call-back, or no longer wish to proceed, their outcome needs to be recorded. This is useful in reports, for understanding who is contacting the service and why.

If the Contact is converted to a Client then the outcome is automatically set to "Converted to Client" by the system.

6.4 Notes

Once a Contact is saved for the first time, notes can be added to the record.

To create a note, click the "New note" button and fill in as required. Click the "Save" button at the bottom of the Contact screen to save the note.



New note

Different types of notes can be added. The note types that show by default are:

- Note
- Callback attempt

Another note type called "Summary" is available. There can only be one Summary note entered, and it will always appear at the top of the list of notes. If your team would like this note type, send in the request to pmhcis.support@nwmphn.org.au

The system logs the date/time a note is created and changed and which user made the change. To see the change history, click on the underlined date next to the note type:

See note history

You can control the notes you see by clicking the link at the top right of the notes list. It will indicate that you can show all notes or show the most recent note. Filter buttons are at the top of the list so you can filter by the note type.

6.4.1 Alerts

Each note can have a **Low** or **High** alert. The alerts are flagged when the Contacts are listed. If the contact has a High alert, the row will be coloured red. If Low, it will be coloured yellow. If alert notes are present, a link appears at the top of the Contact screen to filter the list of notes immediately to the alert notes.

6.4.2 Legacy note field

An earlier version of the Contact screen included a "Notes" field. This is now hidden by default. If information was entered in this field, it automatically displays in the list of notes as a "Legacy note". This note type can't be edited.

There is a configuration that enables this field to be displayed. If you would prefer to see this field, send in the request to pmhcis.support@nwmphn.org.au

6.5 Print contact

Click the "Print" button to view a print-friendly view of the full Contact record. It will automatically activate your computer's Print function. On the right-hand side of the page is a "Copy URL" button. This can be used if you need to send a link to the Contact to someone else.

6.6 Converting contacts to clients

If the person needs to be assessed and referred and they are comfortable to proceed (and they have not previously engaged with the service), their Contact record needs to be converted to a Client record.

First check to see if they have contacted the service before (there may be an existing contact) or have a previous consumer file within the PHN's available Client Information Management System (CIMS). Refer to **Consumers re-engaging after discharge > Process for multiple referrals within a client record**.

To convert, the Contact record must have values for these fields saved:

- First name
- Last name
- Date of birth (enter 9/9/9999 if unknown)

If these fields are present, the **Convert** button will appear.

Converting contacts

When the **Convert** button is clicked, you will be asked to confirm that you wish to proceed. If you proceed, the Contact record will automatically be updated with an *Outcome* of "Converted to client" (and if the *Nature/purpose of contact* field is not entered, it will be set to "Mental health assessment"). From this point in time, the Contact record can no longer be updated. The system will also automatically create a Client record and a related Referral record. Some of the information from the Contact record is used to pre-fill data in the Client and Referral screens.

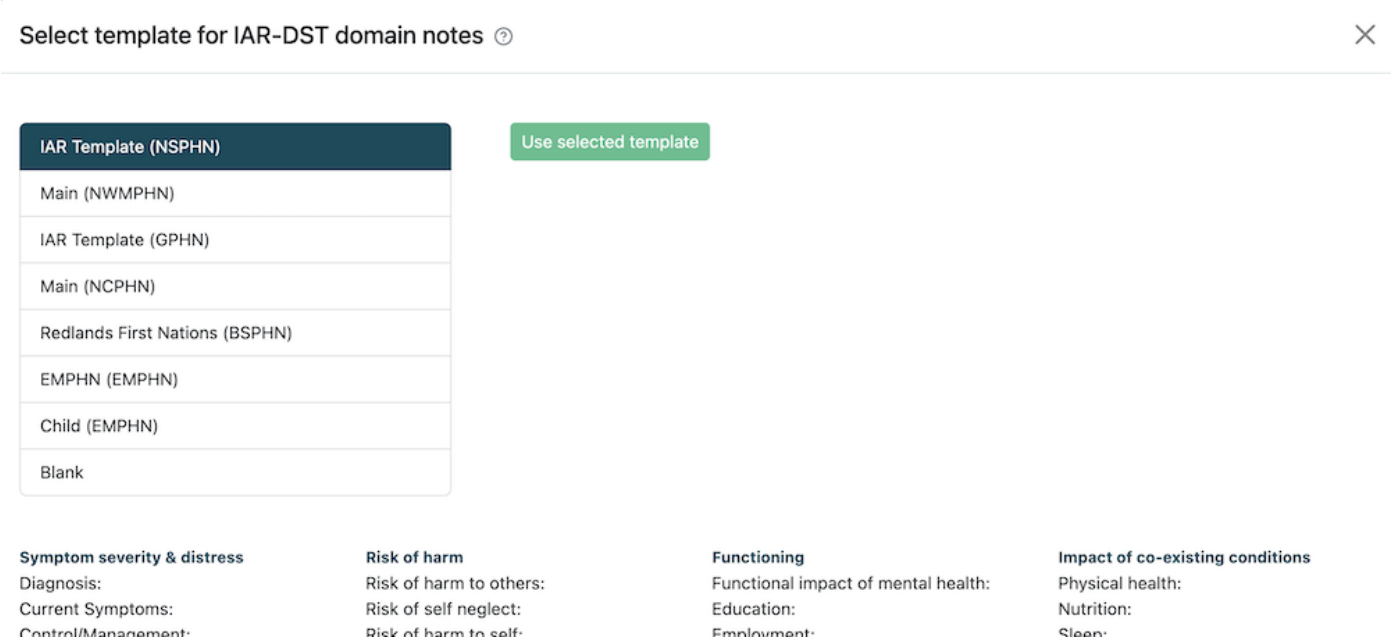
6.7 IAR-DST note templates

You can select an IAR-DST note template when converting a Contact to a Client. At the point of conversion, and if a template is set, then it will be applied to the notes for the IAR-DST domains in the Referral screen.

If an organisation that your user account belongs to has created one or more templates, you can set your default template. To set the default, go to your Profile Details screen. Then choose a template in the **Default IAR note template** field and then click **Save**.

Some organisations have multiple templates. The system enables you to override your default template and choose a different template when you convert to a Client. You can preview your templates or select a blank template.

The screenshot below shows an example of what the IAR-DST template chooser looks like. If you would prefer to see the IAR-DST template chooser when you convert, switch on the **Enable IAR template selection** field and click **Save**.



IAR-DST template chooser

6.8 Third party callers

Third party callers are those who are seeking help information on behalf of a person they are supporting. In most cases this would be considered a service navigation call which is recorded as a contact in the webform.

When receiving a call from a third party for intake to a service:

- Ask the caller to provide the Medicare Mental Health contact information to the person they are supporting and encourage the consumer to call directly in order to complete the IAR-DST, or ask if they have consented to be contacted directly by Medicare Mental Health.
- It is important that where possible an IAR-DST is completed with the consumer directly, in order to obtain informed consent and a true picture of their individual's experience.
- If the consumer is not providing consent, the support navigation with the caller may continue, but the notes will remain recorded as a contact, and the IAR-DST cannot be completed.
- If the caller is calling on behalf of an underage child, or someone they are guardian/ power of attorney for, then an IAR-DST can be completed based on their knowledge of the child/consumer.

6.9 Callers from another PHN intake catchment

If a caller is from another PHN catchment area, and they contact your intake team:

1. In the first instance, when a person residing outside of your PHN catchment, they should be warm transferred through to the appropriate local intake team to complete the IAR-DST (see phone numbers of the intake teams below). Please do not ask them to call 1800 again and put in the correct postcode.
2. If the warm transfer can't be completed, then the consumer can be given the choice of either leaving a message with the correct local intake team or having the IAR-DST completed with the out of catchment intake team and then transferred across to the local intake team should follow up/ referral be required.

6.10 Callers seeking service from another PHN catchment

Preferably, an intake should be undertaken with a consumer by the PHN/ hub intake where the person resides. The reason for this, is that is a person is not eligible for the Hub, then the intake will have a better understanding of other local services appropriate for the person based on their presentation.

If the caller is requesting support in a hub in another PHN catchment, the intake worker can liaise with the appropriate PHN intake team to discuss hub eligibility, and support the transfer of the IAR-DST if appropriate.

If the consumer is to be navigated to services other than the hub, the intake who has undertaken the IAR-DST can liaise with the other PHN intake to discuss local referral pathways or available support services if additional referral options are helpful for navigating that consumer.

In the event that the consumer cannot afford/ access similar service, so eligible for the hub, however the hubs within catchment do not have capacity (and are operating a wait-list) the intake team should be looking at other local support options, such as Stepped care services, general counseling options, bulk billing Better Access Providers, in preference to looking to other hubs out of catchment, in the first instance.

Hubs in other PHN catchments should only be considered when they are the most appropriate options for the consumer- for example, it is local to their place of work, or significantly closer to their home address.

6.11 Callers routed to an out of catchment Medicare Mental Health intake

At times, callers may be routed to an out of catchment PHN due to all staff being on calls within their local intake.

The caller should be advised that you are happy to complete the intake, however, you may not be fully cognisant of the local services, so you can arrange for the appropriate area to call them back to complete the IAR, or you can do your best to complete the intake at that time

Please do not ask the caller to ring 1800 again, and enter a new postcode.

If the person is requesting for the intake to be completed with their local intake, It is also vital that an initial risk assessment is completed with the consumer prior to requesting this call back, so there is no delay in accessing emergency care, in the event that the person is presenting with immediate risk.

6.12 Direct numbers for Medicare Mental Health Intake

Contact phone numbers of the Medicare Mental Health intake teams are available in the National Directory, accessed from the Documents & Links menu at the top.

Users who are in the "PHN Admin" role can change the phone numbers from the Admin > Organisations menu.

6.13 Handling callbacks

Local and national Medicare Mental Health websites may have the ability to forward callback requests to the appropriate intake team based on postcode entered for follow up.

Suggested Script: *'Good morning, I'm calling from Medicare Mental Health, a service to help people find mental health support. I'm just checking to see if you requested a call back from us recently?'*

a) 'You did? Excellent.' (continue with call) or

b) 'You didn't? We received a call back request in the name XXXX with number XXXXX? Is that correct? Would you like to speak to us about mental health support?'

I. 'No, OK. Thank you for your time and best wishes. Goodbye.'

II 'Yes' (continue with call)

If you are unable to reach the caller, it would be expected to try and make contact on 3 separate days/ times, which may include an SMS with the contact details for Medicare Mental Health, inviting a call back if consent has been provided.

Suggested SMS Script: *'Good morning, this is the Medicare Mental Health service, we recently received a message indicating that you would like a call back. We have attempted to reach you but have so far been unsuccessful. You are welcome to call us again during business hours from Monday-Friday on 1800 595 212 if we can be of assistance. Thank you.'*

6.14 Calls to be returned

If a consumer has indicated that they would like to participate in an IAR, but they wish to do this at another time, please undertake a risk assessment to ensure there is no immediate risk for them.

Suggested Script: *'We are able to call you back tomorrow at your preferred time to complete the assessment, can I ask about any current risk to yourself, to ensure you will be safe until we speak again?'*

If the consumer is indicating a risk of suicide, self-harm, or harm to others, depending on the immanency of that risk the consumer may to supported with a safety plan, or escalated to tertiary health (as appropriate).

April 9, 2026 15:54:50

7. Clients

Training videos - Clients

The Client screen records demographic data about the Client, as well as communication consents and next of kin contact details.

7.1 Intersex field

Intersex people have innate sex characteristics that don’t fit medical and social norms for female or male bodies, and that create risks or experiences of stigma, discrimination and harm.

Sex characteristics are physical features relating to sex, including chromosomes, genitals, gonads, hormones, and other reproductive anatomy, and secondary features that emerge from puberty.

7.2 Removing data from system

A client may have reason to request data about them is removed. Complete removal is not possible and would conflict with obligations to State law. In this situation, the preferred option is to redact personally identifiable information (PII).

If a client requests redaction, send a request to pmhcis.support@nwmphn.org.au, including the Client ID or Contact ID. The team will run a process that replaces PII fields in the record/s with "redacted". This means the record/s will no longer be able to be located using the person's name. If there is a Client record, the process automatically removes the linked Contact record.

January 27, 2026 12:35:04

8. Callback requests

8.1 Overview

The national Medicare Mental Health website enables a consumer to create a callback request that will appear in the Medicare Mental Health Intake System and be assigned to their local PHN.

The callback request process begins after the consumer completes a 'quiz', in which consumers answer questions about their mental wellbeing. The quiz was developed by Melbourne University and uses the Patient Health Questionnaire 9 (PHQ-9) and Generalised Anxiety Disorder 7 (GAD-7). The responses from a completed quiz are analysed using an algorithm and options for next steps are presented to the consumer.

If the quiz analysis results in a certain range of severity (approximately equating to IAR level 3 or 4), one of the options is to request a callback from a mental health service.

If the result indicates mild or no distress, then the website will suggest digital resources. For a severe result, the website will suggest urgent and digital options, in addition to the callback request. The urgent options include: 000, 24/7 crisis helplines (e.g. Lifeline), and State-based helplines and suicide prevention support services.

The national Medicare Mental Health Check In website enables a consumer to create a callback request that will appear in the PMHCIS and be assigned to their local PHN. The callback request process begins after the consumer uses the 'I need help now' button to request a call back from Medicare Mental Health while providing their postcode, preferred name, phone number and preferred contact days and time.

8.2 Notifications

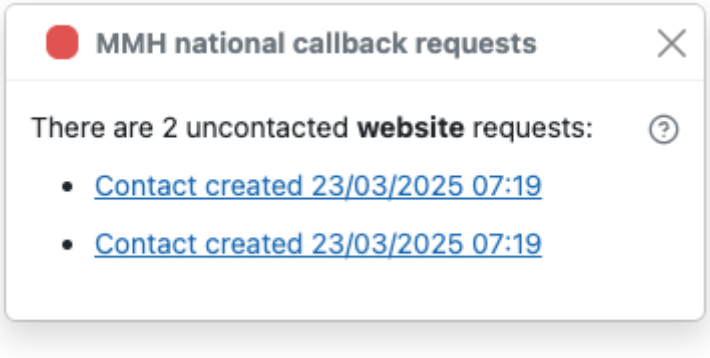
8.2.1 Pop up

When an intake user logs in, the system will check for **uncontacted callback requests** allocated to any of the PHNs the user's account is assigned to.

An uncontacted callback is defined as: an *incomplete* Contact created by the national website that has *less than 3 callback attempts*.

A Contact is completed when it is given a value in the **Outcome** field.

The screenshot below shows how the notification will look. It will appear in the top right of the screen. A user can click on the "Contact created ..." link to display the usual **Edit contact** screen.



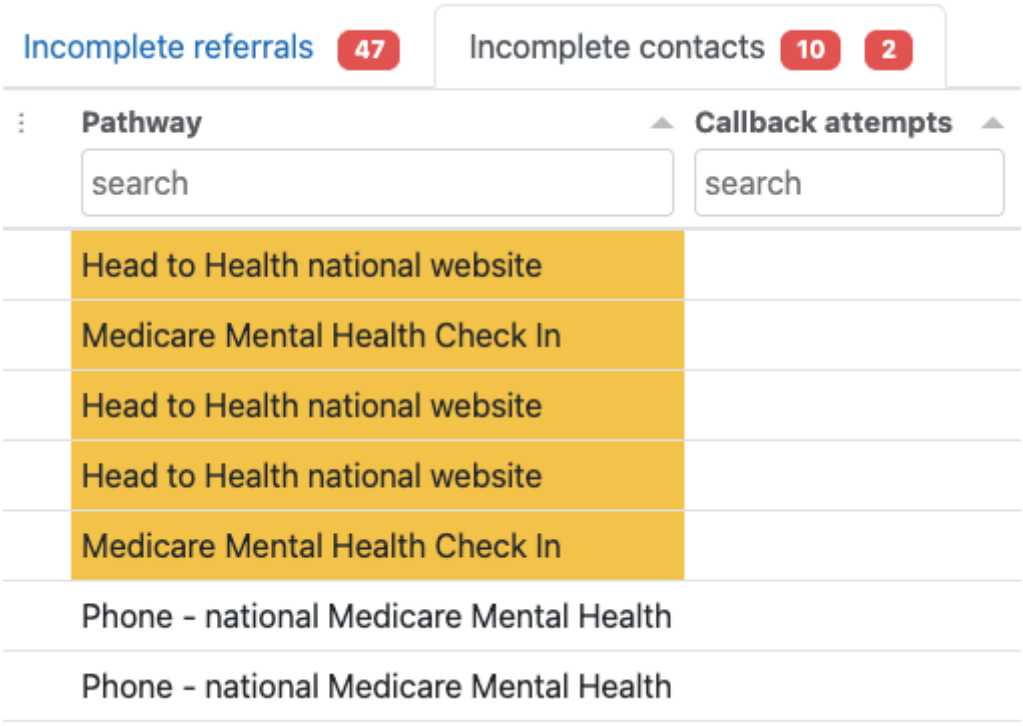
Notification Uncontacted requests

In the screenshot above, the user is logged in to North Western Melbourne PHN. Because that user is also able to see Eastern Melbourne PHN records and there are uncontacted EMPHN callbacks, the notification includes the contact created for EMPHN:

The NWMPHN contact cannot be viewed until the user switches to NWMPHN. The link beneath the “Contact created …” text will switch the user directly to NWMPHN.

8.2.2 Distinguishing between national website callback and Check In callbacks

To distinguish between national website callbacks and Check In callbacks, you can refer to the pathway field.



Callback pathways

8.2.3 Incomplete contacts tab

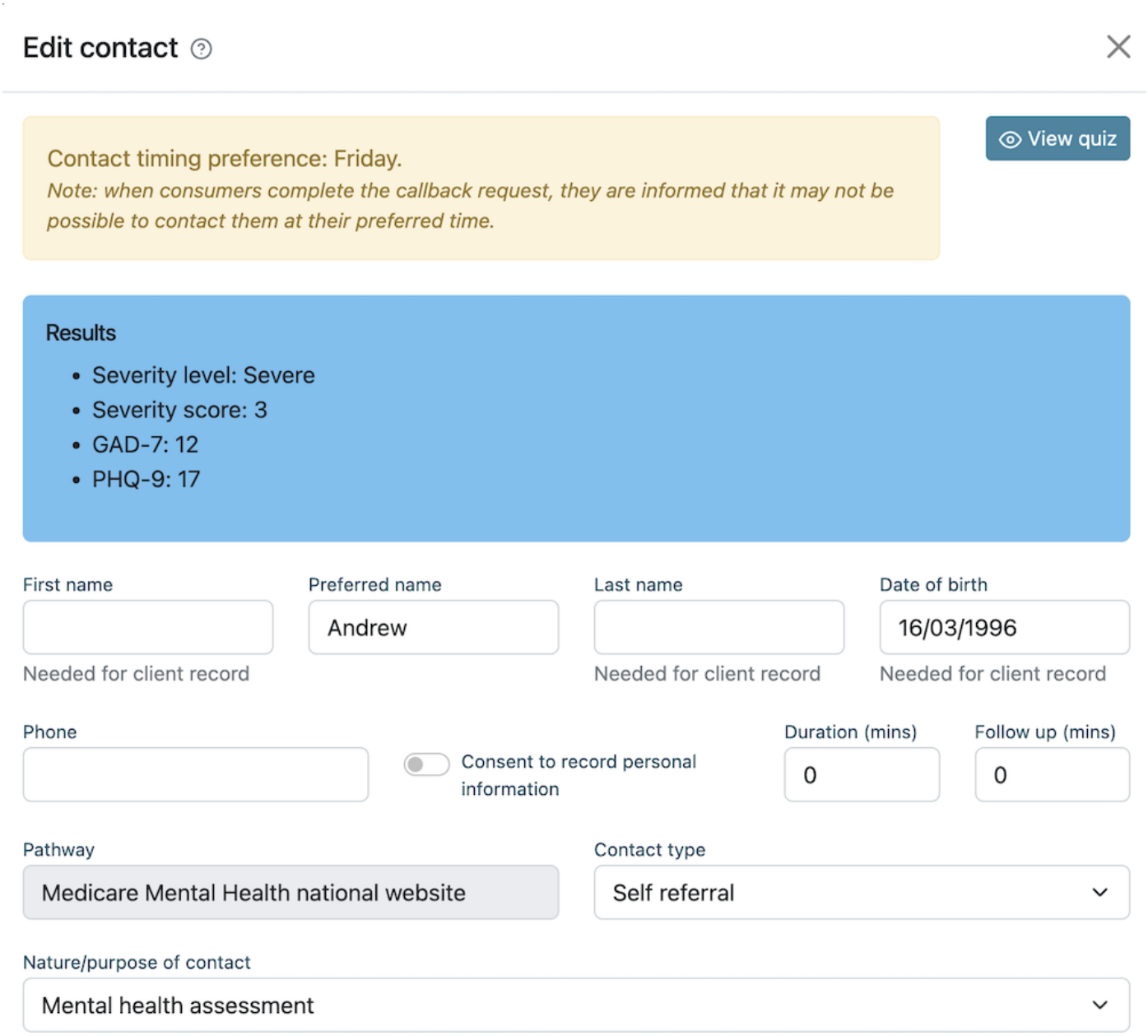
Another type of notification will be a new counter badge appearing next to the **Incomplete contact**s tab label. The screenshot below shows that there are 4 incomplete contacts. Of those 4, 1 is an uncontacted callback request.

Incomplete contacts tab

8.3 Edit contact screen

When a contact is created by the **national website**, the **Edit contact** screen displays information from the details completed in the national website form. Consumers will have the option of not sending their quiz data, so the details will only appear if they chose to share them. The screenshot below shows what the screen looks like when the consumer has specified preferred days of week/times to be contacted and shared their quiz data.

When a contact is created by the **Check In website**, the **Edit contact** screen displays information from the details completed in the form.

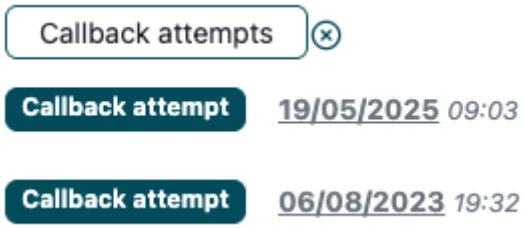


Edit contact screen.png

Note that the form on the national site only has a “Preferred name” field. It does not split the name into first/last. The **Pathway** field is filled in automatically and cannot be changed.

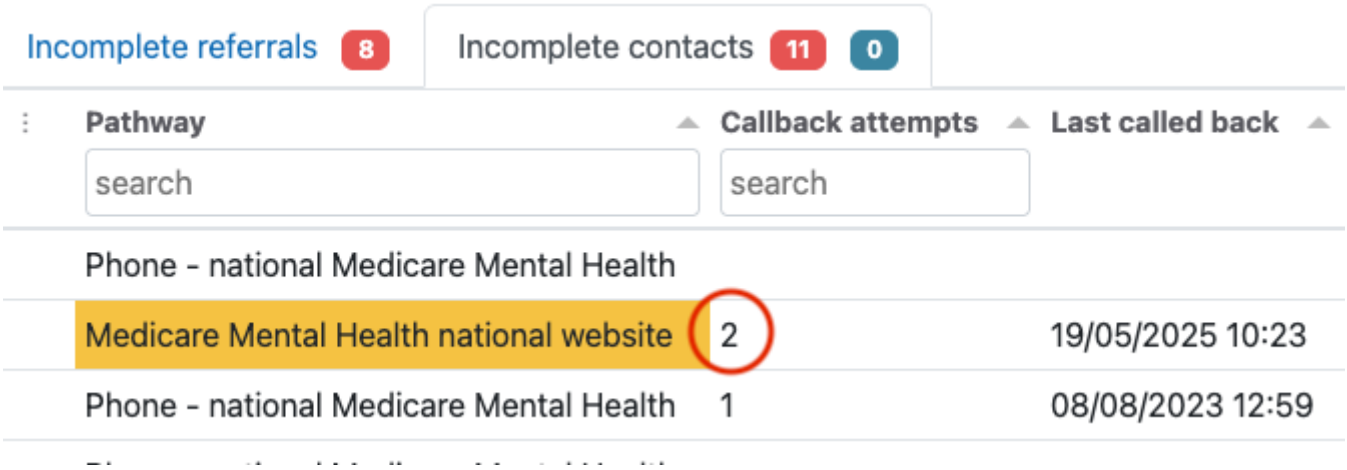
8.4 Callback attempts

Each time you attempt to call back a contact, you should enter a callback attempt activity. To enter an activity, add a new **Callback attempt** note. You don't need to write anything in the note field. When finished, save the Contact record. The screenshot below shows saved callback attempts.



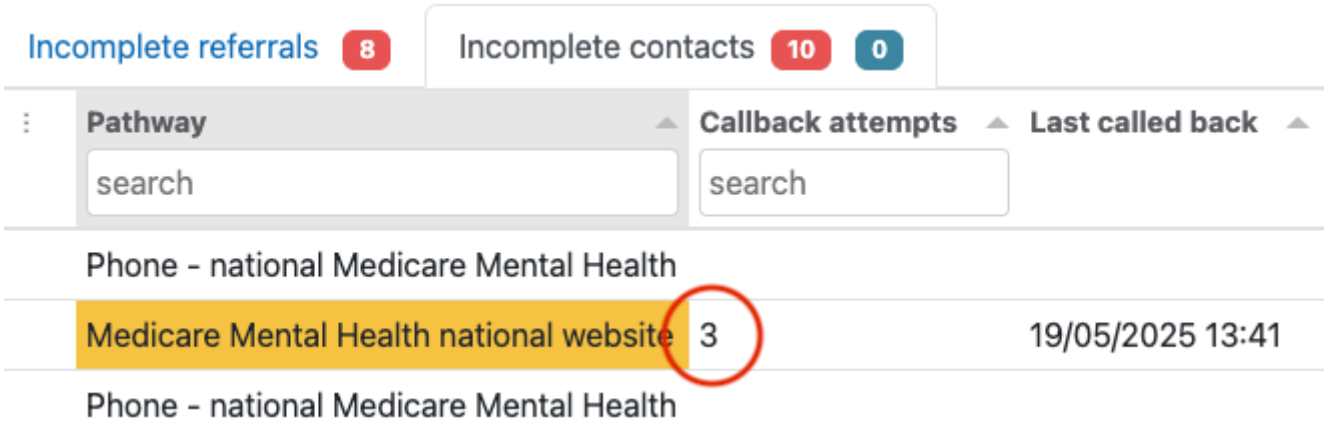
Callback activity

When you click on the **Incomplete contacts** tab, you will see that the **Callback attempts** column will keep track of the number of callbacks:



Callback attempts indicator

Once 3 callback attempts are made, the Contact will no longer be considered an uncontacted callback. It will disappear from the notification pop up and the badge number will reduce by one. The screenshot below shows the **Incomplete contacts** tab with no uncontacted callbacks.



Callback attempts indicator attempts

8.5 Completing a callback

In all other respects, a callback request Contact is the same as other Contacts. It will be removed from the **Incomplete contacts** tab when it has been completed (i.e. it is saved with a value in the **Outcome** field).

8.6 Progressing to a referral

From here, contacts and referrals are managed as usual, given the Check In is not currently available as a referral outcome. Please refer to scripts provided by DoHDA to advise consumers of this and suggest alternative options for support.

8.7 Further information

NWMPHN can support with questions on technical functionality of the callback requests and related records within the PMHCIS, please contact us at pmhcis.support@nmwphn.org.au

April 9, 2026 15:06:26

The **Medicare Mental Health Check In** (MMHCI) program provides low intensity mental health support for people experiencing mild mental health challenges or transient distress. Access to MMHCI is via the Medicare Mental Health phone service. The PMHCIS supports users to assess eligibility and determine the appropriateness of MMHCI for each help seeker. Eligible individuals are referred to the MMHCI provider, St Vincent's Health Australia (SVHA), for treatment, including guided or self guided low intensity Cognitive Behavioural Therapy (LiCBT). Referral to the MMHCI service from the Medicare Mental Health phone service is support through API integration from the PMHCIS to SVHAs systems.

All clinical and operational questions about the MMHCI treatment services should be directed to mmhci_delivery@svha.org.au

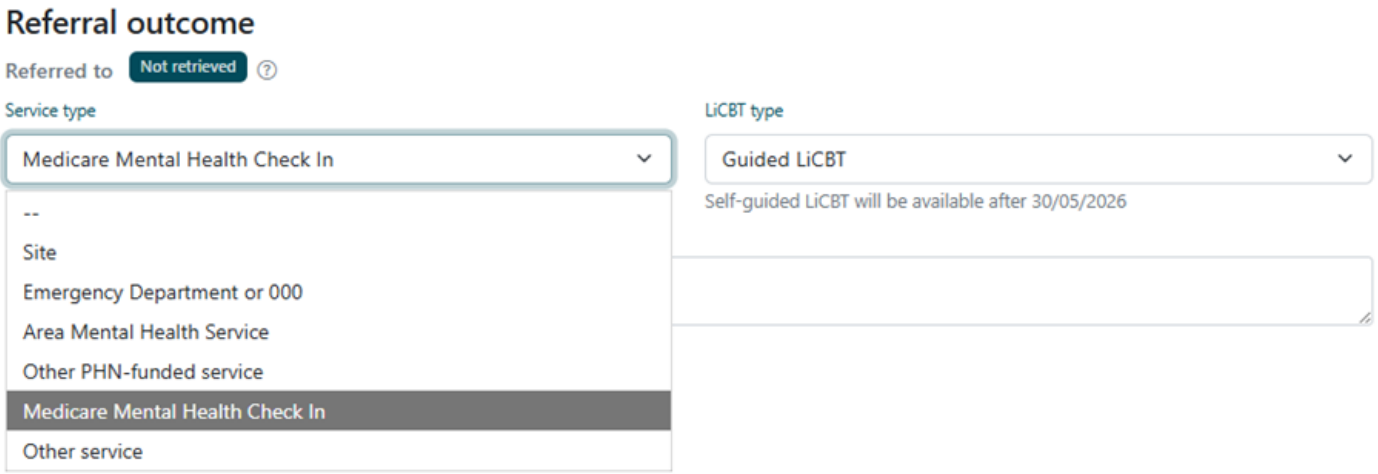
9. Referring to Medicare Mental Health Check In

9.1 Determining eligibility for "Check In" a Referral Outcome option

The conditions to display Medicare Mental Health Check In (MMHCI) as a referral outcome in the PMHCIS include: 1. Client is being referred from the Medicare Mental Health phone service 2. Client is over 16 3. The Derived Level of Care (LoC) is 1 or 2 The derived LoC is the Practitioner LoC if it is provided, otherwise it is the Recommended LoC. Clinical judgement should drive the decision to refer help-seekers to MMHCI.

9.2 Consumers eligible for Check In

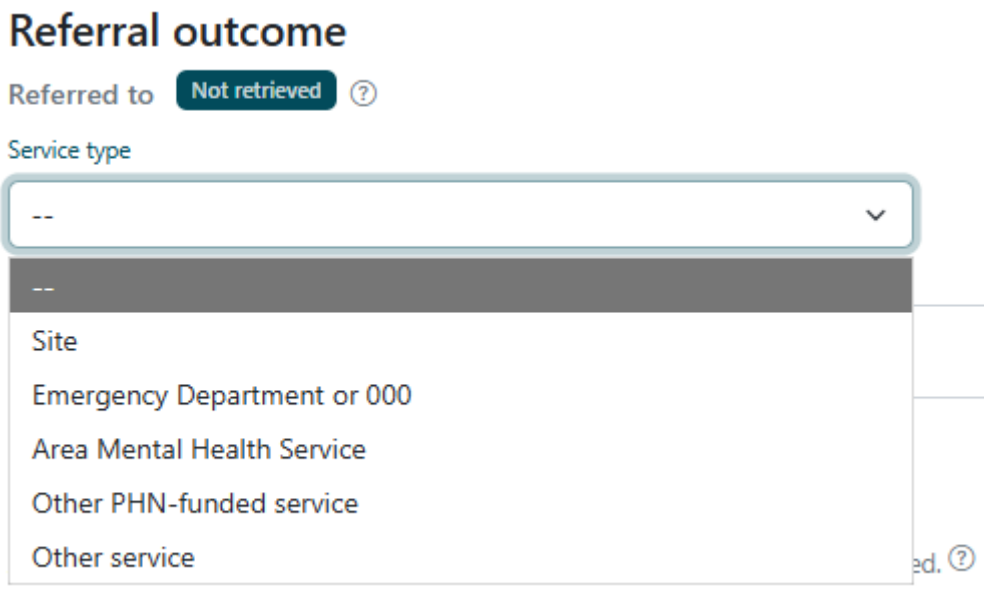
If a consumer meets the eligibility criteria for the MMHCI (Consumer is LoC=1 or 2 and 16+ years of age) MMHCI will be displayed as an option in the Referral Outcome drop-down box.



Eligible for Check In

9.3 Consumers not eligible for Check In

If a consumer does not meet the eligibility criteria for the MMHCI (Consumer is LoC greater than 2 and under 16 years of age) MMHCI will not be an option in the Referral Outcome drop-down box.



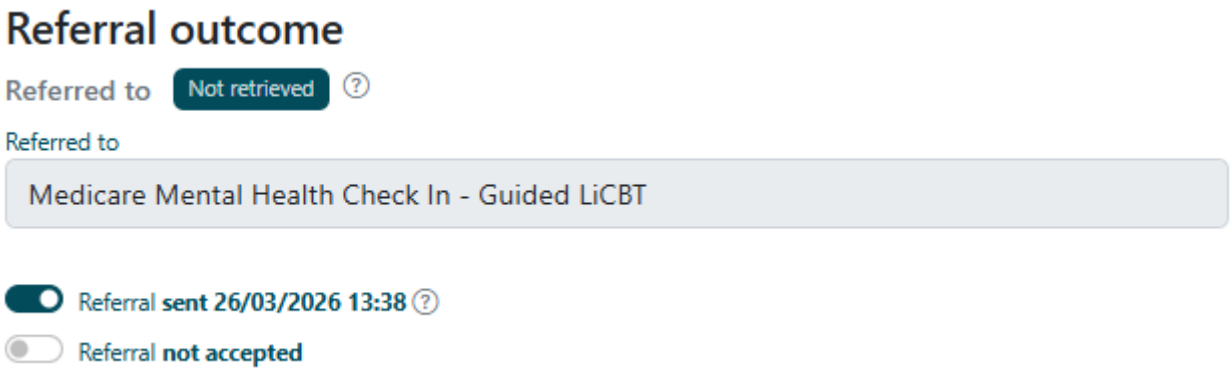
Not Eligible for Check In

9.4 Referring to MMHCI

If eligible for MMHCI, the option will need to select ‘Guided LiCBT’ or ‘Self-Guided LiCBT’. Please note Self-Guided LiCBT will be available after 30/05/2026 and cannot currently be selected.

9.5 Sending a referral to MMHCI

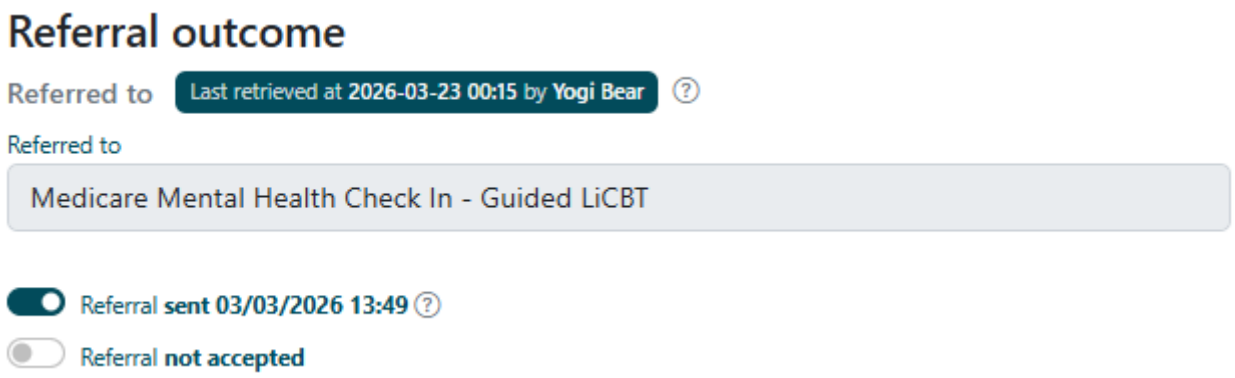
Once the referral outcome is selected and referral is ready, toggling the Referral to ‘Sent’ will trigger the API to pull through to the MMHCI systems. The API securely transfers the referral to SVHA – no further action is required by MMHps teams to action the referral. The Check In team will see any other referrals for the relevant client.



Referring to Check In

9.6 Flag to indicate API retrieval

A flag has been added above each Referral outcome to indicate whether a referral has been retrieved from by API integration.

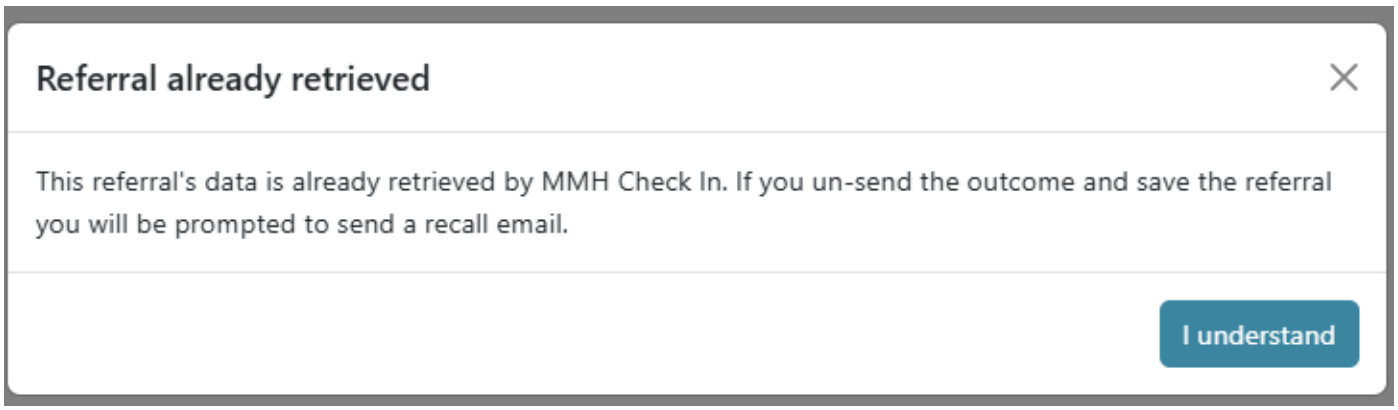


API Retrieval Flag

Further information is available here regarding the API retrieval flag.

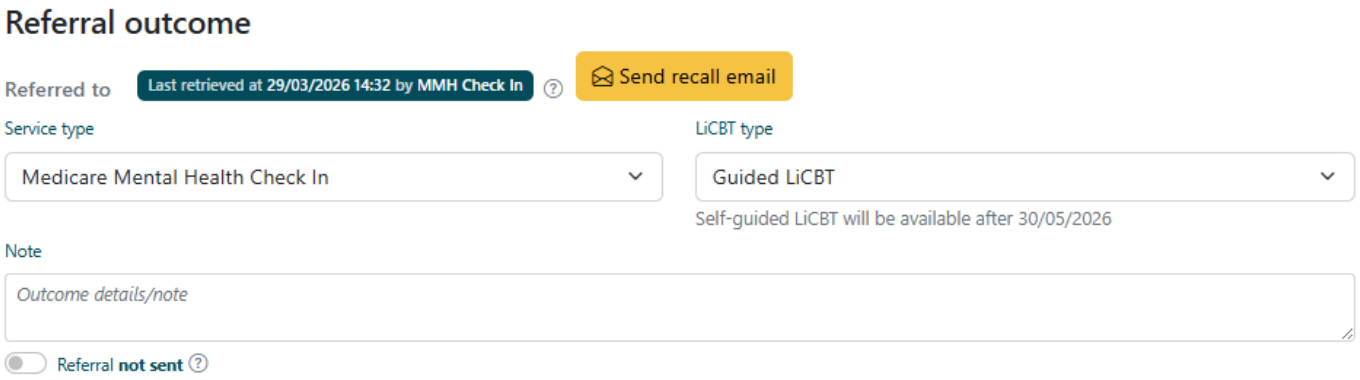
9.7 Unsending Check In Referrals and Recall Referral Email

If you need to unsend a referral to Check In, you will be prompted to send a recall email to notify them. When untoggling 'Sent' for the Check In outcome, a pop-up will appear



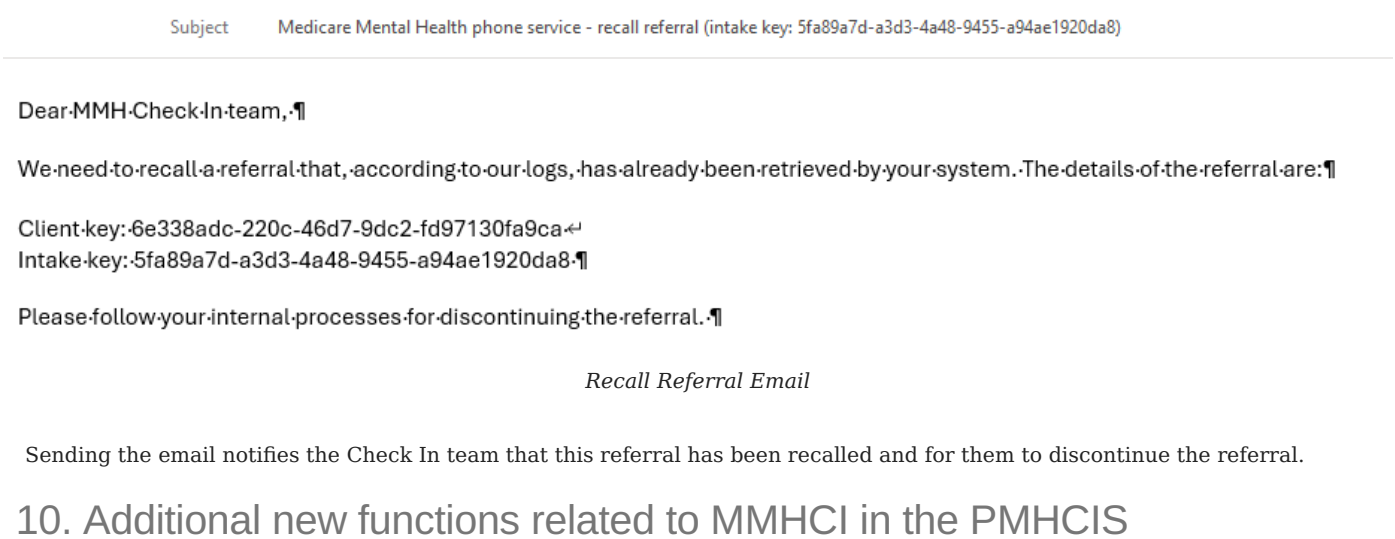
Unsend Check In Referral

Once you progress and save the referral, the outcome will show a button to 'Send recall email'



Send recall email

This will open an email in your emails with the following contents:



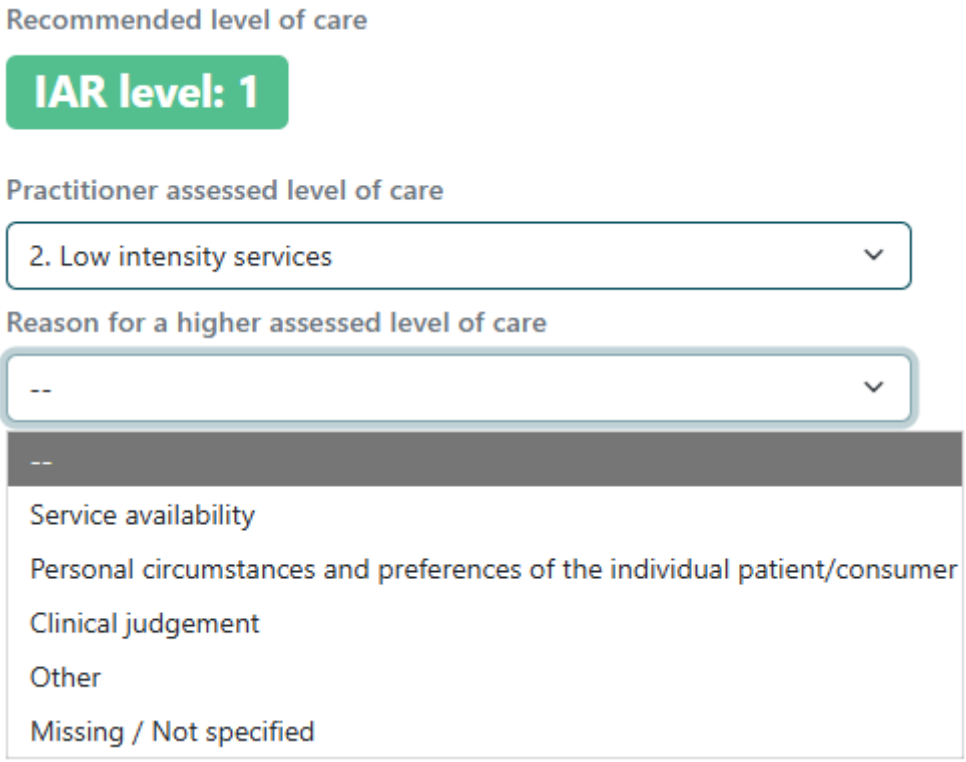
Recall Referral Email

Sending the email notifies the Check In team that this referral has been recalled and for them to discontinue the referral.

10. Additional new functions related to MMHCI in the PMHCIS

10.1 Practitioner-assessed LoC differs from recommended LoC

If the practitioner assessed LoC differs from recommended LoC i.e. recommended LoC is a 3, but clinical decision has been made to step down to a LoC 2, a rationale for override will be required as per the PMHC-MDS v5. This applies for any stepping up or down of consumers' IAR-DST scores.



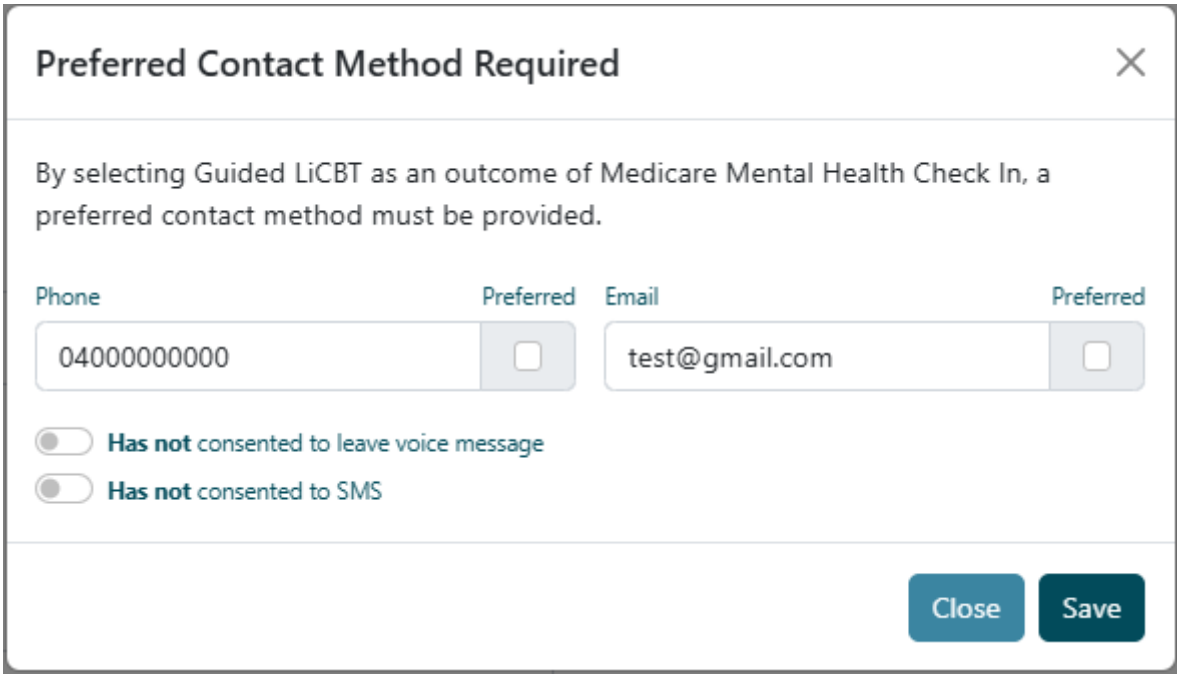
Practitioner override

10.2 Preferred Contact Method

New fields have been added to collect preferred contact method on the client page.

Preferred Contact Method

Communication consent has moved locations and the options to consent to mail and email have been removed, while voicemail and SMS consent have been retained primarily for safety considerations. If the referral is sent the MMHCI and preferred contact method is not selected on the client page, a pop up will prompt users to select a preferred contact method.

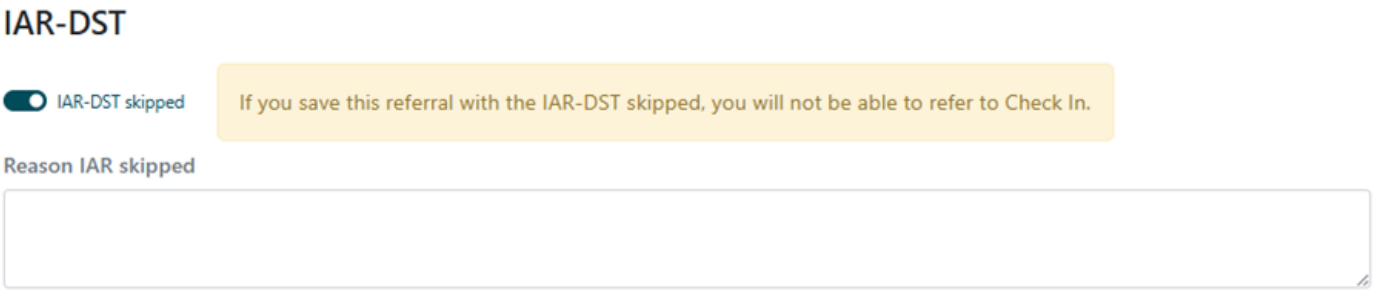


Preferred Contact Method Pop-up

If the pop up is closed without selecting a preferred method of contact, MMHCI will automatically be removed as the referral option.

10.3 Skipping the IAR-DST and referring to MMHCI

If your organisation has the ability to skip the IAR-DST (this is an organisation setting), you will see a prompt when skipping the IAR-DST to indicate that this action makes MMHCI unavailable as a Referral outcome. An IAR-DST is a requirement for all referrals to MMHCI.



Check In and Skipping the IAR-DST

March 31, 2026 16:33:03

11. Delivering intake and assessment

Training videos - Referrals

11.1 Initial Assessment and Referral - Decision Support Tool

Medicare Mental Health provides navigation to local services and supports that best suit a consumer, based on their presenting treatment needs and recovery goals.

The best way to explore their presenting needs/risks and preferences, is through the completion of the Initial Assessment and Referral Decision Support Tool (IAR-DST).

11.2 When not to undertake an IAR-DST

Most calls to Medicare Mental Health will require an IAR-DST to be undertaken.

The following are examples of when it may not be necessary to utilise the IAR-DST.

- The caller is **seeking information** or resources only.
- The caller **seeking information about relevant or local services only**.
- An **initial assessment has already been undertaken** (e.g. by a referrer) and the level of care required has been identified. In this instance, referrer, consumer, carer, family member, or friend may simply require support identifying an appropriate local service (navigational supports only).
- The **consumer does not give consent** for an IAR assessment.
- The **consumer is identified as requiring immediate referral** to specialist, acute or emergency services (the IAR-DST can also guide this decision).

11.3 Accessing the IAR-DST form

To access the IAR-DST you must create a Contact and convert to a Client record. At the bottom of the Client screen, click on the "Data for Intake" button.

Data for intake button

11.4 Referral Origin

When an IAR-DST call has been directly set up by a third-party referrer (such as a General Practitioner (GP) or support worker), or the IAR-DST is taken from a parent of an underage child, Guardian or Power of Attorney, that third party involvement should be listed on the webform as the referrer. The referrers details need to be recorded on the webform or the referral will not progress to the next stage. If details are unknown, write ‘unknown’.

The fields in the ‘Referrer section’ are mandatory:

- Referrer profession
- Referrer first name
- Referrer last name
- Referrer organisation

11.5 Upload a document

For guidance on uploading files/documents, see the Additional documentation section.

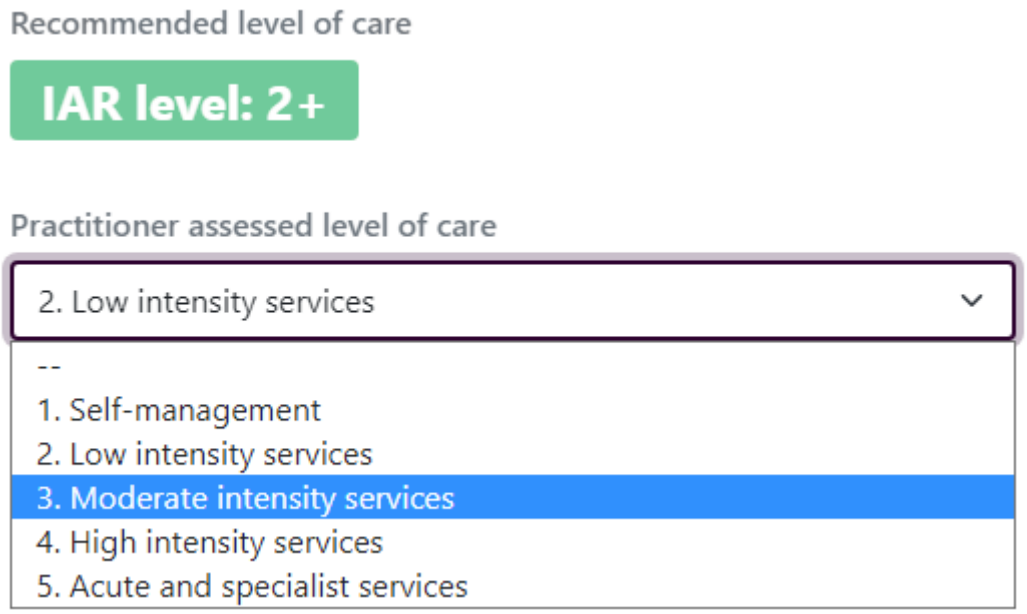
11.6 Referral criteria to Levels of care

Sitting behind the assessment domains is an algorithm that leads to a recommended level of care.

As the domains are interactive (in that each of the assessment factors can interact with judgements on other domains) there is considerable complexity in the possible combinations. The suggested referral criteria aim to simplify the approach by focusing only on the main patterns of presenting problems likely to be found in primary mental health care. It is important to emphasise that the proposed referral criteria are offered only to **guide judgements** about the likely best treatment option.

Each presenting individual will have unique requirements that must always take precedence in decision making.

The option to 'override' the DST level of care has been built into the webform. A decision to override the DST can be based on clinical judgement, and consumer choice.



Setting level of care

11.7 IAR-DST Levels of Care

Primary mental health care falls into Levels 1 to 4, with Level 5 being more appropriate for acute and specialist mental health services.

Level 1 (self-management) for people with relatively minor problems on the primary domains. Contraindications to Level 1 care include problems with engagement and severe problems in treatment/recovery history or very severe environmental stressors.

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

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

Level 4 (high intensity interventions) for people with severe symptoms/distress, where these occur in the context of significant other problems (up to severe levels). Level 4 is not suitable for people with severe symptoms who present with very severe

problems on either risk or functioning. Individuals referred with this array of presenting problems are suggested as best referred to Level 5 care.

Level 5 (for acute and specialist mental health services) for people who usually have significant symptoms (e.g. hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions) and problems in functioning independently across multiple or most everyday roles (work, education, parenting, volunteering) and/or is experiencing:

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

11.8 Medicare Mental Health Hubs/Pop-ups/Centres

Consumers are eligible for services through the Medicare Mental Health-funded Centres (Hubs in Victoria and Pop-ups in NSW) for IAR-DST rated Level 3 and 4, and the consumer cannot afford or otherwise access similar services.

This could be based on one or more factors:

- Inability to afford a similar service such as Better Access
- Complexity of need and requiring a multidisciplinary team approach
- Location with respect to service availability
- Would not be better suited to a specialised service in their area of need i.e.: Victims of Crime Counselling and Assistance Program, Work Cover, TAC, Child First, Directline, Family Violence Services, Homelessness Services etc.

Where an IAR is completed with a consumer, and their needs are best met by a service other than the Mental Health Hubs, it is the role of the intake worker to support them to navigate to the most appropriate service for them.

11.9 IAR-DST Level 5 referrals

On completion of the IAR, where the person has been rated as a level 5, and/or:

A. If risk of harm is assessed as imminent;

- Wherever possible discuss your need to arrange an urgent/crisis referral with the consumer
- Obtain consumer’s first and last name, phone number and current location
- Refer consumer to 000 as appropriate and provide handover of pertinent information
- Inform supervisor / manager as soon as possible on the day of the contact.

B. If risk of harm is not assessed as imminent, the intake worker must;

- Discuss consumer’s support needs and risk level with worker’s supervisor / manager (see local guidelines/ practice guidelines).
- It may be appropriate to seek collateral information from providers currently involved in the consumer’s care to determine history of risk, and their assessment of the presenting needs for the consumer. The intake worker would need to consider the consumers presenting risk, and whether the consumers consent would need to be gained to engage with the wider care team. This consent will also need to be documented.
- Consider appropriate referral pathways
- Refer to local area mental health services as appropriate

There may be circumstances where a practitioner may assess that a Level 5 where an Area Mental Health Service intervention may not be appropriate.

Examples:

- Consumer is already well engaged with existing mental health support services i.e: psychiatrist or psychologist.
- Consumer is booked in to access these professionals within the next 48 hours or these professionals can provide support over the phone in the interim.
- Consumer has agreed to a safety plan and is agreeable to accessing these supports in the next 48 hours.

11.9.1 Clinical decision override

- Intake/Hub worker may choose to make clinical override judgment to step down from Level 5. The decision to over-ride a level 5 decision, must be discussed with a senior, the reasoning must be clearly documented why alternative practitioner rating was agreed upon and clearly annotate support and safety plan.
- Where possible, the original intake worker who took the call with the consumer is to call the consumer back to agree on support plan and support them to develop a safety plan for the next 24-48 hours (reference local safety planning processes). Schedule text message to be sent no later than 7 days later to check in on consumer's progress. Clinician may assess that an earlier text message or a call may be more appropriate dependent on support plan in place.

11.10 Suicide Referral

The Risk Assessment section includes a 'Suicide referral' flag. This flag automatically switches to **Yes** when the risk of suicide is assessed as medium or high, and/or the consumer has a suicide plan and/ or intent.

A referral with a suicide flag requires appropriate supports are put in place to help manage that risk and start a time check point for consumer follow up. That support will be dependent on the needs, and the circumstances for the consumer. It may be a referral to a tertiary health service, a referral to a rapid response service, or the increased support from currently engaged supports/ services.

Discuss referrals with a suicide flag with your supervisor to ensure appropriate care planning and engagement.

Suicide assessment

Where the referral is allocated to a Hub/Centre for their ongoing care, consumers **must** be contacted within 24 hours, to further assess risk, and engage them in care.

January 27, 2026 12:35:28

12. Status of referrals/referral timeline

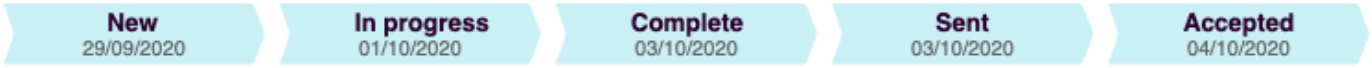
Training videos - Referral to MMHCs using the PMHCIS

Training videos - Referral to other providers

Training videos - Follow up

12.1 Track the progress of a referral

As each step of intake is completed, a timeline appears along the top of a client's referral page. The timeline signposts the progress of the referral and the date each step was completed. This is a fully completed referral's timeline:



Progress of a referral

Note: the Accepted status only applies to Hub referrals.

12.2 Incomplete referrals

A referral is considered incomplete if its status is **New** or **In Progress**. It will remain in the **Incomplete referrals** tab on the main page until it moves to the **Completed** status.

12.3 Finalising referrals

A referral moves to Completed status when:

- the client record has:
- forename
- family name
- gender
- phone or email
- postcode
- the referral has:
- referral origin
- and if the origin is not a self-referral that it has the referrer details
- and the IAR-DST level (unless the current organisation's setting enables an IAR-DST to be skipped)
- and the practitioner assessed level
- and the suicide referral flag
- and the 3 risk levels in the Risk Assessment
- and the consent to service (the first consent)
- and the outcome

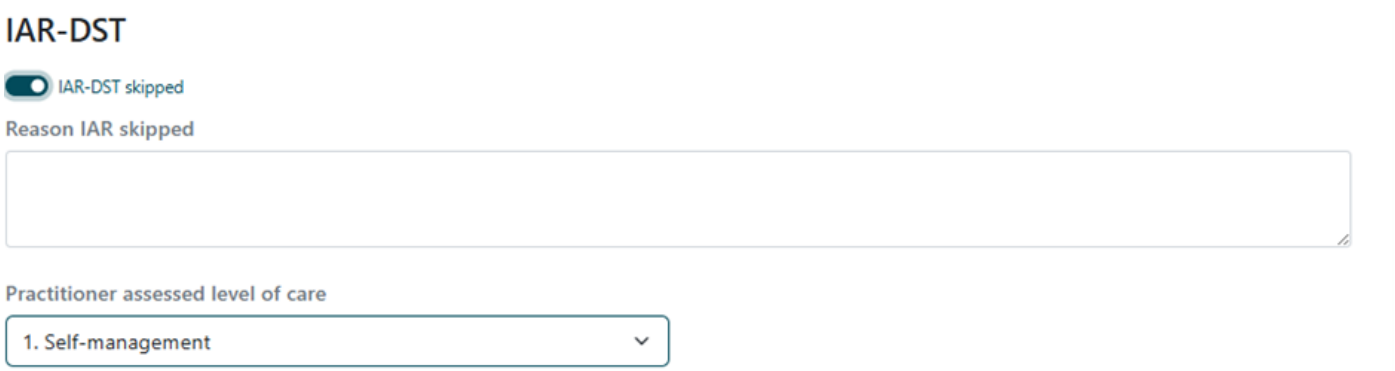
Once the IAR form has been completed, **Referral not sent** appears at the bottom of the form. If this button is clicked it sets the referral sent date and time field to the current date and time. It also moves the status to **Sent** and locks the referral screen to prevent referral details being updated.

The form can only be unlocked by a user in the PHN Admin or Intake Manager role. Their user accounts are permitted to 'unsend' the referral.

Note: All referrals should be moved to Sent.

12.4 Skipping the IAR-DST and Risk Assessment

There is a function available in the PMHCIS that allows users to skip the IAR-DST. This is an Organisation setting. If the setting is applied, when on the referral page you will see a toggle 'Skip IAR-DST'

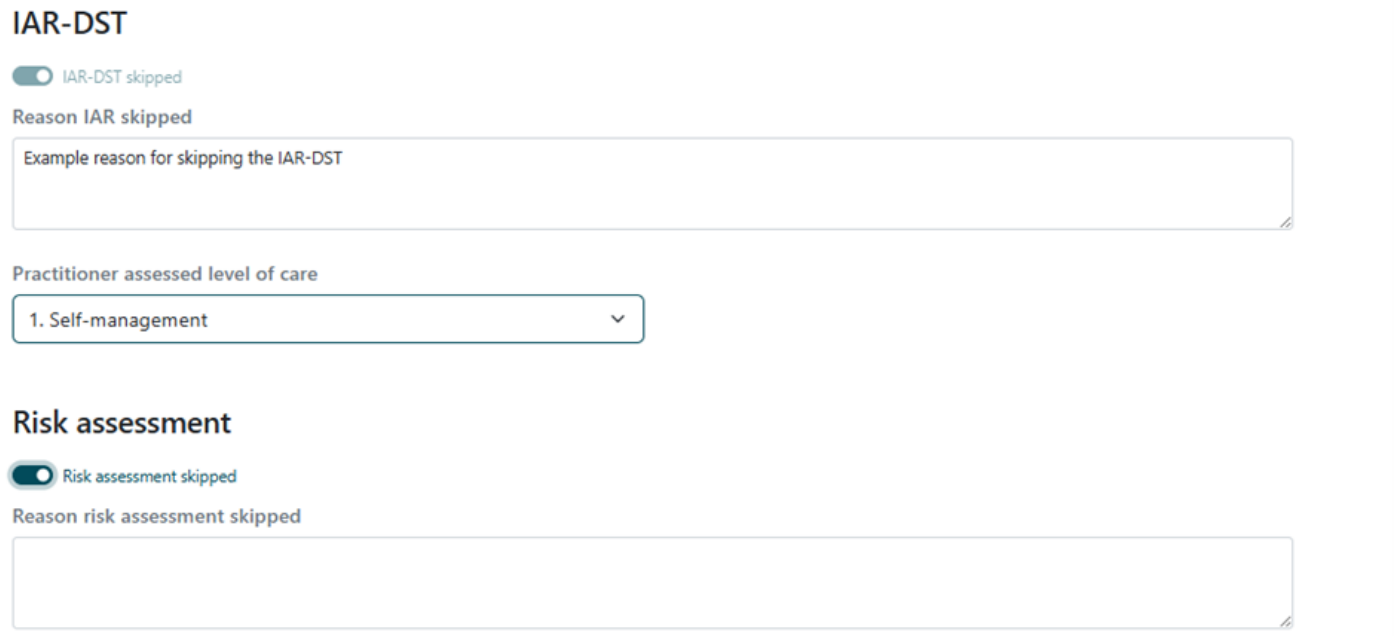


Skip IAR-DST

Once toggled on, a note box will appear to provide a reason that the IAR-DST has been skipped. This is mandatory.

12.4.1 Skipping the Risk Assessment

Once the IAR-DST has been skipped and the page has been saved, the option to skip the Risk Assessment will also be available.

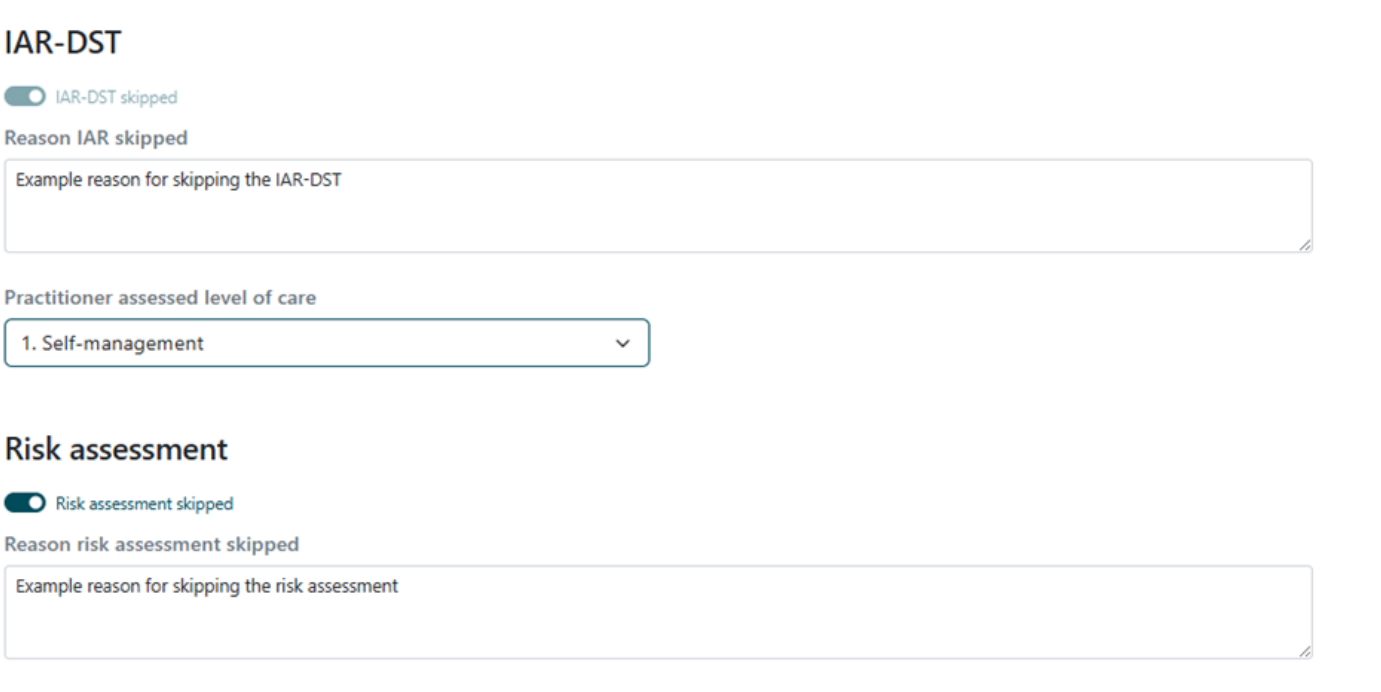


Skip IAR-DST and Risk Assessment

Similarly, once toggled on, a note box will appear to provide a reason that the Risk Assessment has been skipped. This is mandatory.

12.4.2 Unskipping the Risk Assessment and IAR-DST

If you need to unskip the IAR-DST, you will need to unskip the Risk Assessment first. You cannot only skip the Risk Assessment. You will need to unskip the Risk Assessment to then unskip the IAR-DST.



Unskip IAR-DST and Risk Assessment

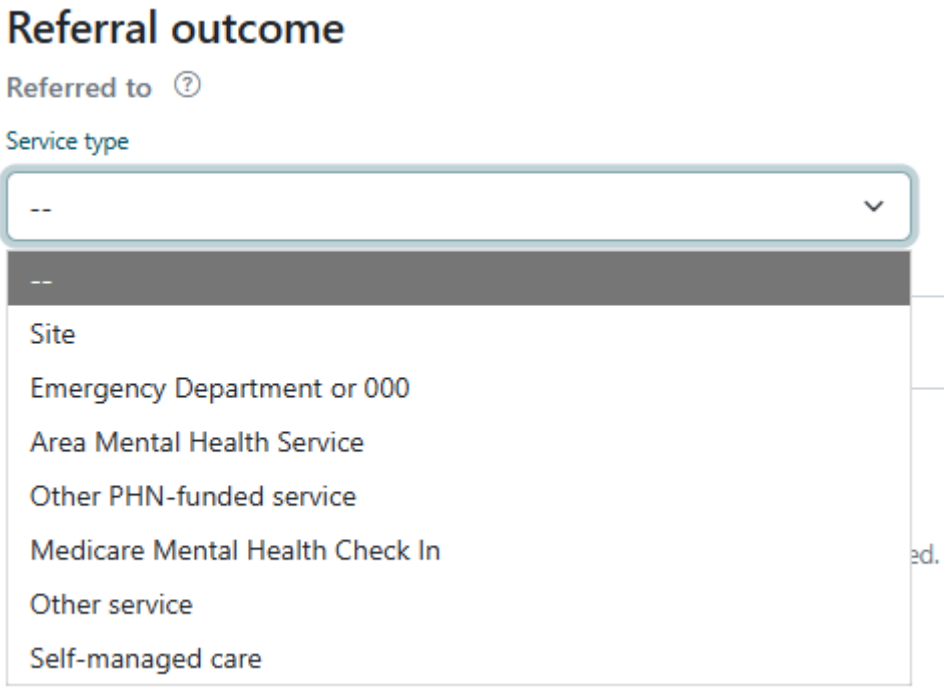
12.5 Referring

Once the Referral record is Completed, the referral can be processes as required.

When referring, please refer to your local PHN local process. It is vital local processes are adhered to, or there is the potential for a consumer allocation to be missed.

12.6 Self-managed care outcome

A referral outcome for ‘Self-managed care’ is available to indicate that the referral is closed because the client has chosen to manage their care independently.



Self-managed care

12.6.1 Sending

In most cases, the Referral should be marked as **Sent**. Once it is Sent, most of the data on the Referral screen is locked from editing. To unlock it, it needs to be un-Sent. Only a user account assigned to the Intake Admin role can un-Send a referral.

12.6.2 Referring a consumer to a Site

To refer a consumer to a Medicare Mental Health Site via email the following steps must be completed.

1. Complete the IAR form including the risk assessment and consent domains. Ensure that current referral owner field is allocated to the hub.
   (Note: The 'Referral origin' field and 1st Consent is mandatory and must be completed.)
2. Once the relevant information has been recorded, click 'Save'.
3. Click on the email referral link button to create a URL of this client record. The URL will appear in a new email message.
   (Note: only staff registered with PMHC IS webform will be able to access this URL).
4. Send the email to the hub, do not include consumer identifiable information.
5. An alternate process may be to 'print' the referral and save it as a PDF into the PHN/ providers locals CIMS.
6. To refer a consumer to a Medicare Mental Health Site via phone steps 1 to 3 must be completed. During the warm transfer phone call (see 'Warm referral' section), ask the hub staff member to search for the client referral using the search function (see 'Search for a client record' section).

12.6.3 Referring a consumer to another (non-Medicare Mental Health Centre) service

To refer a consumer to another service the following steps must be completed.

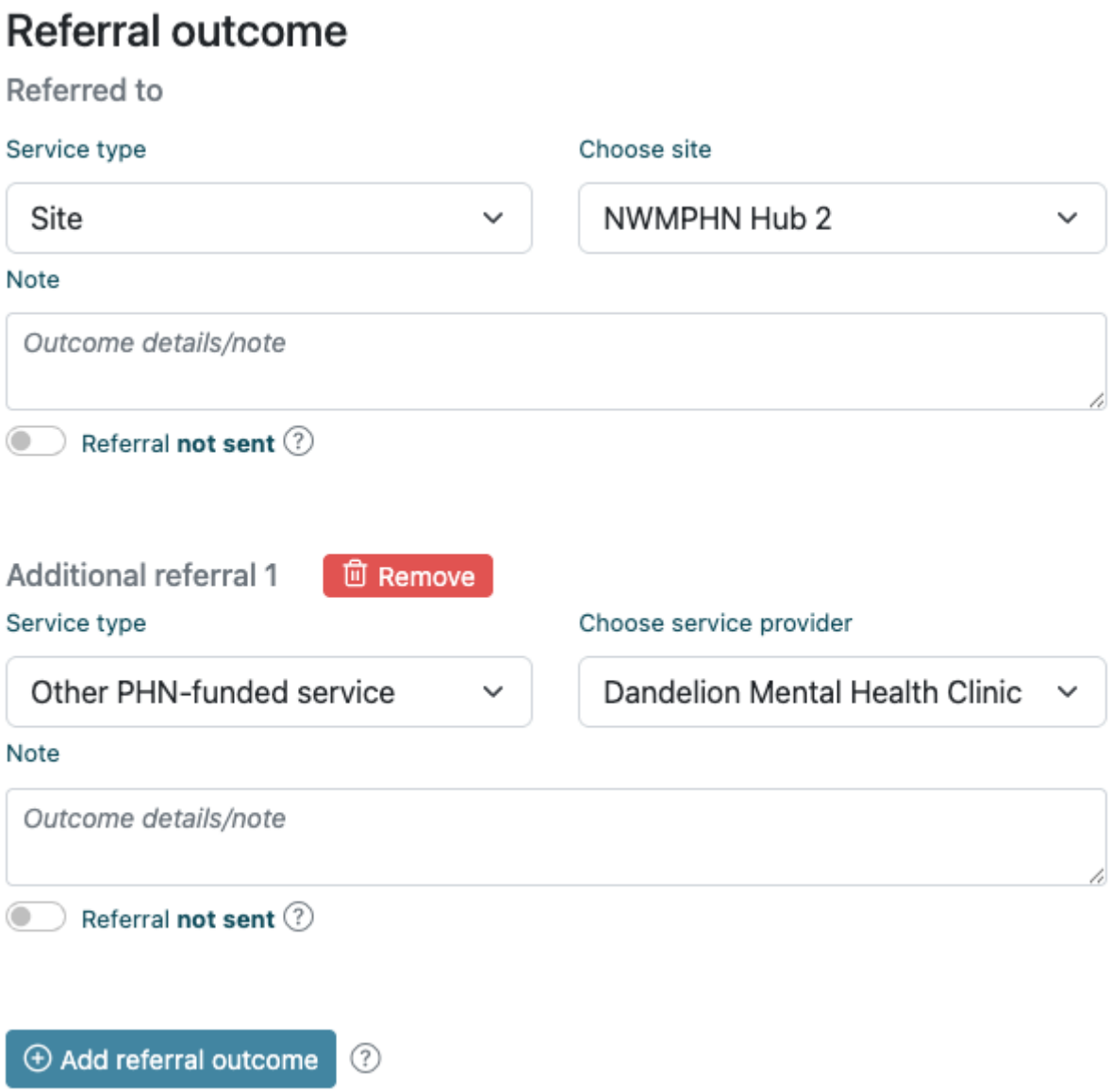
1. Complete the IAR (Note: the current referral owner field does not need to be changed)
2. Call the service provider. During the phone call indicate a referral is being made and request a fax number for the notes and IAR assessment to be sent to.
3. To send the completed IAR form via fax - click on the “Print view” button at the top right of the form, then click the “Print” button.
4. In the drop-down box for destination, select ‘save as PDF’ to save the document to a secure drive, then send the fax.
5. Complete the referral by selecting the referral outcome from the drop-down list at the bottom of the form. You may enter the specific name of the service in the free text field.

12.6.4 Referring to more than one service provider

A client sometimes needs to be referred to more than one service provider. When applicable, the Intake form enables you to record more than one in the **Referral Outcome** section.

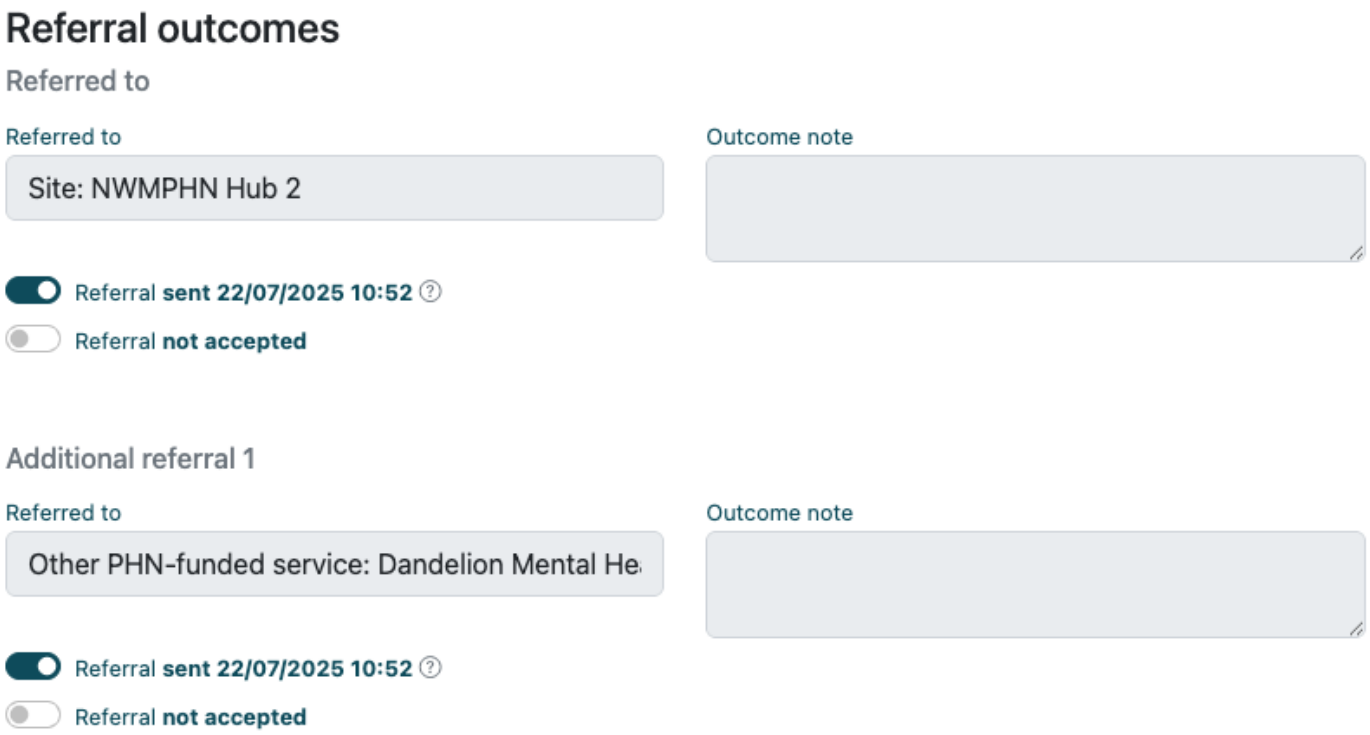
Once an outcome has been entered and the record saved, the **Add referral outcome** button will appear underneath the primary outcome. The screenshot below shows a record with a primary and secondary outcome already entered, and the button appearing underneath to enable another outcome.

Please note: After adding new outcomes, users should ensure they save the referral first. After saving, the Sent toggle will be enabled when the referral status is Completed, allowing it to be marked as Sent. If the referral is incomplete (status is New or In Progress), the toggles will be locked, and outcomes cannot be marked as Sent.



Add additional referral

Sent and accepted toggles will be visible for each outcome. The overall status of the referral will only change once all outcomes have progressed to the next status. I.e. once all referrals have been **Sent**, the overall referral status will be **Sent**.

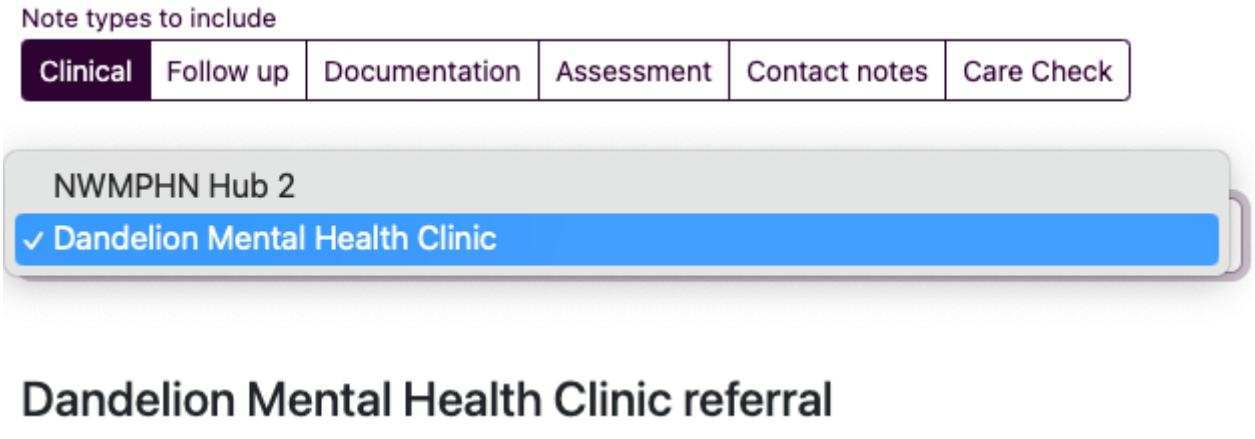


Referral outcomes

Note that a secondary outcome can only be to a **PHN-funded service** or **Other service**. It does not permit a secondary referral to a Hub/Pop-Up, emergency, or acute service.

Once all referrals are toggled as sent, the referral will become locked and uneditable. If the referral is unsent, the record becomes editable again.

On the referral's print view, you can use the dropdown to choose which provider to display in the PDF. The dropdown does not appear in the PDF, but the name of the service provider will.



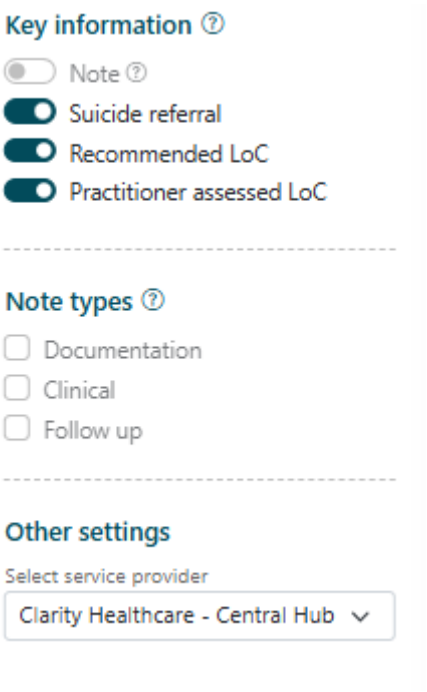
Referral print view for multiple outcomes

12.7 Referral Print PDF

The referral PDF has a side bar ‘Key information’ function that allows users to 'pin' fields including the Recommended LoC, Practitioner Assessed LoC, and the suicide referral fields, along with **one** note that can be selected. These fields are shown in

their regular spot on the referral PDF regardless but are toggled on to show in the pinned section at the top of the referral PDF by default. This can be toggled off if desired.

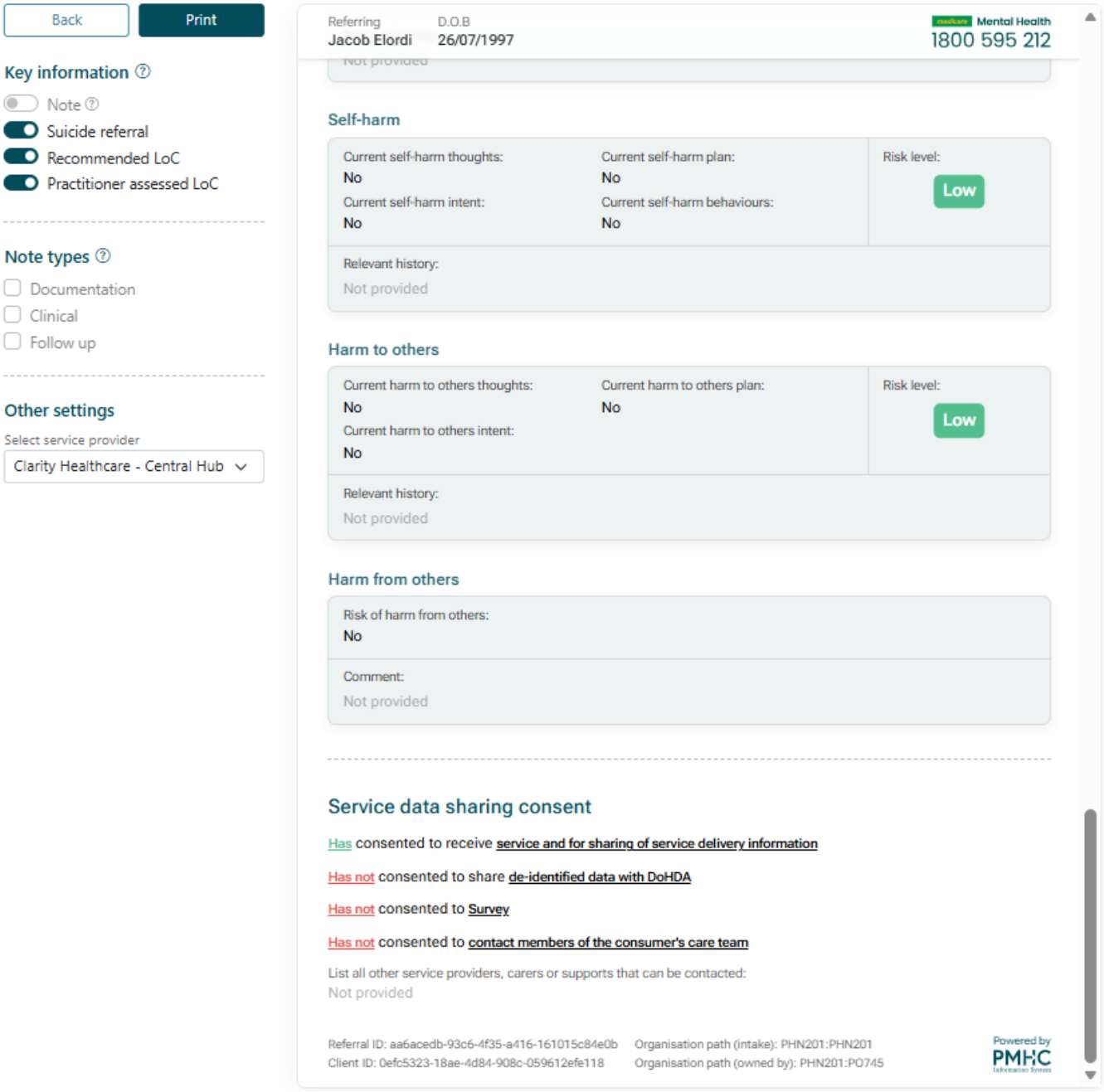
Note types to be shown can also be selected.



Print PDF sidebar

If referring to multiple service providers, you can select from a drop down which provider to label the referral to.

The referral PDF can be printed or saved as a PDF for sharing with external service providers.



Print PDF

12.8 Communications Preference

When finalising referral options with consumer, ask whether they would prefer;

- A call back to confirm service support options
- A text / SMS message
- An email

When information is relayed by phone, make sure wherever possible to follow up with contact details of service provider by text message or email.

If the consumer prefers to have information delivered by email, the intake worker should ask the referrer to make sure they check their junk mail if the email does not arrive.

12.9 Advising the consumer of referral outcome

The intake/hub staff must advise the consumer of the outcome of referral using their preferred communication method; call, text or email.

Text / SMS message: Send a text message to the consumer with the referral outcome.

Suggested Script: *Thanks for calling Medicare Mental Health, we're glad you reached out. We referred you to _____ get further support. You can reach them on (add webpage, phone number etc.). You are welcome to call Medicare Mental Health again if additional support is required. Please do not reply to this text.*

Email: Send an email with interim support numbers/service suggestions as appropriate.

This may include:

- Lifeline 131114
- Beyond Blue Corona Virus Mental Health Wellbeing Support Service 1800 512 348
- Mental Health triage number appropriate for consumer's region if appropriate
- An invitation to call again if additional support is needed.

12.10 7 Day check in

Following completion of the IAR ask for consumer consent to send a check in text message in 7 days.

Suggested Script: *Hi, this is the Medicare Mental Health intake team. We hope that you've been able to get the support you need. If you've had any difficulties connecting with the service, we referred you to, please call us back on 1800 595 212. Please do not reply to this text.*

12.11 Correspondence- Medicare Mental Health Branding

Email: All emails should be sent from a Medicare Mental Health e-mail address, with branded signature.

Written correspondence: All letters sent to consumers and professionals as a result of Medicare Mental Health call must be on Medicare Mental Health letterhead.

12.12 Navigating appropriate services

When determining the type of service, a consumer might require, take into consideration the following:

- The benefits of a warm referral in connecting consumers with care, and having this process supported.
- The consumer's history of successfully connecting with services.
- Whether the consumer is experiencing substantial psychosocial stressors that may inhibit their ability to connect with another service i.e.: homelessness, violence.
- Whether the consumer is subject to other factors that may make facilitating a connection challenging i.e.: from a CALD background, communication difficulties or disability.
- Whether the consumer is assessed as high risk for suicide, self-harm, harm to others or harm from others.
- If a consumer appears capable and confident to facilitate action plan on their own, provide support provider's phone number or website by phone, SMS, or e-mail (see Appendix 7 – Sample consumer email).
- Provide a copy of the IAR with consent (sent via secure method).

12.13 Warm referral

A warm referral is a supported referral that aids a consumer to access care by sharing their personal information and presenting needs (with consent) to another service/ support, to facilitate in the engagement in care. A warm referral may include;

Calling the provider with the consumer on the phone to facilitate a hand over/ transfer. Where this is not possible intake may:

- Call the provider to determine eligibility, waitlist and narrowing down to a particular professional that meets consumer's needs.
- Once provider is determined, giving a verbal handover before providing a copy of the IAR to the ongoing provider.
- Ask the provider to contact the consumer directly to facilitate linkage.
- Provide the consumer with the service contact details.

May include warm referral to a GP or general practice if the consumer does not currently have a provider.

April 24, 2026 13:01:52

13. Confidentiality and consent

13.1 Confidentiality

If an IAR-DST is to be undertaken with a consumer, prior to commencing, intake and Hub staff are required to advise the consumer of the circumstances under which their information would be shared with others.

Suggested Script: *'Before we start, I want you to know that anything you share with me today is confidential. I won't be sharing any of your information, or any of the detail you provide me, with anyone, without first getting your permission except if during our conversation you disclosed that you were at risk of harm, or at risk of hurting someone else, I would need to arrange a referral for urgent support for you, which would involve sharing your information. Wherever possible, I would have a conversation with you before doing this. Does that all sound okay?'*

13.2 Overall consent

The webform seeks four separate levels of consent that will need to be discussed with the consumer. There is an '!' icon which will reveal the full text when clicked.

The first consent field is mandatory and must be selected for the person to receive service, and for the IAR document to be shared with the Mental Health service or Hubs for care provision.

Consumers have the option to consent, or not to the second, third or fourth consent questions which relate to the sharing of their data, and personal information with their broader care team.

13.3 Consent to record Demographics

Prior to recording a person's demographics, intake and hub staff are required to obtain the caller's consent to create a file. This is both for contacts and client records.

Suggested Script: *'We will start by taking some basic information like your name and address so that we can create a record of our conversation. Is that okay?'*

If a caller does not want to be identified, please record the caller as Anonymous and save the data as a contact.

13.4 Suggest consent wording

Consent 1 (to receive service and for sharing of service delivery information)

Suggested Script: *'To give you the best care today, I need to take/I have taken notes of your information and our discussions. This information is kept safe and private and is used to determine what help you need. It is only shared with the Medicare Mental Health team, your local Primary Health Network (who manages the service) and, if you are referred onto a service, it will be shared with the service provider and other health professionals involved in your care.'*

Option if they say No: *'If you prefer that we do not take these notes and to share the information, we will be unable to progress the call today. (If you need urgent care, we recommend you contact Lifeline on 13 11 14 or Beyond Blue on 1300 22 4363.)*'

Consent 2 (to share de-identified data with DoHAC and state/territory agencies)

Suggested Script: *'As the funder of the Medicare Mental Health service, the Commonwealth Department of Health and Aged Care, state and territory health departments and evaluators need to know what kind of people are using the service and why. To support this, we need to tell them about the type of people that have contacted the service and share some de-identified personal information like date of birth, gender, postcode and health outcomes. We do not share your name, address or other personally identifiable details that can be linked back to you. Is it ok to share these de-identified details?'*

Option if they say No: *'If you prefer that your de-identified details are not shared, you understand that we will still count and include data about your use of services in summary reports that do not require personal information.*'

Consent 3 (survey)

Suggested Script: *'After we have finished this conversation, we would like to send you a short optional survey about your experience. Your feedback will be used to improve the service. Are you OK for us to use your email or phone number to send you a link to this survey and to receive invitations to provide additional feedback in the future?'*

Consent 4 (to contact members of the consumer's care team)

Suggested Script: *'To give you the best coordinated care, we try to work together with your other care providers such as your doctor or psychologist. We might need to contact an existing care provider to discuss your future care planning. Is this OK?'*

April 8, 2025 15:37:33

14. Overview

The **Tag** functionality enables customised tagging or categorisation of referrals. They can be applied at any time after the referral is created.

Tags can be used to identify incidents, such as "Bushfire", "Floods", or be used as a quick reference comment or category, e.g. "Waiting for documents".

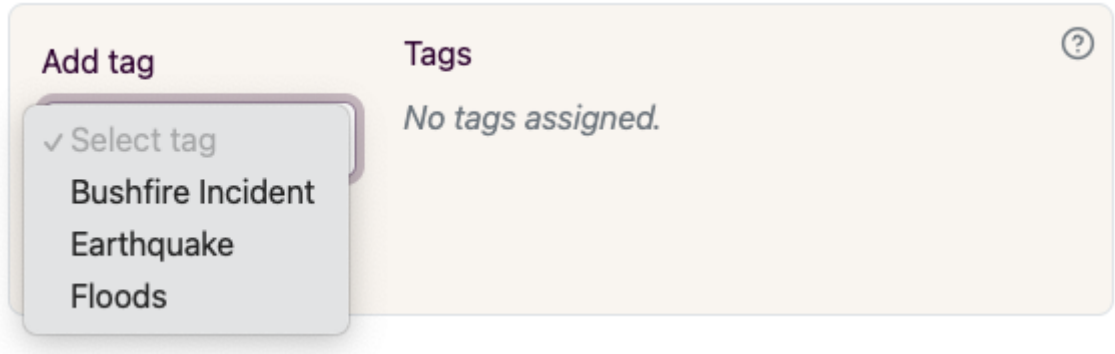
Depending on the situation, tags can be applied as an indicator to the team that an action is required, or to show what the record relates to so it can be actioned accordingly.

Applied tags will display prominently in the lists on the main page.

The function includes the option to generate an email notification when the tag is applied.

15. Process

On the referral screen, the **Manage tags** button will appear at the top right of the screen if tags have been set up. Click this button to display the dropdown for adding a tag.



Selecting a tag

The tag behaves the same as most other fields on the screen, in that the referral will need to be saved in order to apply the tag.

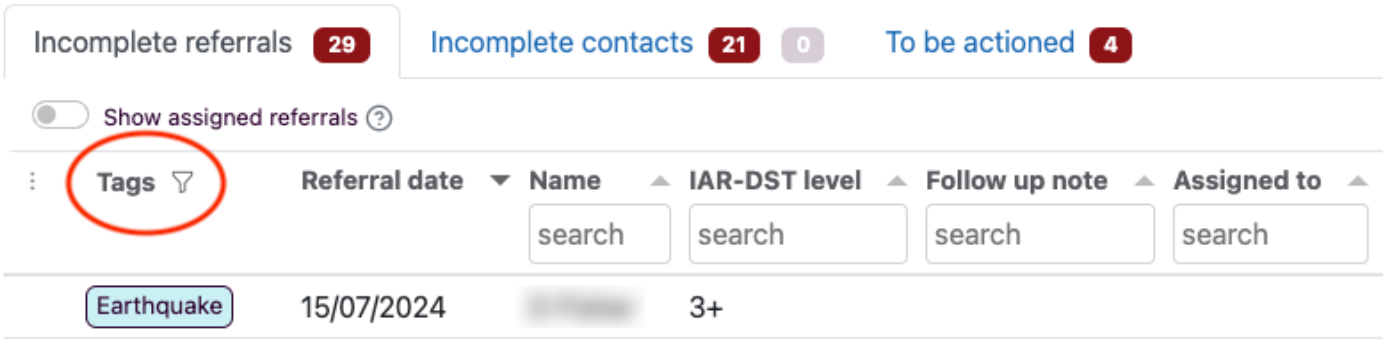
Once saved, another tag can be added.

Applied tags will display in the lists on the main screen.

If the tag is configured for email notifications, an email will be sent. An example is shown below.

16. Tags filter

On the landing page, the Tags filter is accessible from the header for the Tags column.

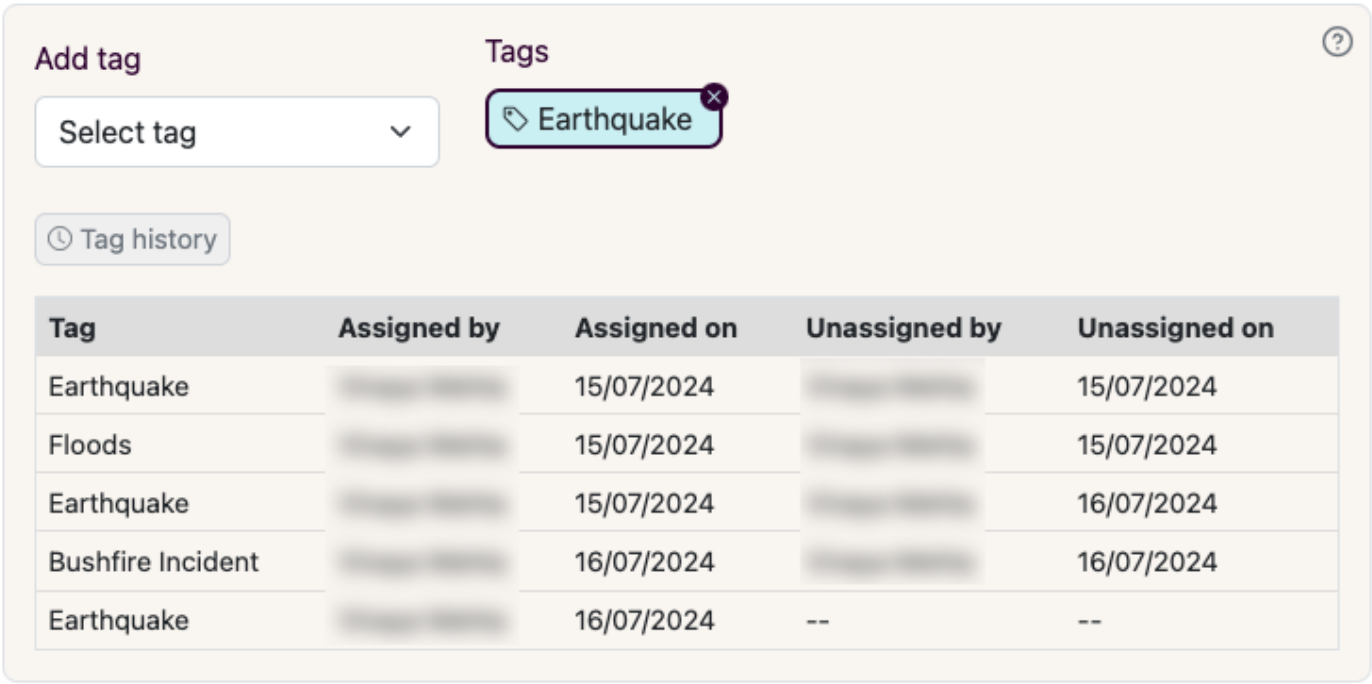


Tags filter

The list will filter according to the setting on the Tag filter screen.

17. Tag History

In the section of the screen where Tags are applied there is a “Tag history” button for displaying a history of tags applied and removed.



Tags history

18. Setting up Tags

To set up a tag contact Medicare Mental Health Support at pmhcis.support@nwmphn.org.au.

May 13, 2025 16:50:57

19. Additional documentation/file uploads

PDF files can be uploaded to a **Contact** or a **Referral** record in the **Additional documentation** section (just before the **Notes** section).

Files uploaded to a Contact record will automatically transfer over to the Referral record if it is converted to a Client.

Before uploading a file, a file type must be selected. Only one file per type can be uploaded.

19.1 How to upload

1. Click the **New PDF file** button. *Note that this button **will not be visible** if a file has already been uploaded for each available file type*.
2. Select the file type.
3. Locate the file.
4. Once the file type and file are entered, the **Upload** button will appear. Click this button to upload the file and complete the process.

Once the file is uploaded, you will see the **View** button, and an actions button (⋮) for accessing the **Delete** and **Download** functions.

Note:

- you do not have to click the main **Save** button. The upload process is independent of the screen's save process.
- the document must be in a PDF format and less than 3 MB. If you have PDF files that are larger, your IT Support team may be able to provide you with a tool to reduce PDF sizes.

19.2 File types

The available file types are:

- Assessment documents
- Clinical documentation
- Discharge Summary
- Mental Health Treatment Plan (GP)
- Referral in **(this is the default type)**
- Referral confirmation
- Waitlist letters

Intake teams can choose from the list above which file options are available to their team, please contact pmhcis.support@nwmphn.org.au with any requests.

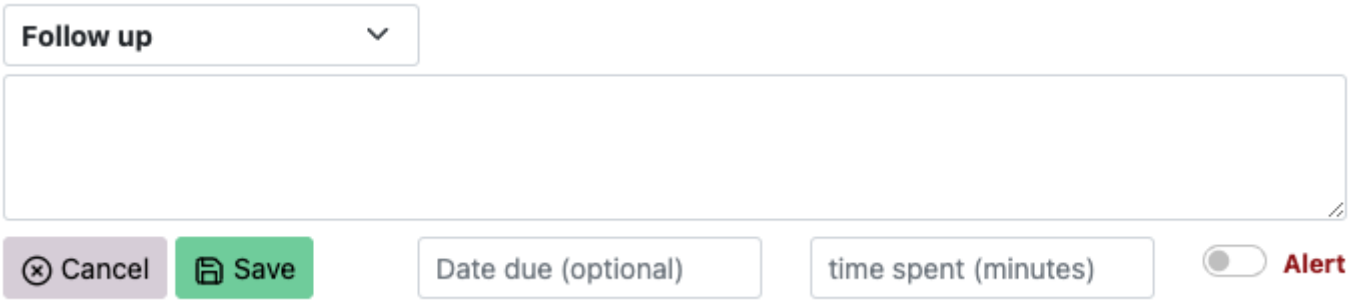
May 13, 2025 16:51:31

20. Recording case notes

20.1 Intake case notes

Case notes are entered referral screen just above where the IAR domains are set:

To enter a note, click the “New note” button. The little form below will appear in the main form. Fill in the field/s as needed and click the “Save” button to save the note.



Entering a note

By default, the “Follow up” type appears, but you can click that field to set one of the other available types (“Clinical” and “Documentation”):

20.1.1 Edit a note

You can edit a saved note by clicking on the text of the note. The display will switch to the form view (as per the screenshot above).

20.1.2 Note fields

Each type is treated differently in the system:

- *Clinical* notes can only be entered when the referral is unlocked (i.e. not Sent or Accepted).
- *Follow up*, *Documentation*, and *Assessment* notes can be entered even when the referral is locked.
- *Clinical* notes will always appear when you print.
- *Follow up* and *Clinical review* notes can use the reminder function (see below).

The intent of the *Documentation* type is to record a copy of documents/emails. The use of this type is optional.

The intent of the *Time spent* field is to record the time taken to work with the client. The use of this field is optional.

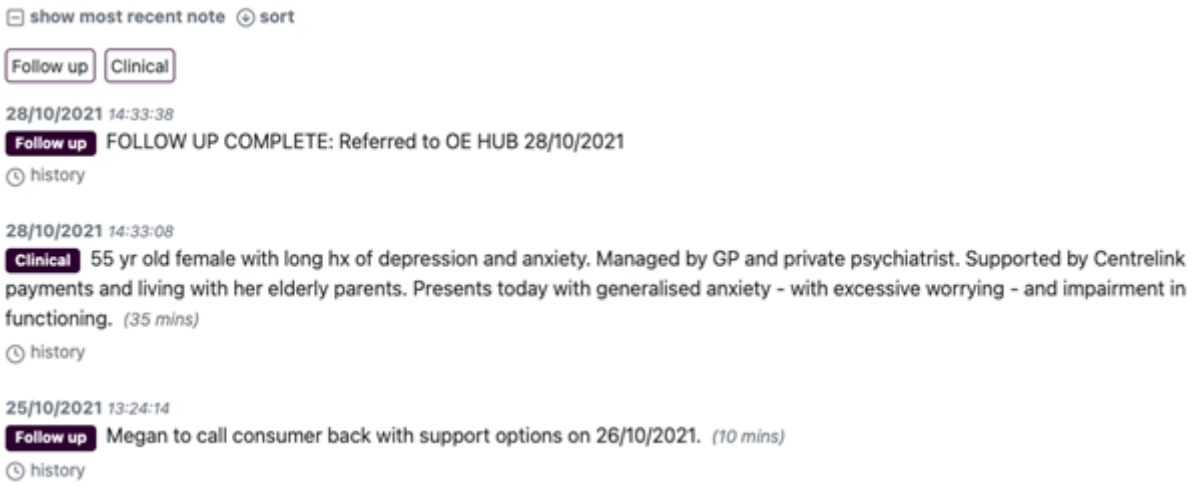
The intent of the *Assessment* type is to record time spent on an assessment so that this can be monitored by intake managers.

The alert toggle switch can be used to alert other clinicians to an aggressive or violent history. If a client has a note with the alert switched on, it will highlight in red in the Reports section:

You can use the **Date due** field to set a reminder. Refer to the Setting reminders and assigning to a staff member section.

It will also display the button shown below on the Client screen. You can click on the button to display the note where the alert is recorded and a link to open the referral.

When more than one note is saved, the screen displays only the most recent note by default. But you can click a link to show all notes or go back to showing only one. You can also sort notes and filter by type. The screenshot below is an example when all notes are shown.



List of notes

20.2 Medicare Mental Health Hub/Pop-up/Centre case notes

Once the referral has been sent to the Medicare Mental Health treatment centre by the PHN intake team staff are not to record further information (such as attempts to contact). Case notes should be recorded in their own client information management system (CIMS). Even though the 'Follow up' notes can be added/edited, this is reserved for PHN intake staff to enter case notes.

However, where the intake was done at the centre, staff can continue to add/edit notes.

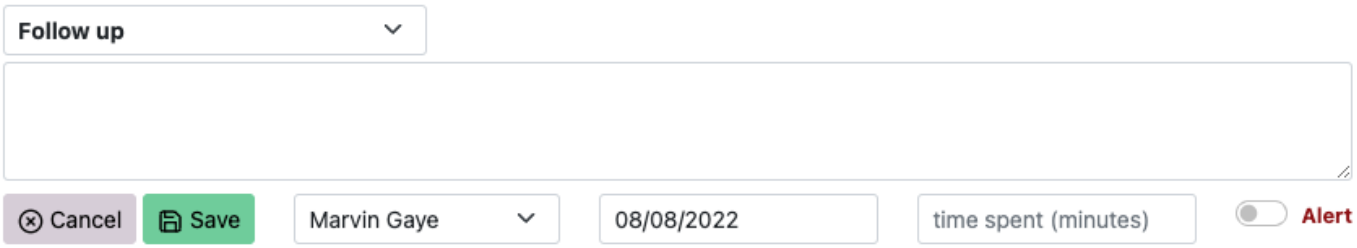
April 8, 2025 15:37:33

21. Setting reminders and assigning to a staff member

Training videos - Landing page

21.1 Set a reminder

A reminder can be set on a referral when entering/editing a Follow Up or Clinical Review note. To set a reminder, enter a Due Date in the field (to the left of the Time Spent field).



Note reminder fields

When the Due Date has been reached, the referral will appear on the main screen in the **To Be Actioned** list.

To Be Actioned list

21.2 Assign a referral to a staff member

When a Due Date is entered, you also have the option of setting who the referral is assigned to. The screenshot above shows that the note (and therefore the referral) has been assigned to Marvin Gaye.

January 26, 2026 14:39:13

22. Transfer a referral

The **Current referral owner** field on the Referral/IAR-DST screen controls where the intake data belongs to.

To transfer a referral, change the value in the **Current referral owner** field and save the record.

Once saved, if you are transferring from one PHN to another, the system will take you to a screen advising it has been transferred. If you have access to that PHN, it will display a button to automatically change your account to that PHN and then open the referral record.

PHN Intake staff can transfer from PHN to another, so long as they have access to the PHN they need to transfer to. If a referral needs transferring to a PHN you do not have access to, then system support need to do this on your behalf. In this case, send the referral ID link or URL to: pmhcis.support@nwmphn.org.au

22.1 Transferring a referral that is already Sent

When a referral is Sent it becomes locked, and can no longer be changed. In some circumstances, it may need to be sent to another Hub/Centre. In this case, these are the steps to transfer:

1. Once in the referral that you wish to change the referral owner of, toggle off ‘referral sent’ and click save. This will change the referral's status from 'Sent' back to 'Complete'
2. You will be taken back to the main (editable) referral screen, and be able to change the value in the **Current referral owner** field.
3. Click save

22.1.1 Notes

- This function is only available to PHN Admin users.
- Ensure that the receiving organisation is notified of the move so they know to expect the referral.

May 13, 2025 16:54:32

23. Clients calling back or re-engaging

Training videos - Re-engaging

23.1 Process for when an existing client calls back

When receiving a call always search for the client first.

- If they are not in the system create a new Contact as usual.
- If they are already in the system, determine why they are calling:
- If they are calling for further information/clarity on an existing referral, or you are expecting the call in order to finish an IAR, or they are repeat calling for no real reason, or they are just calling for further generalist support: **Continue existing IAR** - make notes in existing IAR.
- If they are calling because their circumstances have changed clinically, and the clinician believes they may need to step up or step down in intensity of provided service, in other words that if another IAR was completed there would likely be a change of IAR level from the original IAR: **New IAR** - complete a new intake assessment to determine new level of IAR. Clinician then decides if they need a different lower/higher intensity service or if the service they already have can still accommodate their needs:
- If their existing service can still accommodate their needs, then the “outcome “in the second IAR should be marked at “Did not proceed and inform” and the clinician informs the service of the conversation and new IAR with content. This new IAR information can then be changed in the clients CMS record at the service.
- If it is determined they need a different service, then choose the outcome according to what that new service is. Clinician should notify the original service with consent and if appropriate (i.e. they are still an active client).
- *See the section below (**Consumers Re-engaging after Discharge**) for the process of creating multiple referrals within a client record.*
- If they are calling because they are no longer receiving a service from the original place they were referred to or that service was not appropriate/desirable (and more than a month has passed):
- *See the section below (**Consumers Re-engaging after Discharge**) for the process of creating multiple referrals within a client record.*
- If they are calling because you assess that they require services/supports additional to the original service they were initially referred to: **Determine if a second referral is best organised by existing service provider**.
- If yes, warm transfer/conversation to enable this with the original referee.
- If not, clinician completes a new intake assessment to determine level of IAR and suitability for additional service. Clinician then decides the outcome according to what that additional service is.
- Clinician should notify the original service with consent and if appropriate (i.e they are still an active client).
- *See the section below (**Consumers Re-engaging after Discharge**) for the process of creating multiple referrals within a client record.*

23.2 Consumers re-engaging after discharge

Clients sometimes re-engage with the Medicare Mental Health intake service. Re-engagement may require reassessment, which means a new Referral record needs to be created.

Where a consumer has received treatment at a commissioned service provider, they are discharged, and are seeking to re-engage for support, another IAR should be completed at the re-commencement of care to reflect the new presenting issues and the current risk profile.

A new referral is not always required, however these are the likely reasons a new referral **would** be needed:

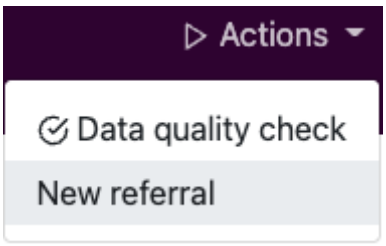
- The outcome of the client's previous referral is resolved; therefore their episode of care is now closed.
- In some circumstances, the original service provider may need to administratively close the episode of care, but the treatment needs to be continued at another service provider. In this case, handover to the new service provider may first require a reassessment (i.e. a new referral). Note that transfers to another service provider do not always require a reassessment/new referral.
- An assessment is required to determine if clinical circumstances have changed. Particular attention should be paid to the Risk Assessment. The assessment will require a new referral (IAR).
- The client is currently being treated at a commissioned service provider and engages with the intake service to request an additional service. The intake clinician may determine that the service provider currently caring for the client can organise the additional supports. In this case, intake conduct a warm transfer with the service provider and no new referral is needed. If the intake clinician determines that they need to arrange the referral, they create a new referral and conduct a new assessment.

23.3 Process for multiple referrals within a client record

Note: The system currently displays the *New referral* menu item only if the "Add new referral" User Role is assigned to your account. This can only be assigned by a System Admin or PHN Admin user account. Contact your PHN Admin for assistance to request the add new referral function.

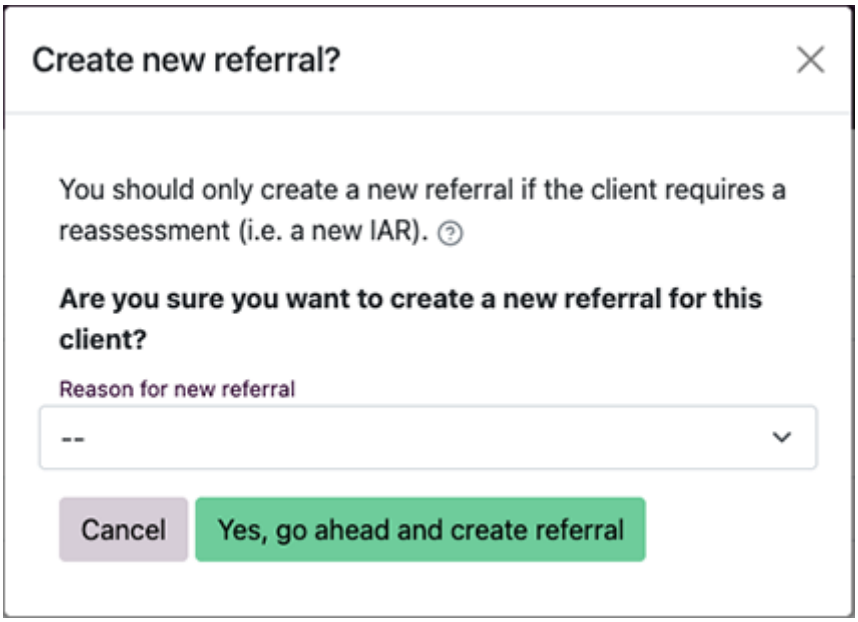
If you have the User Role, to add a new referral open the client's record (the Client screen, not the Referral screen).

From the top-right, select 'Actions' and then click 'New referral'.



Create new referral

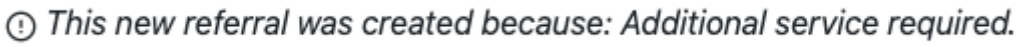
Select a reason for the new referral from the options provided. If any of the options in the drop down options are not suitable, select 'Other' and type the reason in the notes section that will appear.



New referral options

If the previous referral record was created within 30 days, a warning will appear to alert you to the fact, but you can continue if needed.

On the referral screen, a new referral will have a note appear at the top to show the reason the new referral was created. For example:



Reason a referral was created

Once the reason for the new referral has been selected and new referral has been created, a second ‘Data for Intake’ button will now appear at the bottom of the client Demographics page.

Click on the new **Data for Intake** button to being the new IAR Assessment.

For PHN Admin or Intake clinicians creating a new referral upon request from a commissioned service provider: on the new referral, check that the “Current referral owner” field is accurate. It may need to be changed to the relevant service provider in order for the new referral to show on their end.

Additional note: you will also need to ensure the ‘Referral origin’ field is complete on the new referral, as the form will not save if this field is empty.

January 26, 2026 14:37:59

24. Management of referrals for Mental Health Sites

Training videos - Accepting referrals as an MMHC

24.1 Receive a referral via email

MMHCs/sites will receive referrals either via email or through a warm transfer via a phone call. If a referral is received via email, please follow the steps outlined below.

- Email referrals generated from a PHN intake to Medicare Mental Health Hub will appear with the header 'Mental Health referral from [PHN Intake name]'
- To access a referral, click on the URL in the email

24.2 Accept a referral

To accept a referral a button appears on the top right-hand side of the referral page.

Accept a referral

If the 'Referral accepted' button is clicked it sets the report status to ‘Accepted’. This means that the hub is the owner of the referral.

24.3 Un-accept a referral

To reverse the acceptance of a referral, please contact your Medicare Mental Health intake team.

24.4 Download a referral

MMHCs/sites can save the information in the referral for upload/entry into their Client Information Management System (CIMS) by clicking on the print button at the top right of the form and selecting ‘Save as PDF’, then importing to their own clinical database.

24.5 Process for transfer to another PHN or Hub in another PHN catchment

- Seek and document consumer consent in the webform consent section
- Clearly outline the steps taken, and steps yet to be completed in the webform ‘Follow up notes’ section
- Advise the consumer of the next steps
- Email IAR webform referral link to new PHN intake
- Seek webform admin support to alter the ‘Current referral owner’ field to the desired Intake point
- Seek written confirmation of the referral by the destination intake point on receipt

24.6 Process for transferring consumers to a Hubs in a different PHN catchment.

Where a consumer has already been engaged with services in a particular Hub, and wishes to transfer to another hub, please follow the below:

- Seek and document consumer consent for the webform to be transferred to another catchment.
- Ensure there is capacity for the consumer to be seen at the desired hub, and the consumer is eligible for service at the preferred hub.
- Either attach the consumer progress notes to the webform as a PDF, or arrange to send them securely via another means.
- The Hub staff can request webform admin support from their relevant PHN intake team to alter the ‘Current referral owner’ field to the desired PHN catchment.
- PHN intake team to alert the new PHN intake team of the transfer, and of the preferred location the consumer wishes to be seen at.
- Hub staff to contact the new hub and verbally handover the consumers information.
- Hub staff to save the written notes into their own CIMS
- Engage the consumer in care.
- A hand over appointment/ phone call may also be beneficial to support ongoing consumer engagement, particularly if the consumer has been well engaged with their initial treatment team.

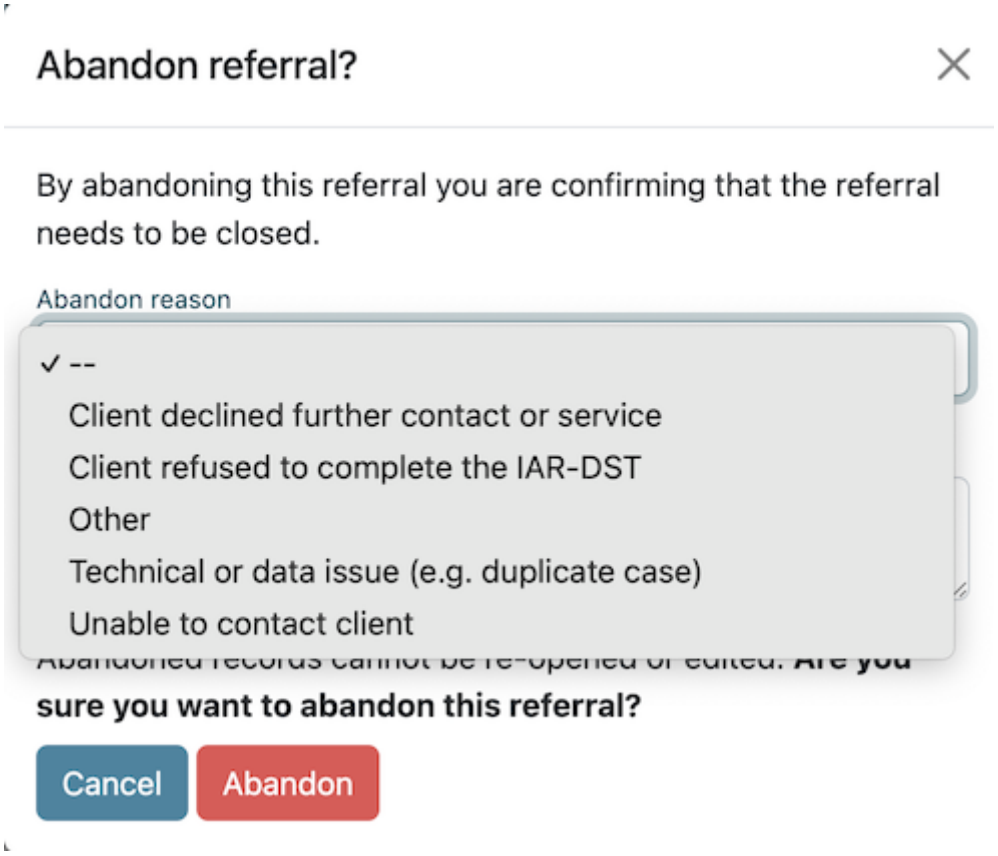
January 26, 2026 12:48:02

25. Abandoning referrals

To abandon, open the referral and click on **Actions** from the top right-hand side menu, then **Abandon**.

You can abandon a referral only if it has not been Sent.

You must provide a reason for the referral being abandoned. Notes are optional but recommended, as it will help clarify the specific reason why it was abandoned.

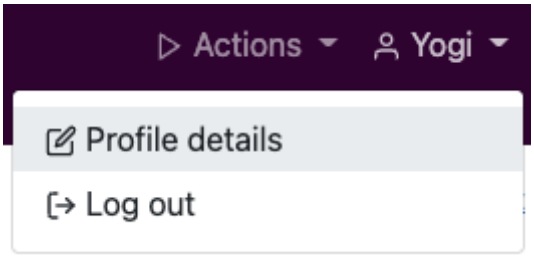


Abandoned

Once a Referral is abandoned **it cannot be re-opened or edited**.

May 18, 2025 10:12:19

Access to your own user account settings is available from the top-right menu. Click your name, then Profile details.



Profile details menu

From the Profile details screen you can:

- Change your name
- Change the IAR-DST note template (if a template has been set for your PHN).
- Change your password.
- Turn on Multi-Factor Authentication (MFA).
- Change the MFA method.

26. Multi-Factor Authentication

MFA adds an extra layer of protection on top of username and password credentials. Once MFA is activated, you need to also supply a verification code before the login can be completed.

1. In the Security section, click the button labelled **Turn 2FA On**.
2. Choose your preferred method for retrieving the verification code. The options are an authenticator app (such as Google Authenticator) or SMS.
3. Follow the instructions for setting the method up.
4. Enter the confirmation verification code.
5. Test that it's working as expected by logging out of your account and then logging in again. When you log back in you should be asked for your verification code.

27. IAR-DST note template

PHNs have the option to set a template for the note fields that are under each IAR-DST domain. A user in an administrator role can create a template or templates by clicking on Actions > Manage organisation.

In your own Profile details screen, you can set your user account to use a template (if one has been set) or none at all.

November 16, 2022 10:07:43

28. Sending in feedback

Training videos - Feedback and Support

28.1 For urgent issues

Such as complete loss of function, please contact your relevant PHN intake manager, who will escalate the matter to the development team.

28.2 For non-urgent issues

The development team are always working to improve the Medicare Mental Health Intake System, your feedback is critical to driving those improvements.

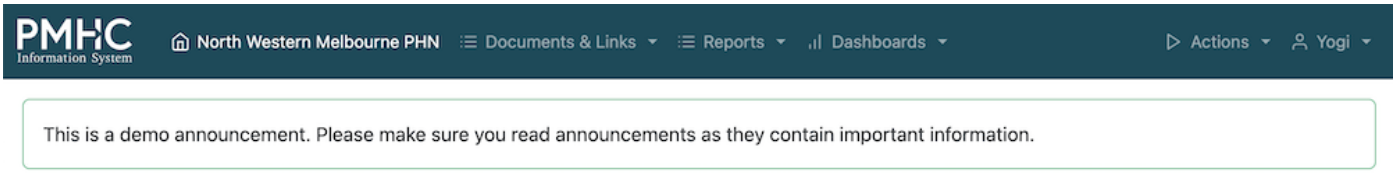
To give feedback, click on the **Feedback & support** link that is at the top-right of the main screen:

Feedback link

And then click **Send in feedback**

The team regularly reviews the feedback. They may get in touch with you to get more information. Changes may need to take into account the workflow of other organisations. You will be notified of the outcome of the feedback review.

When major changes and updates are implemented, the team may put up an announcement, such as the below example, on the main page to explain the change. Please pay attention to any announcements, as they will always contain important information.

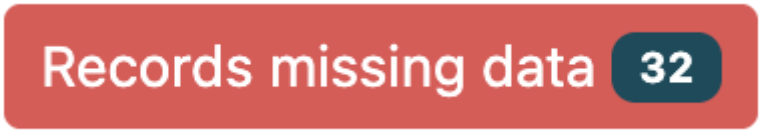


Example announcement

January 26, 2026 12:30:49

29. Data quality

To ensure that the data collected which is reported directly from the webform is of the highest quality, there is a field which reflects the number of files that have records with missing Data option (top-right of the home screen).



Quality

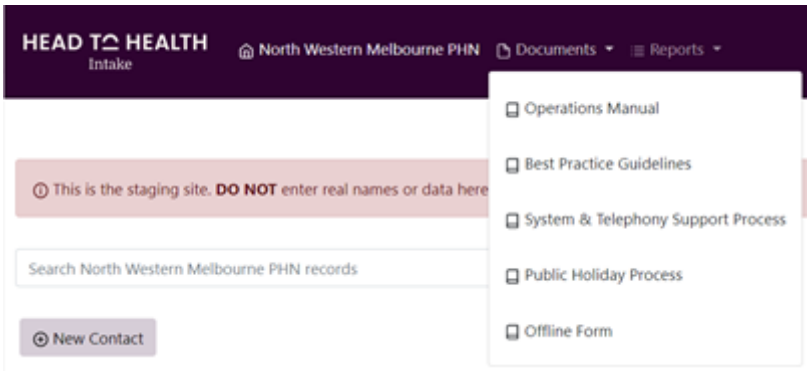
Clicking on this will take you to another screen which lists the files with missing data.

Each file can then be individually accessed to complete the minimum data.

The fields that are mandatory have an indication underneath.

April 6, 2022 18:46:14

30. Offline form



Offline

This document should **only** be used to complete the IAR and record client information in the event that the webform is not accessible.

To enter client information, save a copy of this webform to your computer for editing.

Information recorded on this form **must** be entered into the online webform as soon as possible (ideally within 1 business day). To protect client privacy, the saved form with client information should be deleted or destroyed as per your organisations record retention and destruction policies.

Each intake team should also have a copy of the Offline Webform saved locally for easy access.

April 6, 2022 18:46:14

31. Reporting

Training videos - PowerBI Reports

Data collected via the Medicare Mental Health Intake System is reported at various levels and in various formats.

31.1 Scheduled reports

This list contains the reports that are produced according to a set schedule, the scope of the data included in each report, and the report's audience.

31.1.1 PHN level reporting

- *Daily*
- **Calls Dashboard** - All PHNs and services using the national 1800 phone line.
- **National Intake Dashboard** - Any PHN using the PMHCIS.
- *Monthly*
- **Contact Report** - Any PHN using the PMHCIS or uploading data to NWMPHN.
- **PMHC-MDS Report** - Currently at NSW & VIC hub-level only. Can be further expanded nationally to include MMHC data.

31.1.2 Department of Health level reporting

- *Monthly*
- **Medicare Mental Health Monthly Report** - Cumulative data covering calls, contacts, Intake, referrals and consumer experience survey data.
- *Quarterly*
- **Medicare Mental Health Quarterly Data Report** - National and jurisdictional deep dive analysis report.
- 6-Monthly
- **Telephony, Data & Analytics 6 Month Report** - NWMPHN project status report.

31.1.3 How to gain access

Access requests should come via the PHN lead or key contact for Medicare Mental Health at each PHN. These can be sent to pmhcis.support@nwmphn.org.au to be actioned by NWMPHN. Please include the name and email of the user, and note which reports they should have access to.

31.1.4 Terms of Use for reports

NWMPHN owns the copyright of these reports. The user must ensure that the report is not reproduced, shared, disclosed or published in any forms unless the user has received the prior consent of NWMPHN. The user is permitted to publish an analysis of the data based on these reports but the user undertakes to consult with NWMPHN about the validity and interpretation of any such analysis for publication. A copy of any such analysis should be provided to NWMPHN for approval prior to submission for publication. We acknowledge the peoples of the Kulin nation as the Traditional Custodians of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

January 29, 2026 08:49:49

32. Data breach process

The data in the Medicare Mental Health Intake System is very sensitive. NWMPHN is obligated to identify areas of risk and implement controls that mitigate the risk of data breaches. You are obligated to be vigilant in protecting the data and report possible breaches. A data breach occurs when personal information that an entity holds is subject to unauthorised access or disclosure or is lost.

You must be aware of how data is stored and shared, particularly when doing something outside the normal process. You should avoid sending data insecurely, such as screenshots containing names in an email. It is safe to email the URL of a client or referral, as the URL cannot be used by an external party to identify a person.

Your organisation's data breach policy will guide you on what you should do in the event of a potential breach. If you or your manager believe that a data breach may have occurred you must also notify the NWMPHN Medicare Mental Health Support team by sending an email **marked urgent** to pmhcis.support@nwmphn.org.au. The NWMPHN team will follow their Data Breach Response Plan for investigating potential breaches and taking remedial action, if required to do so. The NWMPHN's Plan's high level steps are:

1. Identify, Contain, Collect. Identify the breach, contain it, and collect information.
2. Evaluate the risks for associated with the breach and conduct preliminary assessment.
3. Notification.

May 13, 2025 16:52:38

33. Appendix - IAR DST Domains Quick reference guide - Version 1

33.1 Domain 1 - Symptom Severity and Distress

Assessment of an individual on this domain should consider:

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

33.1.1 Scoring

0 = No problem in this domain

No descriptors apply.

1 = Mild or sub diagnostic

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

2 = Moderate

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

3 = Severe

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

4 = Very severe

- A history of significant & persistent symptoms that are indicative of a severe mental illness (e.g., hallucinations, paranoia, disordered thinking, extreme mood variation, delusions, severe avoidant behaviour) and symptoms are mostly poorly managed.
- Recent onset of symptoms that are indicative of a severe mental illness (e.g., hallucinations, paranoia, disordered thinking, extreme mood variation, delusions, severe avoidant behaviours) presenting in the context of significant complexity requiring multiple agency involvement.
- Other long-term mental health condition presenting in the context of significant complexity that requires multiple agency involvement.

33.2 Domain 2 - Risk of Harm

This domain is focussed on examining:

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

33.2.1 Scoring

0 = No problem in this domain

No descriptors apply.

1 = Low risk of harm

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

2 = Moderate risk of harm

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

3 = High risk of harm

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

4 = Very high risk of harm

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

33.3 Domain 3 - Functioning

Assessment of an individual on this domain should consider:

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

33.3.1 Scoring

0 = No problem in this domain

No descriptors apply.

1 = Mild impact

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

2 = Moderate impact

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

3 = Severe impact

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

4 = Very severe to extreme impact

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

33.4 Domain 4 - Impact of Co-existing Conditions

Assessment of an individual on this domain should consider:

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

33.4.1 Scoring

0 = No problem in this domain

No descriptors apply.

1 = Minor impact

- Occasional episodes of substance misuse but any recent episodes are limited, are not currently causing any concerns and do not impact on the concurrent mental health condition of the person.
- Physical health condition(s) present but are stable and do not have an impact on the concurrent mental health condition of the person.

2 = Moderate impact

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

3 = Severe impact

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

4 = Very severe impact

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

33.5 Domain 5 - Treatment and Recovery History

Assessment of an individual on this domain should consider:

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

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

33.5.1 Scoring

0 = No prior treatment history

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

1 = Full recovery with previous treatment

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

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

3 = Minor recovery with previous treatment

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

4 = Negligible recovery with previous treatment

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

33.6 Domain 6 - Social and Environmental

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

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

33.6.1 Scoring

0 = No problem in this domain

No descriptors apply.

1 = Mildly stressful environment

- Person experiences their environment as mildly stressful.

2 = Moderately stressful environment

- Person experiences their environment as moderately stressful.

3 = Highly stressful environment

- Person experiences their environment as highly stressful.

4 = Extremely stressful environment

- Person experiences their environment as extremely stressful.

33.7 Domain 7 - Family and Other Supports

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

33.7.1 Scoring

0 = Highly supported

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

1 = Well supported

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

2 = Limited supports

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

3 = Minimal supports

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

4 = No supports

- No useful sources of support are available.

33.8 Domain 8 - Engagement and Motivation

Assessment of an individual on this domain should include:

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

33.8.1 Scoring

0 = Optimal

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

1 = Positive

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

2 = Limited

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

3 = Minimal

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

4 = Disengaged

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

October 4, 2024 11:52:32

34. Appendix - IAR DST Domains Quick reference guide - Version 2

34.1 Domain 1 - Symptom Severity and Distress

34.1.1 **Children (5 - 11 years)**

Assessment of a child on this domain should consider:

- Current and past symptoms and duration.
- Level of distress associated with the mental health issues.
- Previous experience of a mental health condition.
- Are symptoms improving/worsening, is distress improving/worsening, and are new symptoms emerging?

Scoring

0 = No problem in this domain

1 = Mild Symptoms are likely to be sub-diagnostic and have been experienced for less than three months (but this may vary)

a. Mild anxiety-related symptoms (e.g., occasional fears, worry, difficulty concentrating, occasional unexplained somatic symptoms like headache and stomach pain) without significant avoidant behaviour.

b. Mild mood-related symptoms (e.g., sadness, fatigue, apathy, some reluctance to participate in previously enjoyed activities, irritability, occasional disrupted sleep).

c. Mild behavioural symptoms (e.g., distractibility, overactivity, occasional difficulty following instructions or completing tasks, occasional concerning or aggressive behaviours, minor interpersonal difficulties).

d. Currently experiencing a mental health condition associated with mild distress or mild reduction in quality of life.

2 = Moderate Symptoms are at a level that would likely meet diagnostic criteria and have been experienced for more than three months (but this may vary)

a. Moderate anxiety-related symptoms (e.g., excessive worry, agitation, panic, difficulty concentrating, significant self-consciousness or significant concerns about body image, appearance or weight, frequent unexplained somatic complaints) with significant avoidance of anxiety provoking situations.

b. Moderate mood-related symptoms (e.g., excessive sadness, apathy, exhaustion, frequent irritability, loss of interest and pleasure and/or frequent reluctance to participate in previously enjoyed activities, frequent sleep disturbance).

c. Moderate behavioural symptoms (e.g., frequent impulsivity, hyperactivity, non-adherence to age-appropriate rules or social norms, frequent concerning or aggressive behaviours, significant interpersonal difficulties).

d. Currently experiencing a mental health condition associated with moderate levels of distress and/or moderate reduction in quality of life.

e. History of a diagnosed mental health condition earlier in childhood that has not responded to treatment, with continuing symptoms but only associated with mild to moderate levels of distress.

3 = Severe

a. Severe anxiety-related symptoms are present most of the time, the child has difficulty controlling or managing the symptoms and seeks to avoid anxiety provoking situations and/or experiences severe distress if asked to engage in anxiety provoking situations such that there is severe distress and/or significant disruption to the child’s (and/or parent/family’s) life.

b. Severe mood-related symptoms are present most of the time, the child has difficulty controlling or managing the symptoms and the symptoms are associated with severe distress and/or significant disruption to the child’s (and/or parent/family’s) life.

c. Severe behavioural symptoms are present most of the time, the child has difficulty controlling or managing the symptoms and the symptoms are associated with severe disruption and/or distress for the child, and/or their parent/family and interpersonal relationships.

d. Currently experiencing other severe mental health symptoms or severe psychological distress (e.g., complex trauma responses, obsessions, compulsions, severely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Symptoms suggestive of an early form of a severe mental health condition (e.g., odd thinking/ behaviour/speech, abnormal perceptions, short periods of unusually elevated mood, a substantial decrease in the need for sleep) or symptoms suggestive of an eating disorder.

f. Has been treated by a specialist community mental health service or admitted to hospital for a mental health condition in the previous 12 months.

4 = Very severe

a. Very severe and pervasive anxiety symptoms are present virtually all the time, the child can rarely control or manage the symptoms and the child refuses to engage in anxiety provoking situations or activities. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the child's (and/or parent/family's) life.

b. Very severe and pervasive mood-related symptoms are present virtually all the time, and the child can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the child's (and/or parent/family's) life.

c. Very severe or extreme behavioural symptoms are present virtually all the time and the child can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the child's (and/or parent/family's) life.

d. Currently experiencing very severe symptoms (e.g., disordered thinking, extreme mood variation, obsessions, compulsions, extreme avoidant behaviour, extreme interpersonal difficulties, extremely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Highly unusual and bizarre symptoms/behaviours indicating a severe mental illness (e.g., hallucinations, delusions). Symptoms may be ongoing or of more recent or sudden onset.

34.1.2 **Adolescent (12 - 17 years)**

Assessment of an adolescent on this domain should consider:

- Current and past symptoms and duration.
- Level of distress associated with the mental health issues.
- Previous experience of a mental health condition.
- Are symptoms improving/worsening, is distress improving/worsening, and are new symptoms emerging?

Scoring

0 = No problem in this domain

1 = Mild Symptoms are likely to be sub-diagnostic and have been experienced for less than three months (but this may vary)

a. Mild anxiety-related symptoms (e.g., occasional fears, worry, difficulty concentrating, body image issues, occasional unexplained somatic symptoms like headache and stomach pain) without significant avoidant behaviour.

b. Mild mood-related symptoms (e.g., sadness, fatigue, apathy, some reluctance to participate in previously enjoyed activities, irritability, occasional disrupted sleep).

c. Mild behavioural symptoms (e.g., distractibility, overactivity, occasional difficulty completing tasks, quick to anger, occasional concerning or aggressive behaviours, occasionally appearing oppositional, minor interpersonal difficulties).

d. Currently experiencing a mental health condition associated with mild distress or mild reduction in quality of life.

2 = Moderate Symptoms are at a level that would likely meet diagnostic criteria and have been experienced for more than three months (but this may vary)

a. Moderate anxiety-related symptoms (e.g., excessive worry, agitation, panic, difficulty concentrating, significant self-consciousness or significant concerns about body image, appearance or weight, frequent unexplained somatic complaints) with significant avoidance of anxiety provoking situations.

b. Moderate mood-related symptoms (e.g., excessive sadness, apathy, exhaustion, frequent irritability, loss of interest and pleasure and/or frequent reluctance to participate in previously enjoyed activities, frequent sleep disturbance).

c. Moderate behavioural symptoms (e.g., frequent impulsivity, hyperactivity, non-adherence to age-appropriate rules or social norms, frequent concerning or aggressive behaviours, significant interpersonal difficulties).

d. Currently experiencing a mental health condition associated with moderate levels of distress and/or moderate reduction in quality of life.

e. History of a diagnosed mental health condition earlier in childhood that has not responded to treatment, with continuing symptoms but only associated with mild to moderate levels of distress.

3 = Severe

a. Severe anxiety-related symptoms are present most of the time, the adolescent has difficulty controlling or managing the symptoms and seeks to avoid anxiety provoking situations and/or experiences severe distress if asked to engage in anxiety provoking situations such that there is severe distress and/or significant disruption to the adolescent’s (and/or parent/family’s) life.

b. Severe mood-related symptoms are present most of the time, the adolescent has difficulty controlling or managing the symptoms and the symptoms are associated with severe distress and/or significant disruption to the adolescent’s (and/or parent/family’s) life.

c. Significant behavioural symptoms are present most of the time the adolescent has difficulty controlling or managing the symptoms and the symptoms are associated with severe disruption and/or distress for the adolescent, and/or their parent/family and interpersonal relationships.

d. Currently experiencing other severe mental health symptoms or severe psychological distress (e.g., complex trauma responses, obsessions, compulsions, severely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Symptoms suggestive of an early form of a severe mental health condition (e.g., odd thinking/ behaviour/speech, abnormal perceptions, suspicious thinking, rapid mood swings, a substantial decrease in the need for sleep) or symptoms suggestive of an eating disorder.

f. Has been treated by a specialist community mental health service or admitted to hospital for a mental health condition in the previous 12-months.

4 = Very severe

a. Very severe and pervasive anxiety symptoms are present virtually all the time, the adolescent can rarely control or manage the symptoms and the adolescent refuses to engage in anxiety provoking situations or activities. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the adolescent’s (and/or parent/family’s) life.

b. Very severe and pervasive mood-related symptoms are present virtually all the time, and the adolescent can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the adolescent’s (and/or parent/family’s) life.

c. Extreme behavioural symptoms are present virtually all the time, and the adolescent can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the adolescent’s (and/or parent/family’s) life.

d. Currently experiencing very severe symptoms (e.g., disordered thinking, extreme mood variation, obsessions, extreme avoidant behaviour, extreme interpersonal difficulties, extremely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Highly unusual and bizarre symptoms/behaviours indicating a severe mental illness (e.g., hallucinations, delusions). Symptoms may be ongoing or of more recent or sudden onset.

34.1.3 **Adult (18 - 64 years)**

Assessment of an individual on this domain should consider:

- Current and past symptoms and duration.
- Level of distress associated with the mental health issues.
- Previous experience of a mental health condition.
- Are symptoms improving/worsening, is distress improving/worsening, and are new symptoms emerging?

Scoring

0 = No problem in this domain

1 = Mild Symptoms are likely to be sub-diagnostic and have been experienced for less than 6 months (but this may vary)

a. Mild anxiety-related symptoms (e.g., occasional fears, worry, difficulty concentrating, occasional unexplained somatic symptoms) without significant avoidant behaviour.

b. Mild mood-related symptoms (e.g., sadness, fatigue, apathy, some reluctance to participate in previously enjoyed activities, irritability, occasional disrupted sleep).

c. Mild behavioural symptoms (e.g., distractibility, overactivity, occasional difficulty completing tasks, quick to anger, occasional concerning or aggressive behaviours, minor interpersonal difficulties).

d. Currently experiencing a mental health condition associated with mild distress or mild reduction in quality of life.

2 = Moderate Symptoms are at a level that would likely meet diagnostic criteria and have been experienced for more than 6 months (but this may vary)

a. Moderate anxiety-related symptoms (e.g., excessive worry, agitation, panic, difficulty concentrating, frequent unexplained somatic complaints) with significant avoidance of anxiety provoking situations.

b. Moderate mood-related symptoms (e.g., excessive sadness, apathy, exhaustion, frequent irritability, loss of interest and pleasure, and/or frequent reluctance to participate in previously enjoyed activities, guilt or worthlessness, frequent sleep disturbance).

c. Moderate behavioural symptoms (e.g., frequent impulsivity, hyperactivity, frequent disinhibited behaviour, non-adherence to social norms, frequent concerning or aggressive behaviours, significant interpersonal difficulties).

d. Currently experiencing a mental health condition associated with moderate levels of distress and/or moderate reduction in quality of life.

e. History of a diagnosed mental health condition that has not responded to treatment, with continuing symptoms but only associated with mild to moderate levels of distress.

3 = Severe

a. Severe anxiety-related symptoms are present most of the time, the person has difficulty controlling or managing the symptoms and seeks to avoid anxiety provoking situations and/or experiences severe distress if asked to engage in anxiety provoking situations such that there is severe distress and/or significant disruption to the person’s life.

b. Severe mood-related symptoms are present most of the time, the person has difficulty controlling or managing the symptoms, and the symptoms are associated with severe distress and/or significant disruption to the person’s life.

c. Significant behavioural symptoms are present most of the time, the person has difficulty controlling or managing the symptoms, and the symptoms are associated with severe distress and/or significant disruption to the person's life.

d. Currently experiencing other severe mental health symptoms (e.g., complex trauma responses, obsessions, compulsions, severely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Symptoms suggestive of an early form of a severe mental health condition (e.g., odd thinking/ behaviour/speech, abnormal perceptions, suspicious thinking, rapid mood swings, a substantial decrease in the need for sleep).

f. Has been treated by a specialist community mental health service or admitted to a hospital for a mental health condition in the previous 12 months.

4 = Very severe

a. Very severe and pervasive anxiety symptoms are present virtually all the time, the person can rarely control or manage the symptoms and the person refuses to engage in anxiety provoking situations or activities. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the person's life.

b. Very severe and pervasive mood-related symptoms are present virtually all the time, and the person can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the person's life.

c. Extreme behavioural symptoms are present virtually all the time, and the person can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the person's life.

d. Currently experiencing very severe symptoms (e.g., disordered thinking, extreme mood variation, obsessions, compulsions, extreme avoidant behaviour, extreme interpersonal difficulties, extremely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Highly unusual and bizarre symptoms/behaviours indicating a severe mental illness (e.g., hallucinations, delusions). Symptoms may be ongoing or of more recent or sudden onset.

34.1.4 Older Adult (65 years and older)

Assessment of an older adult on this domain should consider:

- Current and past symptoms and duration.
- Level of distress associated with the mental health issues.
- Previous experience of a mental health condition.
- Are symptoms improving/worsening, is distress improving/worsening, and are new symptoms emerging?

Scoring

0 = No problem in this domain

1 = Mild Symptoms are likely to be sub-diagnostic and have been experienced for less than six months (but this may vary)

a. Mild anxiety-related symptoms (e.g., occasional fears, worry, difficulty concentrating, occasional unexplained somatic symptoms) without significant avoidant behaviour.

b. Mild mood-related symptoms (e.g., sadness, fatigue, apathy, some reluctance to participate in previously enjoyed activities, irritability, occasional disrupted sleep).

c. Mild behavioural symptoms (e.g., distractibility, overactivity, occasional difficulty completing tasks, quick to anger, occasional concerning or aggressive behaviours, minor interpersonal difficulties).

d. Currently experiencing a mental health condition associated with mild distress or mild reduction in quality of life.

2 = Moderate Symptoms are at a level that would likely meet diagnostic criteria and have been experienced for more than six months (but this may vary)

a. Moderate anxiety-related symptoms (e.g., excessive worry, agitation, panic, difficulty concentrating, frequent unexplained somatic complaints) with significant avoidance of anxiety provoking situations.

b. Moderate mood-related symptoms (e.g., excessive sadness, apathy, exhaustion, frequent irritability, loss of interest and pleasure and/or frequent reluctance to participate in previously enjoyed activities, guilt or worthlessness, frequent sleep disturbance).

c. Moderate behavioural symptoms (e.g., frequent impulsivity, hyperactivity, frequent disinhibited behaviour, non-adherence to social norms, frequent concerning or aggressive behaviours, significant interpersonal difficulties).

d. Currently experiencing a mental health condition associated with moderate levels of distress and/or moderate reduction in quality of life.

e. History of a diagnosed mental health condition that has not responded to treatment, with continuing symptoms but only associated with mild to moderate levels of distress.

3 = Severe

a. Severe anxiety-related symptoms are present most of the time, the person has difficulty controlling or managing the symptoms and seeks to avoid anxiety provoking situations and/or experiences severe distress if asked to engage in anxiety provoking situations such that there is severe distress and/or significant disruption to the person’s life.

b. Severe mood-related symptoms are present most of the time, the person has difficulty controlling or managing the symptoms, and the symptoms are associated with severe distress and/or significant disruption to the person’s life.

c. Significant behavioural symptoms are present most of the time, the person has difficulty controlling or managing the symptoms, and the symptoms are associated with severe distress and/or significant disruption to the person’s life.

d. Currently experiencing other severe mental health symptoms (e.g., complex trauma responses, obsessions, compulsions, severely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Symptoms suggestive of an early form of a severe mental health condition (e.g., odd thinking/ behaviour/speech, abnormal perceptions, suspicious thinking, rapid mood swings, a substantial decrease in the need for sleep).

f. Has been treated by a specialist community mental health service or admitted to a hospital for a mental health condition in the previous 12 months.

4 = Very severe

a. Very severe and pervasive anxiety symptoms are present virtually all the time, the person can rarely control or manage the symptoms and the person refuses to engage in anxiety provoking situations or activities. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the person’s life.

b. Very severe and pervasive mood-related symptoms are present virtually all the time, and the person can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the person’s life.

c. Extreme behavioural symptoms are present virtually all the time, and the person can rarely control or manage the symptoms. The symptoms are associated with severe distress, significantly reduced quality of life and/or severe disruption to nearly all aspects of the person’s life.

d. Currently experiencing very severe symptoms (e.g., disordered thinking, extreme mood variation, obsessions, compulsions, extreme avoidant behaviour, extreme interpersonal difficulties, extremely disordered eating). Symptoms may be ongoing or of more recent or sudden onset.

e. Highly unusual and bizarre symptoms/behaviours indicating a severe mental illness (e.g., hallucinations, delusions). Symptoms may be ongoing or of more recent or sudden onset.

34.2 Domain 2 - Harm

34.2.1 **Children (5 - 11 years)**

This domain is focused on:

- Suicidality – current and past suicidal ideation, intent, planning, and attempts.
- Intentional, non-suicidal self-harm – current and past.
- Impulsive, dangerous, or risky behaviours with the potential for psychological or physical harm to self or others (consider and include risks associated with the use of alcohol and other drugs).
- The psychological or physical harm caused by abuse, exploitation, or neglect by others.
- Unintentional harm to self, arising from symptoms or self-neglect.

The IAR for children includes the harm from others in domain 2 because there are direct implications for the intensity of a mental health response for children at risk of, or experiencing, harm from others is likely to require. Placing harm from others in another domain (e.g., domain 6) does not carry the same weight within the logic that underpins the recommendations about a level of care. Note that the presence of external stressors (e.g., family violence) is rated at domain 6, but the degree of harm arising from those stressors is rated separately at domain 2.

Scoring

0 = No concerns about harm

1 = Previous but no current concerns about harm

a. No current suicidal ideation, but the child has experienced suicidal ideation in the past (with no previous intent, plans, or attempts). Demonstrates future-oriented thinking and has strong protective factors.

b. Occasional non-suicidal self-injurious acts in the recent past and not requiring any medical treatment.

c. May have engaged in past behaviours that posed a risk to self or others, but no current or recent instances.

d. Currently at low risk of harm from abuse, exploitation, or neglect by others.

2 = Some current concerns about harm

a. Previous suicide attempt (more than 12 months ago) but no current ideation, intent, or plan. The child demonstrates future-orientated thinking and has strong protective factors.

b. Frequent non-suicidal self-injurious acts in the recent past but that did not require any medical treatment.

c. Current or recent behaviours that pose a non-life-threatening risk to self or others.

d. Currently at some risk of harm from abuse, exploitation, or neglect by others.

e. Intermittent lapses in self-care that may lead to harm.

3 = Significant current concerns about harm

a. Current suicidal ideation but no current intent and no history of suicide attempts. No plan or strong reluctance to carry out the plan, strong protective factors, and a commitment to engage in a safety plan, including involvement of family, significant others, and services.

b. Recent suicide attempt (within past 12 months) but no current ideation, intent, or plan.

c. Frequent non-suicidal self-injurious acts in the recent past, one or more of which required medical treatment.

d. Recent or current impulsive, dangerous, or risky behaviours that pose a risk of harm to self or others, or that have had or are likely to have a serious negative impact.

e. Serious medical risks and/or complications associated with a mental illness.

f. Significant risk of, or recent experience of, abuse, exploitation, or neglect by others.

g. Clearly compromised self-care ability that is ongoing to the extent that indirect or unintentional harm to self is likely.

4 = Very significant current concerns about harm

a. Current suicidal ideation with intent, typically with a plan and means to carry out the plan, or history of previous suicide attempt. Few or no protective factors. Limited or no future-orientated thinking.

b. History of life-threatening self-injurious acts that are prominent in the current presentation.

c. There is evidence of current severe symptoms (e.g., hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions, impulsivity) with behaviour that is likely to present an imminent or unpredictable danger to self or others.

d. Extremely compromised self-care ability to the extent that there is a real and present danger of the child experiencing harm related to these deficits.

e. Life-threatening medical risks and/or complications associated with a mental illness.

f. Other signs or indicators of imminent risk of serious harm to themselves or others.

34.2.2 **Adolescent (12 - 17 years)**

This domain is focused on:

- Suicidality – current and past suicidal ideation, intent, planning, and attempts.
- Intentional, non-suicidal self-harm – current and past.
- Impulsive, dangerous, or risky behaviours with the potential for psychological or physical harm to self or others (consider and include risks associated with the use of alcohol and other drugs).
- The psychological or physical harm caused by abuse, exploitation, or neglect by others.
- Unintentional harm to self, arising from symptoms or self-neglect.

The IAR for adolescents includes the harm from others in Domain 2 because there are direct implications for the intensity of mental health response an adolescent at risk of or experiencing harm from others is likely to require. Placing harm from others in another domain (e.g., Domain 6) does not carry the same weight within the logic that underpins the recommendations about a level of care. Note that the presence of external stressors (e.g., family violence) is rated at Domain 6, but the degree of harm arising from those stressors is rated separately at Domain 2.

Scoring

0 = No concerns about harm

1 = Previous but no current concerns about harm

a. No current suicidal ideation, but the adolescent has experienced suicidal ideation, plans, or intent in the past. Demonstrates future-oriented thinking and has strong protective factors.

b. Occasional non-suicidal self-injurious acts in the recent past and not requiring any medical treatment.

c. May have engaged in past behaviours that posed a risk to self or others, but no current or recent instances.

d. Currently at low risk of harm from abuse, exploitation, or neglect by others.

2 = Some current concerns about harm

a. Current suicidal ideation, without plan or intent but may have had plans, intent, or suicide attempts in the past. Demonstrates future-orientated thinking and has strong protective factors or previous suicide attempt (longer than 12 months ago) but no current ideation, intent, or plan.

b. Frequent non-suicidal self-injurious acts in the recent past that did not require any medical treatment.

c. Current or recent behaviours that pose a non-life-threatening risk to self or others.

d. Currently at some risk of harm from abuse, exploitation, or neglect by others.

e. Intermittent lapses in self-care that may lead to harm.

3 = Significant current concerns about harm

a. Current suicidal ideation with a plan, but no current intent or a strong reluctance to carry out a plan. May have a history of suicide attempts. Strong protective factors and a commitment to engage in a safety plan, including the involvement of family, significant others, or services.

b. Recent suicide attempt (within past 12 months) but no current ideation, intent, or plan.

c. Frequent non-suicidal self-injurious acts in the recent past and requiring medical treatment.

d. Recent or current impulsive, dangerous, or risky behaviours that pose a risk of harm to self or others, or that have had or are likely to have a serious negative impact.

e. Serious medical risks and/or complications associated with a mental illness.

f. Significant risk of, or recent experience of, abuse, exploitation, or neglect by others.

g. Clearly compromised self-care ability that is ongoing to the extent that indirect or unintentional harm to self is likely.

4 = Very significant current concerns about harm

a. Current suicidal ideation with intent, typically with a plan and means to carry out the plan or history of previous suicide attempt. Few or no protective factors. Limited or no future-orientated thinking.

b. History of life-threatening self-injurious acts that are prominent in the current presentation.

c. There is evidence of current severe symptoms (e.g., hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions, impulsivity) with behaviour that is likely to present an imminent or unpredictable danger to self or others.

d. Extremely compromised self-care ability to the extent that there is a real and present danger of the adolescent experiencing harm related to these deficits.

e. Life-threatening medical risks and/or complications associated with a mental illness.

f. Other signs or indicators of imminent risk of serious harm to themselves or others.

34.2.3 **Adult (18 - 64 years)**

This domain is focused on:

- Suicidality – current and past suicidal ideation, intent, planning, and attempts.
- Intentional, non-suicidal self-harm – current and past.
- Impulsive, dangerous, or risky behaviours with the potential for psychological or physical harm to self or others (consider and include risks associated with the use of alcohol and other drugs).
- The psychological or physical harm caused by abuse, exploitation, or neglect by others.
- Unintentional harm to self, arising from symptoms or self-neglect.

The IAR for adults includes the harm from others in domain 2 because there are direct implications for the intensity of a mental health response a person at risk of or experiencing harm from others is likely to require. Placing harm from others in another domain (e.g., domain 6) does not carry the same weight within the logic that underpins the recommendations about a level of care. Note that the presence of external stressors (e.g., family violence) is rated at domain 6, but the degree of harm arising from those stressors is rated separately at domain 2.

Scoring

0 = No concerns about harm

1 = Previous but no current concerns about harm

a. No recent or current suicidal ideation but has experienced suicidal ideation, plans, or intent in the past. No recent history of suicide attempts but may have made attempts in the past. Demonstrates future-oriented thinking and has strong protective factors.

b. Occasional non-suicidal self-injurious acts in the recent past and not requiring any medical treatment.

c. May have engaged in past behaviours that posed a risk to self or others, but no current or recent instances.

d. Currently at low risk of harm from abuse, exploitation, or neglect by others.

2 = Some current concerns about harm

a. Current suicidal ideation, without plan or intent, but may have had plans, intent, or suicide attempts in the past. Demonstrates future-orientated thinking and has strong protective factors.

b. Frequent non-suicidal self-injurious acts in the recent past that did not require any medical treatment.

c. Current or recent behaviours that pose a non-life-threatening risk to self or others.

d. Currently at some risk of harm from abuse, exploitation, or neglect by others.

e. Frequent lapses in self-care that may lead to harm.

3 = Significant current concerns about harm

a. Current suicidal ideation with a plan but no current intent or a strong reluctance to carry out a plan. May have a history of suicide attempts. Strong protective factors and a commitment to engage in a safety plan, including the involvement of family, significant others, or services.

b. Recent suicide attempt (within the past 12 months) but no current ideation, intent, or plan.

c. Frequent non-suicidal self-injurious acts in the recent past and requiring medical treatment.

d. Recent or current impulsive, dangerous, or risky behaviours that pose a risk of harm to self or others, or that have had or are likely to have a serious negative impact.

e. Serious medical risks and/or complications associated with a mental illness.

f. Significant risk of, or recent experience of, abuse, exploitation, or neglect by others.

g. Clearly compromised self-care ability that is ongoing to the extent that indirect or unintentional harm to self is likely.

4 = Very significant current concerns about harm

a. Recent suicide attempt (within the past 12 months) or current suicidal ideation, with intent, typically with a plan and means to carry out the plan. Few or no protective factors. Limited or no future-orientated thinking.

b. History of life-threatening self-injurious acts that are prominent in the current presentation.

c. There is evidence of current severe symptoms (e.g., hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions, impulsivity, disinhibition) with behaviour that is likely to present an imminent or unpredictable danger to self or others.

d. Extremely compromised self-care ability to the extent that there is a real and present danger of the person experiencing harm related to these deficits.

e. Life-threatening medical risks and/or complications associated with a mental illness.

f. Other signs or indicators of imminent risk of serious harm to themselves or others.

34.2.4 **Older Adult (65 years and older)**

This domain is focused on:

- Suicidality – current and past suicidal ideation, intent, planning, and attempts.
- Intentional, non-suicidal self-harm – current and past.
- Impulsive, dangerous, or risky behaviours with the potential for psychological or physical harm to self or others (consider and include risks associated with the use of alcohol and other drugs).
- The psychological or physical harm caused by abuse, exploitation, or neglect by others.
- Unintentional harm to self, arising from symptoms or self-neglect.

The IAR for older adults includes the harm from others in domain 2 because there are direct implications for the intensity of mental health response an older adult at risk of or experiencing harm from others is likely to require. Placing harm from others in another domain (e.g., domain 6) does not carry the same weight within the logic that underpins the recommendations about a level of care. Note that the presence of external stressors (e.g., family violence) is rated at domain 6, but the degree of harm arising from those stressors is rated separately at domain 2.

Scoring

0 = No concerns about harm

1 = Previous but no current concerns about harm

a. No recent or current suicidal ideation, but has experienced ideation, plans, or intent in the past. No recent history of suicide attempts but may have made attempts in the past. Demonstrates future-oriented thinking and has strong protective factors.

b. Occasional non-suicidal self-injurious acts in the recent past and not requiring any medical treatment.

c. May have engaged in past behaviours that posed a risk to self or others, but no current or recent instances.

d. Currently at low risk of harm from abuse, exploitation, or neglect by others.

2 = Some current concerns about harm

a. Current suicidal ideation, without plan or intent but may have had plans, intent, or suicide attempts in the past. Demonstrates future-orientated thinking and has strong protective factors.

b. Frequent non-suicidal self-injurious acts in the recent past and not requiring any medical treatment.

c. Current or recent behaviours that pose a non-life-threatening risk to self or others.

d. Currently at some risk of harm from abuse, exploitation, or neglect by others.

e. Frequent lapses in self-care that may lead to harm.

3 = Significant current concerns about harm

a. Current suicidal ideation with a plan, but no current intent or a strong reluctance to carry out a plan. May have a history of suicide attempts. Strong protective factors and a commitment to engage in a safety plan, including the involvement of family, significant others, or services.

b. Recent suicide attempt (within past 12 months) but no current ideation, intent, or plan.

c. Frequent non-suicidal self-injurious acts in the recent past and requiring medical treatment.

d. Recent or current impulsive, dangerous, or risky behaviours that pose a risk of harm to self or others, or that have had or are likely to have a serious negative impact.

e. Serious medical risks and/or complications associated with a mental illness.

f. Significant risk of, or recent experience of, abuse, exploitation, or neglect by others.

g. Clearly compromised self-care ability that is ongoing to the extent that indirect or unintentional harm to self is likely.

4 = Very significant current concerns about harm

a. Recent suicide attempt (within past 12 months) or current suicidal ideation, with intent, typically with a plan and means to carry out. Few or no protective factors. Limited or no future-orientated thinking.

b. History of life-threatening self-injurious acts that are prominent in the current presentation.

c. There is evidence of current severe symptoms (e.g., hallucinations, avoidant behaviour, paranoia, disordered thinking, delusions, impulsivity, disinhibition) with behaviour that is likely to present an imminent or unpredictable danger to self or others.

d. Extremely compromised self-care ability to the extent that there is a real and present danger of the person experiencing harm related to these deficits.

e. Life-threatening medical risks and/or complications associated with a mental illness.

f. Other signs or indicators of imminent risk of serious harm to themselves or others.

34.3 Domain 3 - Functioning

34.3.1 **Children (5 - 11 years)**

Assessment of a child on this domain should consider the impact of the mental health issues on:

- The child’s ability to fulfil usual roles/responsibilities appropriate to their age, developmental level, capability, and cultural background.
- The child’s functioning within the family or home environment, in educational settings, with friends and peers, at play and in the community.
- The child’s ability to undertake basic activities of daily living appropriate to their age, capability, and developmental level (e.g., self-care, mobility, toileting, nutrition, and personal hygiene).

Scoring

0 = No problem in this domain

1 = Mild impact

a. Mildly diminished ability to function in one or more of their usual roles (e.g., at home, in educational settings, with friends and peers, at play and in the community), but without significant or adverse consequences.

b. Mental health issues contribute to brief and transient disruptions in one or more areas of functioning.

2 = Moderate impact

a. Moderate functional impairment in more than one of their usual roles (e.g., at home, in educational settings, with friends and peers, at play and in the community) to the extent that they are frequently unable to meet the requirements of those roles, but without significant adverse consequences.

b. Mental health issues contribute to occasional difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, and toileting) or instrumental activities of daily living (e.g., preparing food, tidying up, completing tasks) but without threat to health.

3 = Severe impact

a. Significant difficulties with functioning, resulting in disruption to many areas of the child’s life most of the time (e.g., limited participation in educational or recreational activities, deterioration in or some withdrawal from relationships with friends and peers), but the child can function independently with adequate treatment, appropriate accommodations and supports e.g., in educational settings and family, and community support.

b. Mental health issues frequently contribute to difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, and toileting) or instrumental activities of daily living (e.g., preparing food, tidying up, completing tasks) on a consistent basis but without threat to health.

4 = Very severe to extreme impact

a. Profound difficulties with functioning, resulting in significant disruption to virtually all areas of the child's life (e.g., unable to participate in educational activities, complete withdrawal from friends and peers).

b. Mental health issues contribute to severe and persistent self-neglect that poses a threat to health.

34.3.2 **Adolescent (12 - 17 years)**

Assessment of an adolescent on this domain should consider the impact of the mental health issues on:

- The adolescents' ability to fulfil usual roles/responsibilities appropriate to their age, developmental level, and cultural background.
- The adolescent's functioning within the family or home environment, in educational or vocational settings, with friends and peers, and in the community.
- The adolescent's ability to undertake basic activities of daily living appropriate to their age and developmental level (e.g., self-care, mobility, toileting, feeding, and personal hygiene).

Scoring

0 = No problem in this domain

1 = Mild impact

a. Mildly diminished ability to function in one or more of their usual roles (e.g., at home, in educational settings, with friends and peers, at play and in the community), but without significant or adverse consequences.

b. Mental health issues contribute to brief and transient disruptions in one or more areas of functioning.

2 = Moderate impact

a. Moderate functional impairment in more than one of their usual roles (e.g., at home, in educational settings, with friends and peers, at play and in the community) to the extent that they are frequently unable to meet the requirements of those roles, but without significant adverse consequences.

b. Mental health issues contribute to occasional difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, and toileting) or instrumental activities of daily living (e.g., preparing food, tidying up, completing tasks) but without threat to health.

3 = Severe impact

a. Significant difficulties with functioning, resulting in disruption to many areas of the adolescent's life most of the time (e.g., limited participation in educational or vocational activities, deterioration in or some withdrawal from the community or relationships with friends and peers), but the adolescent can function independently with adequate treatment, family, and community support.

b. Mental health issues frequently contribute to difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, and toileting) or instrumental activities of daily living (e.g., preparing food, tidying up, completing tasks) on a consistent basis but without threat to health.

4 = Very severe to extreme impact

a. Profound difficulties with functioning, resulting in significant disruption to virtually all areas of the adolescent's life (e.g., unable to participate in educational, social, or vocational activities, complete withdrawal from community, friends, and peers).

b. Mental health issues contribute to severe and persistent self-neglect that poses a threat to health.

34.3.3 **Adult (18 - 64 years)**

Assessment of an individual on this domain should consider the impact of mental health issues on:

- Their ability to fulfil usual roles/responsibilities appropriate to their age, capability, and cultural background.
- Their functioning within the family or home environment, vocational or social settings, caregiving roles, and in the community.
- Their ability to undertake basic activities of daily living appropriate to their age and capability (e.g., self-care, mobility, toileting, nutrition, and personal hygiene).

Scoring

0 = No problem in this domain

1 = Mild impact

a. Mildly diminished ability to function in one or more of their usual roles (e.g., at home, vocational or social settings, caregiving roles or in the community), but without significant or adverse consequences.

b. Mental health issues contribute to brief and transient disruptions in one or more areas of functioning.

2 = Moderate impact

a. Moderate functional impairment in more than one of their usual roles (e.g., at home, vocational or social settings, caregiving roles or in the community) to the extent that they are reasonably frequently unable to meet the requirements of those roles but without significant or adverse consequences.

b. Mental health issues contribute to occasional difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed toileting) or instrumental activities of daily living (e.g., preparing food, cleaning, transportation, managing money) but without threat to health.

3 = Severe impact

a. Significant difficulties with functioning, resulting in disruption to many areas of the person's life (e.g., limited participation in vocational or social activities, deterioration in or some withdrawal from community or relationships), but the person can function independently with adequate treatment, family, and community support.

b. Mental health issues contribute to frequent difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, toileting) or instrumental activities of daily living (e.g., preparing food, cleaning, transportation, managing money) on a consistent basis but without threat to health. The person requires treatment, family, and community support to maintain independent functioning.

4 = Very severe to extreme impact

a. Profound difficulties with functioning, resulting in significant disruption to virtually all areas of the person's life (e.g., unable to participate in vocational or social activities, complete withdrawal from the community).

b. Mental health issues contribute to severe and persistent self-neglect that poses a threat to health.

34.3.4 **Older Adult (65 years and older)**

Assessment of an older adult on this domain should consider the impact of the mental health issues on:

- Their ability to fulfil usual roles/responsibilities appropriate to their age, capability, and cultural background.
- Their functioning within the family or home environment, vocational or social settings, caregiving roles, and in the community.
- Their ability to undertake basic activities of daily living appropriate to their age and capability (e.g., self-care, mobility, toileting, nutrition, and personal hygiene).

Scoring

0 = No problem in this domain

1 = Mild impact

a. Mildly diminished ability to function in one or more of their usual roles (e.g., at home, vocational or social settings, caregiving roles or in the community), but without significant or adverse consequences.

b. Mental health issues contribute to brief and transient disruptions in one or more areas of functioning.

2 = Moderate impact

a. Moderate functional impairment in more than one of their usual roles (e.g., at home, vocational or social settings, caregiving roles or in the community) to the extent that they are reasonably frequently unable to meet the requirements of those roles but without significant or adverse consequences.

b. Mental health issues contribute to occasional difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, toileting) or instrumental activities of daily living (e.g., preparing food, cleaning, transportation, managing money) but without threat to health.

3 = Severe impact

a. Significant difficulties with functioning, resulting in disruption to many areas of the person's life (e.g., limited participation in vocational or social activities, deterioration in or some withdrawal from community or relationships). The person requires treatment, family, and community support to maintain independent functioning.

b. Mental health issues contribute to frequent difficulties with basic activities of daily living (e.g., eating, mobility, bathing, getting dressed, toileting) or instrumental activities of daily living (e.g., preparing food, cleaning, transportation, managing money) on a consistent basis but without threat to health.

4 = Very severe impact

a. Profound difficulties with functioning, resulting in significant disruption to virtually all areas of the person's life (e.g., unable to participate in vocational or social activities, complete withdrawal from the community).

b. Mental health issues contribute to severe and persistent self-neglect that poses a threat to health.

34.4 Domain 4 - Impact of co-existing conditions

34.4.1 **Children (5 - 11 years)**

Assessment of a child on this domain should consider the presence, and impact of, three possible coexisting conditions:

- Physical health conditions.
- Cognitive impairment, intellectual disability, developmental delay, neurological conditions, or learning and communication disorders.
- Substance use.

Where the child has more than one of the coexisting conditions, consider the condition which has the most impact.

Scoring

0 = No problem in this domain

1 = Minor impact

a. Physical health condition(s) present but are stable and have no or a minimal impact on the child's mental health.
b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present but has no or minimal impact on the child’s mental health. c. Past experimentation or experience with substances, but no recent episodes and no impact on the child's mental health.

2 = Moderate impact

a. Physical health condition(s) present and moderately impacts the child's mental health. b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder and moderately impacts, or has the potential to moderately impact the mental health of the child. c. Occasional substance use impacts on, or has the potential to impact on, the child’s mental health. d. Non prescribed use of prescription medications impacts on, or has the potential to impact on, the child’s mental health.

3 = Severe impact

a. Physical health condition(s) present, which requires intensive medical monitoring, and severely impacts the child's mental health (e.g., worsened symptoms, heightened distress).

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present and severely impacts the child’s mental health.

c. Frequent substance use threatens health and wellbeing or represents a barrier to mental health-related recovery.

d. Non prescribed use of prescription medications significantly impacts the child’s mental health or presents a barrier to mental health-related recovery.

e. Occasional use of high or extreme risk substances. (e.g., substances with a high risk of adverse outcomes such as injury, loss of life, criminal charges and/or use of injection drugs which have a high risk of infection of blood-borne diseases).

4 = Very severe impact

a. One or more significant physical health conditions exist that are poorly managed or life-threatening and in the context of a concurrent mental health condition.

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present and very severely impacts the child’s mental health.

c. Regular and uncontrolled substance use.

d. Frequent non-prescribed use of prescribed medications that has the potential to threaten health and well-being.

e. Frequent use of high or extreme-risk substances (e.g., substances with a high risk of adverse outcomes such as injury, loss of life, criminal charges and/or use of injection drugs which have a high risk of infection of blood-borne diseases).

34.4.2 Adolescent (12 - 17 years)

Assessment of an adolescent on this domain should consider the presence, and impact of, three possible coexisting conditions:

- Physical health conditions.
- Cognitive impairment, intellectual disability, developmental delay, neurological conditions, or learning and communication disorders.
- Substance use.

Where the adolescent has more than one of the coexisting conditions, consider the condition which has the most impact.

Scoring

0 = No problem in this domain

1 = Minor impact

a. Physical health condition(s) present but are stable and have no or a minimal impact on the adolescent's mental health.

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present but has no or minimal impact on the adolescent's mental health.

c. Recent episodes of substance use are limited, are not currently causing any concerns, and do not impact the adolescent’s mental health.

2 = Moderate impact

a. Physical health condition(s) present and moderately impacts the adolescent's mental health.

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder and moderately impacts, or has the potential to moderately impact the mental health of the adolescent.

c. Occasional substance use impacts on, or has the potential to impact on, the adolescent's mental health.

d. Non prescribed use of prescription medications impacts on, or has the potential to impact on, the adolescent’s mental health.

3 = Severe impact

a. Physical health condition(s) present, which requires intensive medical monitoring and severely impacts the adolescent's mental health (e.g., worsened symptoms, heightened distress).

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present and severely impacts the adolescent’s mental health.

c. Frequent substance use threatens health and wellbeing or represents a barrier to mental health-related recovery.

d. Non prescribed use of prescription medications significantly impacts the adolescent’s mental health or presents a barrier to mental health-related recovery.

e. Occasional use of high or extreme risk substances. (e.g., substances with a high risk of adverse outcomes such as injury, loss of life, criminal charges and/or use of injection drugs which have a high risk of infection of blood-borne diseases).

4 = Very severe impact

a. One or more significant physical health conditions exist that are poorly managed or life-threatening and in the context of a concurrent mental health condition.

b. Cognitive impairment, intellectual disability, developmental delay, neurological condition, or learning and communication disorder present and very severely impacts the adolescent's mental health.

c. Regular and uncontrolled substance use.

d. Regular and uncontrolled non-prescribed use of prescribed medications that has the potential to threaten health and well-being.

e. Frequent use of high or extreme risk substances (i.e., substances with a high risk of adverse outcomes such as injury, loss of life, criminal charges and/or use of injection drugs which have a high risk of infection of blood-borne diseases).

34.4.3 **Adult (18 - 64 years)**

Assessment on this domain should consider the presence and impact of the following co-existing conditions:

- Physical health conditions (consider all physical health issues).
- Cognitive impairment, intellectual disability, neurological conditions, or learning and communication disorders.
- Substance use.

Where the person has more than one of the coexisting conditions, consider the condition which has the most impact.

Scoring

0 = No problem in this domain

1 = Minor impact

a. Physical health condition(s) present but are stable and have no or minimal impact on the person's mental health.

b. Cognitive impairment, intellectual disability, neurological condition, or learning and communication disorder present but has no or minimal impact on the person's mental health.

c. Recent episodes of substance use are limited, are not currently causing any concerns, and do not impact the person's mental health.

2 = Moderate impact

a. Physical health condition(s) present and moderately impacts the person's mental health.

b. Cognitive impairment, intellectual disability, neurological condition, or learning and communication disorder present and moderately impacts on the person's mental health.

c. Occasional substance use that significantly impacts on, or has the potential to significantly impact, the person's mental health.

d. Non prescribed use of prescription medications that significantly impacts on, or has the potential to significantly impact, the person's mental health.

3 = Severe impact

a. Physical health condition(s) present, which requires intensive medical monitoring and severely impacts the person's mental health (e.g., worsened symptoms, heightened distress).

b. Cognitive impairment, intellectual disability, neurological condition, or learning and communication disorder present and severely impacts the person's mental health.

c. Frequent substance use threatens health and well-being or represents a barrier to mental health-related recovery.

d. Non prescribed use of prescription medications severely impacts the person's mental health or presents a barrier to mental health-related recovery.

4 = Very severe impact

a. One or more significant physical health conditions exist which are poorly managed or life-threatening and in the context of a concurrent mental health condition.

b. Cognitive impairment, intellectual disability, neurological condition, or learning and communication disorder present and very severely impacts the person's mental health.

c. Regular and uncontrolled substance use severely threatens health and well-being.

d. Regular and uncontrolled non-prescribed use of prescribed medications severely threatens health and well-being.

34.4.4 Older Adult (65 years and older)

Assessment on this domain should consider the presence, and impact of three possible co-existing conditions:

- Physical health conditions (consider all physical health issues).
- Cognitive impairment, intellectual disability, neurological conditions, or learning and communication disorders.
- Substance use.

Where the older adult has more than one co-existing condition, the rating selected should be based on the condition which has the most impact.

Scoring

0 = No problem in this domain

1 = Minor impact

a. Physical health condition/s present but are stable and have no or a minimal impact on the person's mental health.

b. Cognitive impairment, intellectual disability, neurological condition, or learning and communication disorder present but has no or minimal impact on the person's mental health.

c. Recent episodes of substance use are limited, are not currently causing any concerns, and do not impact the person's mental health.

2 = Moderate impact

a. Physical health condition/s present and moderately impacts the person's mental health.

b. Cognitive impairment, intellectual disability, neurological condition, or learning and communication disorder present and moderately impacts on the person's mental health.

c. Occasional substance use that significantly impacts on, or has the potential to significantly impact on, the person's mental health.

d. Non prescribed use of prescription medications that significantly impacts on, or has the potential to significantly impact, the person's mental health.

3 = Severe impact

a. Physical health condition/s present, which requires intensive medical monitoring and severely impacts the person's mental health (e.g., worsened symptoms, heightened distress).

b. Cognitive impairment, intellectual disability, neurological condition, or learning and communication disorder present and severely impacts the person's mental health.

c. Frequent substance use threatens health and well-being or represents a barrier to mental health-related recovery.

d. Non prescribed use of prescription medications severely impacts the person's mental health or presents a barrier to mental health-related recovery.

4 = Very severe impact

a. One or more significant physical health conditions exist which are poorly managed or life-threatening and in the context of a concurrent mental health condition.

b. Cognitive impairment, intellectual disability, neurological condition, or learning and communication disorder present and very severely impacts the person's mental health.

c. Regular and uncontrolled substance use severely threatens health and well-being.

d. Regular and uncontrolled non-prescribed use of prescribed medications severely threatens health and well-being

34.5 Domain 5 - Service use and response history

34.5.1 **Children (5 - 11 years)**

This domain considers the child and their family's previous use of services and support focussed on mental health-related assistance for the child. The initial assessment on this domain should consider:

- Whether the child/family has previously sought help from or required mental health services and related supports (including specialist or mental health inpatient services).
- Their progress or benefit from past services and support.

Definition of the term services and support – Relevant services and support refer to safe, developmentally, and culturally appropriate evidence-informed mental health, health or community services focussed on or relevant to the child's mental health (such as a psychological service delivered by a GP or mental health professional, or other behavioural services) rather than the personal supports provided by friends, family, or social networks. Consider both the child and their family's use of previous services and support but do not include those services and support relevant to, but not focused on, the child's mental health.

Scoring

0 = No previous service use

a. Has not previously sought help or required a referral for mental health issues.

1 = Excellent progress from previous service use

a. Previously accessed services for a mental health issue and experienced a significant benefit resulting in no need for additional services at that time.

2 = Moderate progress from previous service use

a. Previously accessed services and experienced a moderate benefit and required some additional services (either ongoing or periodically) to maintain the benefit.

3 = Minor progress from previous service use

a. Previously accessed services with only minor benefits resulting in a need for additional services or longer duration of services.

4 = Negligible or no progress from previous service use

a. Previously accessed services with little or no benefit.

34.5.2 Adolescent (12 - 17 years)

This domain considers the adolescent and their family's previous use of services and support focussed on mental health-related assistance. The initial assessment on this domain should consider:

- Whether the adolescent or their family has previously sought help from or required mental health services and related supports (including specialist or mental health inpatient services).
- Their progress or benefit from past services and support.

Definition of the term services and support - Relevant services and support refer to safe, developmentally, and culturally appropriate evidence-informed mental health, health or community services focussed on or relevant to the adolescent's mental health (such as a psychological service delivered by a GP or mental health professional or other behavioural services) rather than the personal supports provided by friends, family, or social networks.

Consider both the adolescent and their family's use of previous services and support but do not include those services and support relevant to, but not focused on, the adolescent's mental health.

Scoring

0 = No previous service use

a. Has not previously sought help or required a referral for mental health issues.

1 = Excellent progress from previous service use

a. Previously accessed services for a mental health issue and experienced a significant benefit resulting in no need for additional services at that time.

2 = Moderate progress from previous service use

a. Previously accessed services and experienced a moderate benefit and required some additional services (either ongoing or periodically) to maintain the benefit.

3 = Minor progress from previous service use

a. Previously accessed services with only minor benefits resulting in a need for additional services or longer duration of services.

4 = Negligible or no progress from previous service use

a. Previously accessed services with little or no benefit.

34.5.3 **Adult (18 - 64 years)**

This domain considers the person's previous use of services and support focussed on mental health-related assistance. The initial assessment on this domain should consider:

- Whether the person has previously sought help from or required mental health services and related supports (including specialist or mental health inpatient services).
- Their progress or benefit from past or current services and support.

Definition of the term services and support - Relevant services and support refer to safe developmentally and culturally appropriate evidence-informed mental health, health or community services focussed on or relevant to the person's mental health (such as a psychological service delivered by a GP or mental health professional, other behavioural services) rather than the personal supports provided by friends, family, or social networks.

Scoring

0 = No previous service use

a. Has not previously sought help or required a referral for mental health issues.

1 = Excellent progress from previous service use

a. Previously accessed services for a mental health issue and experienced a significant benefit resulting in no need for additional services at that time.

2 = Moderate progress from previous service use

a. Previously accessed services and experienced a moderate benefit and required some additional services (either ongoing or periodically) to maintain the benefit.

3 = Minor progress from previous service use

a. Previously accessed services with only minor benefits resulting in a need for additional services or longer duration of services.

4 = Negligible progress from previous service use

a. Previously accessed services with little or no benefit.

34.5.4 **Older Adult (65 years and older)**

This domain considers the older adult's previous use of services and support focussed on mental health-related assistance. The initial assessment on this domain should consider:

- Whether the person has previously sought help from or required mental health services and related supports (including specialist or mental health inpatient services).
- Their progress or benefit from past services and support.

Definition of the term services and support - Relevant services and support refer to safe, culturally appropriate, evidence-informed mental health, health or community services focussed on or relevant to the person's mental health (such as a psychological service delivered by a GP or mental health professional, other behavioural services) rather than the personal supports provided by friends, family, or social networks.

Scoring

0 = No previous service use

a. Has not previously sought help or required a referral for mental health issues.

1 = Excellent progress from previous service use

a. Previously accessed services for a mental health issue and experienced a significant benefit resulting in no need for additional services at that time.

2 = Moderate progress from previous service use

a. Previously accessed services and experienced a moderate benefit and required some additional services (either ongoing or periodically) to maintain the benefit.

3 = Minor progress from previous service use

a. Previously accessed services with only minor benefits resulting in a need for additional services or longer duration of services.

4 = Negligible progress from previous service use

a. Previously accessed services with little or no benefit.

34.6 Domain 6 - Social and environmental stressors

34.6.1 **Children (5 - 11 years)**

Assessment on this domain should consider the degree to which any or all of the following factors are relevant to the child's current circumstances and the referral decision:

- Significant losses (e.g., loss of friends or social connections, death of a loved one).
- Significant transitions (e.g., disruption to educational activities, parental separation/divorce, death of a loved one, transitions relating to gender identity or sexual orientation).
- Peer group stress (e.g., bullying, conflict with or isolation from the peer group, loss of friendships).
- Trauma (e.g., emotional, physical, psychological, or sexual abuse, exploitation, witnessing or being a victim of violence, family and domestic violence, natural disaster, exposure to suicide in family/community/school or peer group, loss, conflict).
- Victimisation (e.g., human rights abuses, discrimination, racial abuse, victim of crime, refugee, or asylum-seeking experiences).
- Family or household stress (e.g., household drug or alcohol abuse, the parent or family member with an illness or disability, carer stress or stress associated with a caregiver role).
- Performance-related pressure (e.g., unrealistic role expectations or responsibilities, schooling demands, caregiving responsibilities) and stressors related to high-performance demands in school, dance, sport, and other relevant extra-curricular activities.
- Socioeconomic disadvantage (e.g., poverty, parental unemployment, unstable or insecure housing).
- Legal issues (e.g., the juvenile justice system or family court involvement, enforced separation from family).

Evidence points to the contribution made by historical childhood adverse events to longer-term mental health development. Assessment on this domain should consider the child's history but only record higher ratings where earlier experiences impact the current situation and require additional specific resources and services.

Scoring

0 = No problem in this domain

1 = Mildly stressful environment

a. The child is experiencing (or has experienced) one or more stressors that have or are likely to have only a minor impact on the child's mental health.

2 = Moderately stressful environment

a. The child is experiencing (or has experienced) one or more stressors that have, or are likely to have, a moderate impact on the child's mental health.

3 = Highly stressful environment

a. The child is experiencing (or has experienced) one or more stressors that have or are likely to have a significant impact on the child's mental health.

4 = Extremely stressful environment

a. The child is experiencing (or has experienced) one or more stressors that are extreme, enduring or recurring and are having, or are likely to have, a severe impact on the child's mental health.

34.6.2 **Adolescent (12 - 17 years)**

Assessment on this domain should consider the degree to which any or all of the following factors are relevant to the adolescent's current circumstances and the referral decision:

- Significant losses (e.g., loss of friends or social connections, death of a loved one).
- Significant transitions (e.g., disruption to educational activities, parental separation/divorce, death of a loved one, transitions relating to gender identity or sexual orientation).
- Peer group stress (e.g., bullying, conflict with or isolation from the peer group, loss of friendships).
- Trauma (e.g., emotional, physical, psychological, or sexual abuse, exploitation, witnessing or being a victim of violence, family and domestic violence, natural disaster, exposure to suicide in family/community/school or peer group, loss, conflict).
- Victimisation (e.g., human rights abuses, discrimination, racial abuse, victim of crime, refugee, or asylum-seeking experiences).
- Family or household stress (e.g., household drug or alcohol abuse, the parent or family member with an illness or disability, carer stress or stress associated with a caregiver role).
- Performance-related pressure (e.g., unrealistic role expectations or responsibilities, schooling demands, caregiving responsibilities) and stressors related to high-performance demands in school, dance, sport, and other relevant extra-curricular activities.
- Socioeconomic disadvantage (e.g., poverty, parental unemployment, unstable or insecure housing).
- Legal issues (e.g., the juvenile justice system or family court involvement, enforced separation from family).

Evidence points to the contribution made by historical childhood adverse events to longer-term mental health development. Assessment on this domain should consider the adolescent's history but only record higher ratings where earlier experiences impact the current situation and require additional specific resources and services.

Scoring

0 = No problem in this domain

1 = Mildly stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a minor impact on the adolescent's mental health.

2 = Moderately stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a moderate impact on the adolescent's mental health.

3 = Highly stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a significant impact on the adolescent's mental health.

4 = Extremely stressful environment

a. The adolescent is experiencing (or has experienced) one or more stressors that are extreme, enduring, or recurring and are currently having, or are likely to have, a severe impact on the adolescent's mental health.

34.6.3 **Adult (18 - 64 years)**

Assessment on this domain should consider the degree to which any or all of the following factors are relevant to the person's current circumstances and the referral decision:

- Significant losses (e.g., job loss, relationship breakdown, loss of friends or social connections, death of a loved one).
- Significant change and transitions (e.g., a change in living environment, relationship breakdown/divorce, death of loved one, a romantic breakup, transitions relating to gender or sexual identity).
- Trauma (e.g., emotional, physical, psychological, or sexual abuse, exploitation, witnessing or being a victim of violence, family and domestic violence, intimate partner violence, natural disaster, exposure to suicide in family/community, loss, conflict).
- Victimisation (e.g., human rights abuses, discrimination, racial abuse, financial abuse, victim of crime, refugee, or asylum-seeking experiences).
- Family or household stress (e.g., household drug or alcohol abuse, a family member with an illness or disability, carer stress or stress associated with a caregiver role, access to children/grandchildren).
- Performance-related pressure (e.g., unrealistic role expectations and caregiving responsibilities).
- Socioeconomic disadvantage (e.g., poverty, unemployment, unstable or insecure housing).
- Legal issues (e.g., involvement in the criminal justice system or family court, enforced separation from family).
- Loneliness or isolation.
- Self-care (e.g., difficulties with mobility, toileting, nutrition, or personal hygiene).

Scoring

0 = No problem in this domain

1 = Mildly stressful environment

a. The person is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a minor impact on their mental health.

2 = Moderately stressful environment

a. The person is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a moderate impact on their mental health.

3 = Highly stressful environment

a. The person is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a significant impact on their mental health.

4 = Extremely stressful environment

a. The person is experiencing (or has experienced) one or more stressors that are extreme, enduring, or recurring and are currently having, or are likely to have, a severe impact on their mental health.

34.6.4 Older Adult (65 years and older)

Assessment on this domain should consider the degree to which any or all of the following factors are relevant to the person's current circumstances and the referral decision:

- Significant losses (e.g., job loss, relationship breakdown, loss of friends or social connections, death of a loved one).
- Significant change and transitions (e.g., the transition from gainful employment to retirement, unexpected retirement, a change in living environment, transition to residential aged care, uncertainty about future care arrangements, changes in independence, managing an illness).
- Trauma (e.g., emotional, physical, psychological, or sexual abuse, exploitation, witnessing or being a victim of violence, family and domestic violence, intimate partner violence, elder abuse, natural disaster, exposure to suicide in family/community, loss, conflict).
- Victimisation (e.g., ageism, elder abuse, human rights abuses, discrimination, racial abuse, financial abuse, victim of crime, refugee, or asylum-seeking experiences).
- Family or household stress (e.g., household drug or alcohol abuse, a parent or family member with an illness or disability, carer stress or stress associated with a caregiver role, access to children/grandchildren).
- Performance-related pressure (e.g., unrealistic role expectations and caregiving responsibilities).
- Socioeconomic disadvantage (e.g., poverty, unemployment, unstable or insecure housing).
- Legal issues (e.g., involvement in the criminal justice system or family court, enforced separation from family).
- Loneliness or isolation.
- Self-care (e.g., difficulties with mobility, toileting, nutrition, or personal hygiene).

Scoring

0 = No problem in this domain

1 = Mildly stressful environment

a. The person is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a minor impact on their mental health.

2 = Moderately stressful environment

a. The person is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a moderate impact on their mental health.

3 = Highly stressful environment

a. The person is experiencing (or has experienced) one or more stressors that are currently having or are likely to have a significant impact on their mental health.

4 = Extremely stressful environment

a. The person is experiencing (or has experienced) one or more stressors that are extreme, enduring, or recurring and are currently having, or are likely to have, a severe impact on their mental health.

34.7 Domain 7 - Family and other supports

34.7.1 **Children (5 - 11 years)**

This domain considers whether personal supports, including emotionally nurturing relationships, practical support, and social support are present in the child’s environment and their potential to contribute to improved mental health.

This domain does not include or consider professional support. Personal supports include:

- Family/primary caregivers.
- Friends and peers.
- Supports within the school environment.
- Supports within the community (e.g., cultural connections, elders, spiritual leaders, sporting groups, neighbours etc.).

Personal supports may be present, but unable to provide the needed support at the time. There are a range of factors that may impact on whether personal supports are able to be provided, such as competing caring responsibilities, a lack of access to respite or other supports, financial or practical constraints, additional skill development requirements, or illness or distress in family or primary caregivers. It is important to avoid blame or judgement of personal supports when exploring this domain.

Where appropriate, a mental health assessment and intervention for the support person (or family as a whole) should be considered.

Scoring

0 = Highly supported

a. There are family/primary caregivers and other personal supports available that are highly supportive, willing, and capable to meet the child's developmental, emotional, practical, and social needs.

1 = Well supported

a. There are a few family/primary caregivers and other personal supports available that are supportive, willing, and capable of meeting the child's developmental, emotional, practical, and social needs.

2 = Limited supports

a. There are a few family/primary caregivers available to provide support, but their willingness to provide support is variable or difficult to access, or the sources of support have insufficient resources or capabilities to meet the child's developmental, emotional, practical, and social needs whenever it is needed, or the child is reluctant to utilise the available supports.

b. Other personal supports are available for the child but only partially compensate for needs not met within the family.

3 = Minimal supports

a. Very few actual or potential useful sources of support are available, willing, and capable of meeting the child's developmental, emotional, practical, and social needs.

b. There are serious limitations in the capacity or availability of supports outside the family, so that developmental, emotional, practical, or social needs are mostly unmet.

4 = No supports

a. No useful sources of support are available, and developmental, emotional, practical, and/or social needs are mostly unmet.

b. The child has no access to other supports that could compensate for needs not met within the family.

34.7.2 Adolescent (12 - 17 years)

This domain considers whether personal supports, including emotionally nurturing relationships, practical support, and social support are present in the child's environment and their potential to contribute to improved mental health.

This domain does not include or consider professional support. Personal supports include:

- Family/primary caregivers.
- Friends and peers.
- Supports within the school environment.
- Supports within the community (e.g., cultural connections, elders, spiritual leaders, sporting groups, neighbours etc.).

Personal supports may be present, but unable to provide the needed support at the time. There are a range of factors that may impact on whether personal supports are able to be provided, such as competing caring responsibilities, a lack of access to respite or other supports, financial or practical constraints, additional skill development requirements, or illness or distress in family or primary caregivers. It is important to avoid blame or judgement of personal supports when exploring this domain.

Where appropriate, a mental health assessment and intervention for the support person (or family as a whole) should be considered.

Scoring

0 = Highly supported

a. There are family/primary caregivers and other personal supports available that are highly supportive, willing, and capable to meet the child's developmental, emotional, practical, and social needs.

1 = Well supported

a. There are a few family/primary caregivers and other personal supports available that are supportive, willing, and capable of meeting the child's developmental, emotional, practical, and social needs.

2 = Limited supports

a. There are a few family/primary caregivers available to provide support, but their willingness to provide support is variable or difficult to access, or the sources of support have insufficient resources or capabilities to meet the child's developmental, emotional, practical, and social needs whenever it is needed, or the child is reluctant to utilise the available supports.

b. Other personal supports are available for the child but only partially compensate for needs not met within the family.

3 = Minimal supports

a. Very few actual or potential useful sources of support are available, willing, and capable of meeting the adolescent's developmental, emotional, practical, and social needs.

b. There are serious limitations in the capacity or availability of supports outside the family, so that developmental, emotional, practical, or social needs are mostly unmet.

4 = No supports

a. No useful sources of support are available, and developmental, emotional, practical, and/or social needs are mostly unmet.

b. The adolescent has no access to other supports that could compensate for needs not met within the family.

34.7.3 Adult (18 - 64 years)

This domain considers whether personal supports, including emotionally nurturing relationships, practical support, and social support is present in the person's environment and their potential to contribute to improved mental health.

This domain does not include or consider professional support. Family and other supports include:

- Family members and caregivers.
- Friends and peers.
- Supports within the community (e.g., cultural connections, elders, spiritual leaders, social groups, neighbours etc.).

A lack of support might contribute to the onset or continuation of the mental health issue or impact recovery.

Scoring

0 = Highly supported

a. Personal supports are highly supportive and meet the person's emotional, practical, and social needs.

1 = Well supported

a. There are a few personal supports available that are seen as valuable by the person and are willing and capable of providing emotional, practical, and social support.

2 = Limited supports

a. Usual sources of useful support may be reluctant to provide support, difficult to access or have insufficient resources to provide emotional, practical, or social support whenever it is needed, or the person is reluctant to access the available supports.

3 = Minimal supports

a. Very few actual or potential useful sources of support are available, willing to and capable of providing emotional, practical, or social support.

b. Despite the person requiring them, a substitute decision-maker has not facilitated access to services and support in the past.

4 = No supports

a. No useful sources of support are available, and emotional, practical, or social needs are mostly unmet.

34.7.4 Older Adult (65 years and older)

This domain considers whether personal supports, including emotionally nurturing relationships, practical support, and social support are present in the person's environment and their potential to contribute to improved mental health. This domain does consider professional services, where the service is focused on providing practical and social support. Family and other supports include:

- Family members and caregivers.
- Friends and peers.
- Supports within the community (e.g., cultural connections, elders, spiritual leaders, social groups, neighbours etc.).
- Practical and social support services (including aged care-related supports).

A lack of support might contribute to the onset or continuation of the mental health issue or impact on recovery.

Scoring

0 = Highly supported

a. Personal supports are highly supportive and meet the person’s emotional, practical, and social needs.

1 = Well supported

a. There are a few personal supports available, that are seen as valuable by the person and are willing and capable of providing emotional, practical, and social support.

2 = Limited supports

a. Usual sources of useful support may be reluctant to provide support, difficult to access or have insufficient resources to provide emotional, practical, or social support whenever it is needed, or the person is reluctant to access the available supports.

3 = Minimal supports

a. Very few actual or potential useful sources of support are available, willing to and capable of providing emotional, practical, or social support.

b. Despite the person requiring them, a substitute decision-maker has not facilitated access to services and support in the past.

4 = No supports

a. No useful sources of support are available, and emotional, practical, and/or social needs are mostly unmet.

34.8 Domain 8 - Engagement and motivation

34.8.1 **Children (5 - 11 years)**

This domain considers the parent/caregiver's motivation to engage in or accept assistance. Children do not have the agency or resources required to seek services and support independently. Therefore, the parent/caregiver's engagement and motivation are the focus of this domain for children.

Whilst this domain rates the engagement and motivation of the parent/caregivers, the child should be included in discussions, using language they understand, and supported to express their choices, preferences, fears, and goals about referral next steps. Assessment is unlikely to be valid unless rapport is established with the child and the child participates in the assessment process.

Scoring

0 = Optimal

a. The parent/caregiver is motivated and capable of participating fully in the recommended services and supports.

b. The parent/caregiver is capable of taking an active role in supporting the child to manage the condition.

1 = Positive

a. The parent/caregiver is mostly willing to accept and participate in the recommended services and support.

b. The parent/caregiver can mostly take an active role in supporting the child to manage the condition.

2 = Limited or mixed

a. The parent/caregiver is unsure whether they will accept or participate in the recommended services and supports or has limited capacity to do so.

b. There is significant divergence between the parents/caregivers in the level of engagement, motivation, or ability to participate in the recommended services and supports.

3 = Minimal

a. The parent/caregiver cannot participate in the recommended services and support without considerable practical or emotional assistance.

b. Despite the child requiring them, the parent/caregiver has not facilitated access to services and support in the past due to low engagement or motivation.

4 = Disengaged

a. The parent/caregiver cannot support participation in services and supports or avoids potentially useful and available supports.

34.8.2 **Adolescent (12 - 17 years)**

This domain considers the adolescent or their parent/caregiver's awareness of the mental health issue and their motivation to engage in or accept assistance.

Many adolescents do not have the agency or resources required to seek and access services and support independently. Therefore, the engagement and motivation of the parent/caregiver is the primary determinant of access and uptake, and the parent/caregiver sub-scale is used. Whilst the parent/caregiver sub-scale rates the engagement and motivation of the parent/caregivers, the adolescent should be included in discussions, using language they understand, and supported to express their choices, preferences, fears, and goals about referral next steps.

The parent/caregiver sub-scale is used when the adolescent cannot exercise decision-making control of their healthcare decisions. The parent/caregiver sub-scale considers:

- Ability and capacity to support the adolescent to manage the condition.
- The parent/caregiver's motivation to assist the adolescent to access necessary support (critical if considering self-management options).

Conversely, where the adolescent can exercise decision-making control of their healthcare decisions, the adolescent's engagement and motivation take precedence (adolescent sub-scale). The adolescent sub-scale considers:

- The adolescent's motivation to participate in the recommended services and support.

Scoring

34.8.3 PARENT/CAREGIVER SUB-SCALE

Use the parent sub-scale where the adolescent cannot exercise decision-making control of their healthcare decisions.

0 = Optimal

a. The parent/caregiver is motivated and capable of participating fully in the recommended services and supports.

b. The parent/caregiver is capable of taking an active role in supporting the adolescent to manage the condition.

1 = Positive

a. The parent/caregiver is mostly willing to accept and participate in the recommended services and support.

b. The parent/caregiver can mostly take an active role in supporting the adolescent to manage the condition.

2 = Limited or mixed

a. The parent/caregiver is unsure whether they will accept or participate in the recommended services and supports or has limited capacity to do so.

b. There is significant divergence between the parents/caregivers in the level of engagement, motivation, or ability to participate in the recommended services and supports.

3 = Minimal

a. The parent/caregiver cannot participate in the recommended services and support without considerable practical or emotional assistance.

b. Despite the adolescent requiring them, the parent/caregiver has not facilitated access to services and supports in the past due to low engagement or motivation.

4 = Disengaged

a. The parent/caregiver cannot support participation in services and supports or avoids potentially useful and available supports.

34.8.4 ADOLESCENT SUB-SCALE

Use the adolescent sub-scale where the adolescent can exercise decision-making control of their healthcare decisions. In most instances, when working with a mature minor (see Informed Consent Practice Point), the use of the adolescent sub-scale will be appropriate.

0 = Optimal

a. The adolescent is motivated to participate in the recommended services and support.

b. The adolescent is capable of taking an active role in managing the condition.

1 = Positive

a. The adolescent is mostly willing to accept and participate in the recommended services and support.

b. The adolescent can mostly take an active role in managing the condition.

2 = Limited

a. The adolescent is hesitant to accept and participate in the recommended services and support.

3 = Minimal

a. The adolescent is very reluctant to accept or participate in services and support.

b. The adolescent has not participated in services and support in the past, despite requiring them, due to low levels of engagement or motivation.

4 = Disengaged

a. The adolescent refuses to accept or participate in the recommended services and support.

34.8.5 Adult (18 - 64 years)

This domain considers the person's capacity and willingness to engage in or accept assistance.

Assessment of an individual on this domain should include the persons:

- Ability and capacity to manage the condition.
- Motivation to access necessary supports (critical if considering self-management options).

Some people may not have the agency or resources required to seek and access services and support independently of a support person, caregiver, or family member. Subsequently, the initial assessment and referral process needs to include support people, caregivers, and family members in discussions and decision-making where appropriate.

Scoring

0 = Optimal

a. The person is motivated to participate in the recommended services and support.

b. The person is capable of taking an active role in managing the condition.

1 = Positive

a. The person is mostly willing to accept and participate in the recommended services and support.

b. The person can mostly take an active role in managing the condition.

2 = Limited

a. The person is hesitant to accept and participate in the recommended services and support.

b. The person has limited ability to take an active role in managing the condition.

3 = Minimal

a. The person is very reluctant to accept or participate in services and support.

b. The person has not participated in services and support in the past, despite requiring them, due to low levels of engagement or motivation.

4 = Disengaged

a. The person refuses to accept or participate in the recommended services and support.

b. The person has minimal ability to take an active role in managing the condition.

34.8.6 **Older Adult (65 years and older)**

This domain considers the older adult's awareness of the mental health issue and their capacity and willingness to engage in or accept assistance. Assessment of an individual on this domain should include the persons:

- Ability and capacity to manage the condition.
- Motivation to access necessary supports (critical if considering self-management options).

Some older adults may not have the agency or resources required to seek and access services and support independently of a support person, caregiver, or family member. Subsequently, the initial assessment and referral process needs to include support people, caregivers, and family members in discussions and decision-making where appropriate.

Scoring

0 = Optimal

a. The person is motivated to participate in the recommended services and support.

b. The person is capable of taking an active role in managing the condition.

1 = Positive

a. The person is mostly willing to accept and participate in the recommended services and support.

b. The person can mostly take an active role in managing the condition.

2 = Limited

a. The person is hesitant to accept and participate in the recommended services and support.

b. The person has limited ability to take an active role in managing the condition.

3 = Minimal

a. The person is very reluctant to accept or participate in services and support.

b. The person has not participated in services and support in the past, despite requiring them, due to low levels of engagement or motivation.

4 = Disengaged

a. The person refuses to accept or participate in the recommended services and support.

b. The person has minimal ability to take an active role in managing the condition.

March 7, 2025 12:18:39

35. Appendix - Administration

- User Roles and Permissions
- User account management - *create and edit user accounts*
- Organisation management - *create and edit Service Provider records*
- Note templates - *create, edit, and share templates for IAR-DST domain notes and individual note types*
- External data access - *how to access Intake System data*

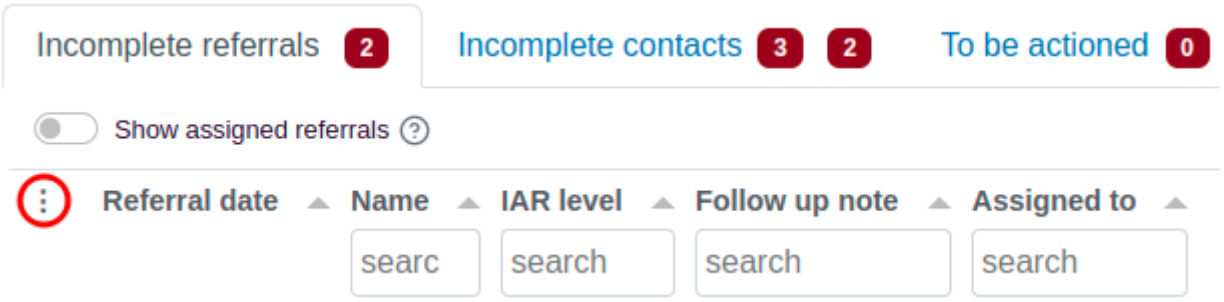
June 1, 2024 10:56:34

36. Appendix - User Interface tips

36.0.1 Hide/Show Columns

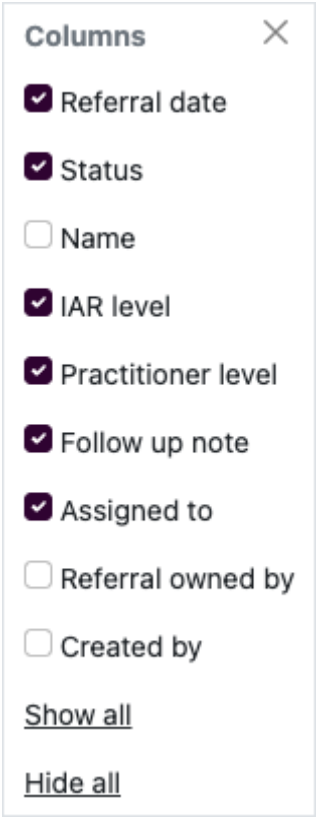
Columns can be hidden or shown on various data tables in the system, such as the list of Incomplete Referrals on the main page, or the Contacts report.

To control which columns are shown/hidden, open the pop-up menu by clicking on the three dots in the leftmost column of the table (circled in red in the example screenshot below of the Incomplete Referrals list).



Location of the Hide/Show Column menu

This menu lists all available columns for that table. Click a column name to hide or show a column. Click *Hide all* to automatically deselect all columns, or click *Show all* to select all the columns.



Example of Hide/Show Column menu

Each table's column visibility settings are stored in your web browser. If you login with the same computer and browser every day, your saved column settings will be stored indefinitely.

36.0.2 Responsive Screen Sizing

Did you know that you can use the Intake System on any sized screen? The screens are built so that they can be used on smartphone and tablet devices. You can securely log in and make updates when you're away from your desk or on the move.

36.0.3 Printing

The application is designed so that when you print a screen the navigation items are removed, so that the content of the screen is more print-friendly. Be mindful of privacy when doing so, and ensure you keep print-outs secure if they contain confidential information.

January 20, 2023 12:26:05

37. Appendix - External contact data upload

The Intake System can store contact data for inclusion in reports to the Department of Health and Aged Care. This upload function is an option provided for PHNs who are not using the system for intake.

37.1 Uploading

To upload, click on the **Upload contacts** menu at the top-right of the screen.

Note: this function is only available to a user account set up for uploading contacts. This is set up by a member of the NWMPHN Medicare Mental Health Support Team.

37.1.1 File format

The uploaded file must be a CSV file and have no spaces after a comma. It must have these column headers:

```
version,intake_organisation_path,contact_key,contact_type,modality,nature_of_contact,outcome,contact_created_datetime
```

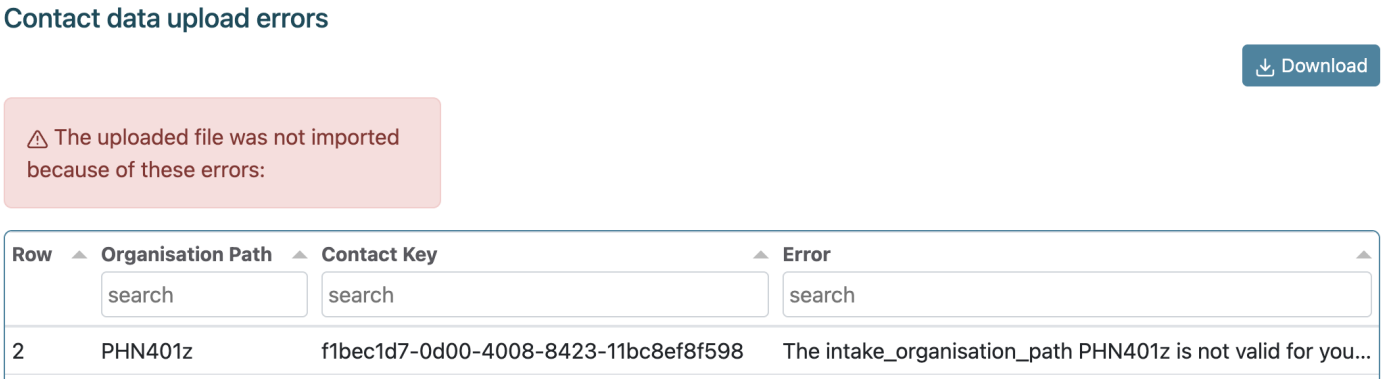
37.1.2 Field formats

Field	Description/values
version	The current version of the specification. All values in this column must be: 1
intake_organisation_path	The unique identifier of the organisation providing the intake service (as per the PMHC- MDS Intake Episode specification). The purpose of this field is to record who is contacting the service either as a consumer or on behalf of a consumer.
contact_key	Optional. The unique identifier of the contact within an organisation. Together, the intake_organisation_path and the contact_key fields form a composite primary key. If not included, a GUID will be assigned to the record. * See note below
contact_type	1: General Practice 3: Private practice 4: Public mental health service 5: Public hospital 6: Private hospital 7: Emergency Department 8: Community Health Centre 9: Drug and Alcohol Service 10: Community Support Organisation NFP 11: Indigenous Health Organisation 12: Child and Maternal Health 13: Nursing service 17: School 18: Tertiary education institution 19: Housing service 20: Centrelink 21: Other 90: Child and Family Services 91: Carer/Family/Friend 92: Justice and/or Forensic 93: Youth services 98: Self-referral 99: Not stated/inadequately described 94: Aged care facility/service 95: Disability support service 96: Medicare Mental Health Adult Mental Health Centre 97: Heath to Health phone service 100: Legal service The purpose of this field is to understand whether the contact is being made by a consumer or carer, or a healthcare professional, and the type of organisation in which the healthcare professional is based.
modality	1: Phone – national 1800 Medicare Mental Health number 2: Phone message 3: Walk in/face-to-face 4: Organisation website 5: Email 6: Medicare Mental Health national website 7: Phone – Other/1300 number 8: Fax/eFax 9: eReferral The purpose of this field is to understand the mode of contact, in other words, how consumers, carers, health professionals or other referring services made the initial contact with the Intake service.
nature_of_contact	1: Mental health assessment 2: Mental health professional enquiry

Field	Description/values
	3: Mental health service navigation 4: Requesting service on behalf of another 5: General enquiry/information 6: Complaint 7: Compliment 99: Other The purpose of this field is to record the reason that contact is being made with the service. If an IAR/assessment/referral is required, then the value of this field is defaulted to 1 (Mental health assessment).
outcome	1: Verbal information: contact resolved 2: Written information provided: contact resolved 3: Referred to external service 4: Escalation to acute service 5: Call directly transferred to other service 6: No action taken 7: Unable to be contacted 8: Not related to Medicare Mental Health intake 99: Converted to Client The purpose of this field is to record the outcome of the contact. If an IAR/assessment/referral is required, then the value of this field is defaulted to 99 (Converted to Client).
contact_created_datetime	The date/timestamp the contact record was created. Format is: YYYY-MM-DD HH:MM

37.1.3 Validation

The system will validate the CSV file format and the data in the file. If there are errors, the upload process skips storing the data and will redirect to an error report containing all the errors that it encountered. The screenshot below shows an example of the error report. You can filter the errors and download them.



Validation error report

37.1.4 Important note about contact_key

If you upload data with **contact_key** filled in, you will be able to re-upload the same data and it will simply overwrite the data when it finds an existing **contact_key** with a matching value from the uploaded data. If you don't use **contact_key** (i.e. if you leave that column blank), then it will only ever add records. This means that if you will either have to upload data month by month, or delete all the data and upload all the data again up to the current month.

37.2 View uploaded data

Go to **Reports > Uploaded contacts**.

From this screen you can filter and sort the contact data. You can also download all the data.

37.3 Delete uploaded data

You can only delete rows that are selected.

You can select individual rows by clicking somewhere in the row, or select all records by clicking the topmost tickbox in the left-hand column.

Once a row is selected, the **Delete selected** button will appear at the top right (next to the **Download** button).

April 8, 2025 15:37:33

38. Appendix - Glossary

Term	Definition
Abandoned	Referrals that are discontinued before an intake assessment can be completed. If a referral is abandoned it cannot be reopened.
Callback requests	The MMH website allows consumers to create callback requests which are then assigned to the relevant PHN who are notified.
Calls received	Count of calls received regardless of whether a call was routed or answer.
Client record	If a contact requires an assessment, the contact record is converted to a client record.
Complete	Referrals where the necessary consumer data has been collected and the consumer has had an assessment, but the referral has not yet been sent to a service.
Consent	Clients are required to give permission for contact and use of details at four different points.
Consumers re-engaging	When a consumer calls back either after discharge from the service or during their initial contact with the service. Consumer’s re-engaging after discharge may require a new assessment if their situation or clinical circumstances have changed.
Contact created by	Indicates where the contact was created, either a PHN or Hub/Pop up centre.
Contact record	Contact record contains information about the person who contacted the service. All required fields must be completed for the contact to move from the incomplete contacts list.
Derived level of care	Clinicians can record a practitioner recommend level of care. If that is recorded, the derived level of care is that value, otherwise it is the IAR-DST recommended level of care.
Hub	Physical site consumers can be referred to and access for support. Hubs are operated by various service providers commissioned by PHN’s.
IAR-DST	Initial Assessment and Referral – Decision Support Tool.
IAR-DST Recommended Level of Care	Level of Care that is recommended by the IAR-DST, based on completion of the eight sub-domains.
Incomplete referrals list	Records that do not contain all required fields for the referral to be completed.
Jurisdiction	All Australian States and Territories.
Modality	How the person contacted the intake service.
Nature of contact	Why the person contacted the intake service.
Not routed	Calls that are abandoned before they’re connected to an answering point. No other information.
Note	Once a contact is saved, notes can be added to the record. Changes can be made to notes, but all changes are logged for notes.
Outcome	What was provided to the person contacting the intake service
Overall experience score	The overall experience in the survey provides an indication of whether the consumer felt it was worthwhile contacting Medicare Mental Health.
Practitioner Recommended IAR Level of Care	Level of Care recommended by the intake clinicians.
Pop-up	Physical site consumers can be referred to and access for support. Pop-ups are operated by various service providers commissioned by PHN’s but are often linked to existing Hub’s and temporary.
Referral created by	If the referral was created by a PHN or Hub/Pop-up/Centre.
Referral outcome	Indicates where the consumer was referred to, categorised into various service types.

Term	Definition
Referrer sources	Where the person presenting to the intake team came from.
Routed calls	Call was routed to an intake team. Postcode or jurisdiction is used to route the call.
Satellite	Point of support that consumers can be referred to that are generally embedded in existing primary care settings but are often smaller have less capacity.
Source of contact	Where the person presenting to the intake service came from.

May 13, 2025 16:55:50

39. Appendix - Change log

Notable changes to this project will be documented in this file. The format is based on Keep a Changelog, and this project adheres to Semantic Versioning.

39.1 v3.23.4 - 23/04/2026

39.1.1 Changes

- Performance improvements to landing and Reports > Referrals screens.

39.2 v3.23.3 - 21/04/2026

39.2.1 Changes

- Fixed bug that prevented an ereferral record from converting if it had more than 2 PDF uploads.

39.3 v3.23.2 - 21/04/2026

39.3.1 Changes

- Fixed bug that caused abandoned referrals to be displayed in the To Be Actioned list.

39.4 v3.23.1 - 02/04/2026

39.4.1 Changes

- Fixed bug that caused To Be Actioned list to error.

39.5 v3.23.0 - 27/03/2026

39.5.1 Changes

- Added MMH Check In (MMHCI) functionality:
- Policy to activate MMHCI per organisation.
- Eligibility for MMHCI
- MMCHI options to referral outcome.
- Visual indicator of referral retrieved by vendor.
- Recall email function for when retrieved referral is un-sent.
- Added preferred contact method
- Added Self-managed care option to referral outcome

39.6 v3.22.13 - 24/03/2026

39.6.1 Changes

- Risk Assessment fields can now be skipped independent of the IAR-DST option to skip.
- To improve the workflow when skipping the IAR-DST or Risk Assessment sections, the required notes to contain the reason for skipping are now embedded, appearing directly beneath the skip toggle.

- The IAR-DST and Risk Assessment can also now be un-skipped.

39.7 v3.22.12 - 23/03/2026

39.7.1 Changes

- In preparation for Check In, the Check In outcome types are prevented from being displayed in the **Service Type** dropdown.

39.8 v3.22.10 - 12/03/2026

39.8.1 Changes

- Fixed bug that disabled the buttons to manage IAR-DST and Notes templates.

39.9 v3.22.9 - 05/03/2026

39.9.1 Changes

- Corrected setting of user cache key so that it uses the current environment stage (e.g. test, prod).

39.10 v3.22.8 - 27/02/2026

39.10.1 Changes

- Fixed bug that prevented an eReferral from being declined.

39.11 v3.22.7 - 25/02/2026

39.11.1 Changes

- Various bug fixes
- The dropdown for the Contact Type and Referral Origin fields now have the same list of options.
- Updated the eReferral view for converted eReferrals that have an abandoned referral so that it displays the status icon as Abandoned and retains the ability to navigate to the abandoned referral.
- Fixed issue where the eReferral Inbox view would error when filtering on Source and redirect to the index page of the app. Changed the free-text filter to a dropdown.
- Fixed data issue with historical referral outcomes that resulted in records reverting back to **Completed** after a new note was added.
- Added missing options for some of the optional PMHC-MDS Episode fields.
- Added ability to add notes to the eReferral after convert/declined.

39.12 v3.22.6 - 19/02/2026

39.12.1 Changes

- Removed leading spaces from parameters sent to the client search function.

39.13 v3.22.5 - 19/02/2026

39.13.1 Changes

- Fixed bug in the display of Callback Request quiz data on the Contact screen.

39.14 v3.22.4 - 17/02/2026

39.14.1 Changes

- Fixed bug that caused referrals requiring action to appear a day earlier than due.

39.15 v3.22.3 - 16/02/2026

39.15.1 Changes

- Improved method for confirming access to referrals initiated in a PHN different to the user's current PHN.

39.16 v3.22.2 - 03/02/2026

39.16.1 Changes

- New fields added to Client screen: *Proficiency in spoken English* and *Interpreter required*
- eReferral fields now appear:
- The new eReferral form's risk assessment fields
- Address lines 1, 2, and 3
- Added document types for assigning eReferral attachments
- Fixed issue with the referral redirect that was not giving the organisation switch option for referrals that were initiated in a users assigned organisation
- Other minor changes

39.17 v3.22.1 - 30/01/2026

39.17.1 Changes

- Fixed bug preventing users from updating MFA settings.
- Fixed bug preventing API users from exporting PMHC-MDS data when using option to download data for all user's assigned organisations.
- Fixed bug preventing users from uploading PMHC-MDS data.

39.18 v3.22.0 - 22/01/2026

39.18.1 Changes

- Various performance improvements:
- Moved user data to a cached class.
- Changed the main clinical screens to be based on raw queries, rather than database views.

39.19 v3.21.11 - 20/01/2026

39.19.1 Changes

- Corrected logic for generating PMHC-MDS download file to account for multiple outcomes.

39.20 v3.21.10 - 06/01/2026

39.20.1 Changes

- The PMHC-MDS download process now populates the `date_referred_to_other_service_at_intake_conclusion` field using the primary outcome's Sent date/time. Previously it was using the date/time the referral was first Sent (this became no longer reliable once multiple outcomes were implemented).

39.21 v3.21.9 - 05/01/2026

39.21.1 Changes

- Improved display of callback requests in pop up by grouping them according to type.
- Included contacts in the callback requests pop up that were being excluded when in a particular state.

39.22 v3.21.8 - 05/01/2026

39.22.1 Changes

- Fixed bug that caused Check In callback requests to be excluded from the pop up.

39.23 v3.21.7 - 16/12/2025

39.23.1 Changes

- New Contact Pathway option for the MMH Check In Callback Requests.
- Corrected merge process so that it retains contact notes from the deleted Client.
- Added a new role (assignable only by System Admin users) to support new user account management for the Intake Delta API.

39.24 v3.21.6 - 10/12/2025

39.24.1 Changes

- Added a new Program Type: (8) MMHC. This meets conformance requirements to v4.1.1 of the PMHC-MDS.

39.25 v3.21.5 - 05/11/2025

39.25.1 Changes

- Phone and email now appear in the Inbox as expected if they were provided in the eReferral.
- The Medication section of the eReferral Inbox is no longer hidden for Clinical users.
- Contact notes now appear for Site Clinicians when the record has been assigned to a site organisation.

39.26 v3.21.4 - 25/09/2025

39.26.1 Changes

- Added field required for new authentication method for API users.

39.27 v3.21.3 - 23/09/2025

39.27.1 Changes

- Re-implemented the changes rolled back to resolve the performance problem experienced between 20/08/2025 and 22/08/2025.

39.28 v3.21.2 - 20/08/2025

39.28.1 Changes

- Further refinements to method for loading the referral when Sent/Accepted.
- Fixed bug that caused an error that can happen in some circumstances when loading a referral assigned to an organisation that is not the user's current one.

39.29 v3.21.0 - 20/08/2025

39.29.1 Changes

- Updated method for loading the referral when Sent/Accepted.

39.30 v3.20.5 - 20/08/2025

39.30.1 Changes

- Client phone number now appears on the referral locked screen.
- Upgraded encryption of JWT token used during password reset process.
- Changed password length of requirements. New minimum is 12 and maximum is 256.
- Bug fixes:
- Updated label of phone number so it applies the protected rul when the mouse hovers over it.
- Fixed issue where Interpreter Required field was always showing 'Not provided' even when a response was provided.
- Updated eReferral details page so that uploaded filenames are hidden from System Admin users.

39.31 v3.20.4 - 19/08/2025

39.31.1 Changes

- Minor change to as part of improving performance.

39.32 v3.20.3 - 18/08/2025

39.32.1 Changes

- Minor change to as part of improving performance.

39.33 v3.20.2 - 06/08/2025

39.33.1 Changes

- Updated save referral process so that it populates `referral.referral_sent_datetime` in all cases (previously, some situations were missed).
- Added additional information from an eReferral to the Referral pages (excluding print).
- The original IAR-DST data from an eReferral is now viewable on the Referral pages (excluding print).

39.34 v3.20.1 - 25/07/2025

39.34.1 Changes

- Fixed issue where the date/time the referral sent was not exactly matching the server time at the time of saving.

39.35 v3.20.0 - 23/07/2025

39.35.1 Changes

- Moved the Sent and Accepted status settings to the outcome, so that each outcome can be tracked individually.

39.36 v3.19.18 - 09/07/2025

39.36.1 Changes

- Included the new "Reason for referral" and "Additional information supporting IAR-DST" fields in the method to protect data from non-clinical users.

39.37 v3.19.17 - 08/07/2025

39.37.1 Changes

- Bug fix: Resolved bug that prevented notes from the contact screen displaying on the referral screen.

39.38 v.3.19.16 - 03/07/2025

39.38.1 Changes

- If eReferral was used, the "Reason for referral" and "Additional information supporting IAR-DST" fields from the form are now displayed on the main referral screen.
- Consolidation of code for checking a user's access to a referral.

39.39 v3.19.15 - 18/06/2025

39.39.1 Changes

- Bug fix: Fix error triggered when setting up the support email template, which caused a referral not to load if it was transferred.

39.40 v3.19.14 - 17/06/2025

39.40.1 Changes

- Moved **Feedback & Support** button to the top menu. The support item now includes contextual email templates.
- Added warning if an eReferral is being converted without first assigning the attachment type.
- Consent wording updated to reflect DoHAC's name change (to DHDA or Department of Health, Disability and Ageing).
- Added a notification when transferring a referral to another PHN to remind user to notify the PHN it is being transferred to.
- Bug fixes:
- Corrected combination of eReferral status options appearing on the Inbox screen.
- Corrected display of medication information for users in the System Admin role.

39.41 v3.19.13 - 05/06/2025

39.41.1 Changes

- Enabled System Admin users to see eReferral Inbox with hidden PII.
- Referrer organisation type added to Inbox detail screen.
- Enabled eReferral tracking page to display more detailed status updates.
- Dropdown options changed to reflect re-brand to Medicare Mental Health.
- Bug fix:
- Survey dashboard: fixed issue that displayed multiple results when only one expected.

39.42 v3.19.12 - 16/05/2025

39.42.1 Changes

- Ensured all ereferral attachments use `.pdf` as file extension.

39.43 v3.19.11 - 13/05/2025

39.43.1 Changes

- Rebrand to PMHCIS.
- Fixed bug that reset referrer profession when referral saved.

39.44 v3.19.10 - 30/04/2025

39.44.1 Changes

- Added a copy button to SLK.
- Updated metadata of PMHC-MDS download to 4.1.
- Added check for permission and limited file type for file uploads.
- Added sanitisation to all values in CSV file downloads and uploads.
- Removed "New note" button for completed contacts.
- Changed role permission settings so an admin user can save an abandoned referral.

39.45 v3.19.9 - 03/04/2025

39.45.1 Changes

- Client merge function now permitted via an Organisation Policy.
- Updates to the text and email address for help desk support.
- Minor bug fixes:
- Referrer profession now automatically sets to 98: NA Self Referral for referrals set to Self-referral type.
- Stopped proliferation of tag column headers if a JavaScript error occurs.
- Medium level vulnerabilities resolved:
- Prevented Reflected Cross Site Scripting.
- Replaced out-of-date version of the JavaScript library for viewing PDF files.

39.46 v3.19.8 - 01/04/2025

39.46.1 Changes

- Changed print view title to "Medicare Mental Health".

39.47 v3.19.7 - 31/03/2025

39.47.1 Changes

- Changed logo that appears on print view to be the Medicare Mental Health logo.

39.48 v3.19.6 - 24/03/2025

39.48.1 Changes

- Fixed bug occurring when saving a user.

39.49 v3.19.5 - 21/03/2025

39.49.1 Changes

- Corrected grouping of Callback Requests report.

39.50 v3.19.4 - 21/03/2025

39.50.1 Changes

- Code cleanup. Removed stdout statements.

39.51 v3.19.3 - 18/03/2025

39.51.1 Changes

- Contact screen now displays an indicator of email validation status.
- Clinical notes on the referral "locked" screen now appear in the main Notes section. Previously they displayed under the IAR-DST section.

- Corrected the phone number that displays on the referral print view so that it displays the phone number of the organisation that performed the intake and assessment.
- Minor bug fixes.

39.52 v3.19.2 - 11/03/2025

39.52.1 Changes

- Fixed bug that prevented search by postcode and suburb from Profile organisation switch drop down.

39.53 v3.19.1 - 05/03/2025

39.53.1 Changes

- Fixed bug that caused screens that pop-up to be hidden behind the header and footer.

39.54 v3.19.0 - 04/03/2025

39.54.1 New feature

- This release implements the eReferral Management (including Inbox) function for processing referrals sent in by GPs using HealthLink SmartForm.

39.55 v3.18.9 - 22/02/2025

39.55.1 Changed

- Process to trigger MFA now includes a check of roles across all organisations, not just the user's current one.

39.56 v3.18.8 - 15/02/2025

39.56.1 Changed

- Fixed bug that returned an error when attempting to print a Contact record.
- In the PMHC-MDS download a client record now gets added per each organisation/referral combination. Previously it was only one record, with an `organisation_path` matching the client's current organisation.

Note, the version number incorrectly skipped 3.8.17.

39.57 v3.18.6 - 10/02/2025

39.57.1 Changed

- Fixed a bug that prevented PHN staff from accessing referrals assigned to Sites that originated in a different PHN

39.58 v3.18.5 - 06/02/2025

39.58.1 Changed

- These bugs were fixed:
- The field to change the referral owner would disappear under certain conditions.
- Search results would show duplicated names for clients with multiple referrals.

39.59 v3.18.4 - 31/01/2025

39.59.1 Changed

- These bugs were fixed:
- Referral notes were appearing as "protected" even when user was permitted to see the notes.
- The save process for client was not saving address lines 1, 2, and 3.

39.60 v3.18.3 - 30/01/2025

39.60.1 Changed

- Fixed a bug occurring with a system admin function for merging records.

39.61 v3.18.2 - 29/01/2025

39.61.1 Changed

- This change fixed a bug with the process to convert a contact to a client, which sometimes resulted in multiple client/referral records being created.

39.62 v3.18.1 - 29/01/2025

39.62.1 Changed

- These bugs were fixed:
- When using the IAR-DST template chooser, the button to confirm the template did not work.
- When policy was activated to enable uploads to contact record, the upload button was deactivated.
- Saving a new user caused an error.
- Main screen would error for a user account whose password had been reset.

39.63 v3.18.0 - 28/01/2025

39.63.1 Changed

- Access to client and referral records is now managed based on the roles assigned per organisation that a user account can access, rather than all their organisations. For more information, see the User account management article.

April 23, 2026 15:11:07

40. Appendix - Announcement log

Announcement	Time and Date	Category
13/4/2026 8.00pm: Remember to log out by 9pm (AEST). Due to a scheduled technical upgrade the PMHCIS will be unavailable between 9pm and 10pm (AEST) tonight.	2026-04-13 20:00	Deployment
9/4/2026 5.00pm: Due to a scheduled technical upgrade on Monday April 13th, the PMHCIS will be unavailable between 9pm and 10pm (AEST). Please ensure you have arranged your schedule so that you are logged out and don't need the system at that time.	2026-04-09 17:00	Deployment
7/4/2026 8:00pm: The callback request issue is now resolved, and requests now show correctly when they are from the MMH Check In wesbite or the national MMH website.	2026-04-07 20:00	System issue
7/4/2026 5:30pm: The callback request issue is now resolved, and **new requests made from now onwards** should correctly show whether they are from the MMH Check In wesbite or the national MMH website.	2026-04-07 15:30	System issue
7/4/2026 3:20pm: We have confirmed that the majority of callback requests are for Check In, not the national MMH website. A fix is underway and should be in place by COB tomorrow. We will confirm when the fix is deployed.	2026-04-07 15:20	System issue
7/4/2026 10:30am: Some PHNs may have noticed that there has been a significant increase in callback requests. They were sent through to the PMHCIS flagged as coming from the national MMH website, however we understand it is possible many are actually from the MMH Check In website. We have asked the national website team to investigate and get back to us as soon as possible. In the meantime, please continue to process the requests as normal. We will provide an update once the team have responded.	2026-04-07 10:30	System issue
30/3/2026 4.30pm: Medicare Mental Health Check In integration is now live with St Vincent's Health Australia! Remember you can refer help-seekers with a level of care 1 or 2 for online LiCBT. More information is available in the Help Documentation or you can contact pmhicis.support@nwmphn.org.au.	2026-03-30	Deployment
30/3/2026 8.00am: The PMHCIS is now updated with changes to support the Medicare Mental Health Check In service. More information is available in the Help Documentation or you can contact pmhicis.support@nwmphn.org.au.	2026-03-30 08:00	Deployment
27/3/2026 11:00pm: Changes to support Medicare Mental Health Check In, which begins on Monday, have been deployed. More information is available in the Help Documentation or you can contact pmhicis.support@nwmphn.org.au.	2026-03-27 23:00	Deployment
Changes to support the launch of Medicare Mental Health Check In have been deployed to the staging instance of the PMHCIS for you to review and testing as required. We are continuing to finalise changes today. Changes in the live system will be deployed prior to 8:30am AEDT Monday March 30. Further information is available in the Help Documentation or you can contact pmhicis.support@nwmphn.org.au.	2026-03-27 11:50	Deployment
Changes are now deployed to the back-end intended to improve performance in some areas. It also improves our structure to continue on future performance improvements. For more information see the Change Log in the Help Documentation.	2026-01-22 15:10	Deployment
NWMPHN has consulted with CESPHN and with endorsement from DoHDA, have created a ‘Bondi Beach’ tag to track any engagement with the service and for consumers who may need specific services as a result of the recent incident. This tag has been applied to all PHNs in order to track any identified link to the incident. Please contact pmhcis.support@nwmphn.org.au if you have any questions.	2025-12-16 09:30	Deployment

Announcement	Time and Date	Category
The temporary unplanned outage affecting the staging instance of the PMHCIS has now been resolved and the staging instance is now accessible again. Apologies for the inconvenience.	2025-09-23 16:10	System Issue
We are aware of a temporary unplanned outage affecting the staging instance of the PMHCIS. Our technical team are working to resolve this, and we will provide another update before COB today. Apologies for the inconvenience.	2025-09-23 15:25	System Issue
A technical bug affecting client addresses on a limited number of referrals submitted via eReferral (both Healthlink and the external Webform) has been identified and resolved. For in-progress referrals received via eReferral/external webform, please confirm the client's street address is correct before finalising and sending. At this stage, the impact appears minimal. We are continuing to review and will contact any affected PHNs if required.	2025-09-09 09:58	System Issue
Thank you all for your patience last week as we managed challenges in accessing and using the PMHCIS. Critical issues are now resolved, but we are continuing to monitor performance and make improvements. We appreciate your understanding.	2025-08-28 14:56	System Issue
An issue that held up referrals moving to external client managements systems via API is now resolved. The systems' vendors have all been notified and to re-request the data. If you're made aware of a referral not being imported, please try unsending and sending again, or contact us at pmhcis.support@nwmphn.org.au. Apologies for the inconvenience and thank you for your understanding.	2025-08-26 10:26	System Issue
Work is ongoing and we are actively monitoring the system. Some recent changes have been rolled back over the weekend to improve performance, they will progressively be restored today.	2025-08-25 09:16	System Issue
We are finalising the solution for system to be restored to normal on Monday. We appreciate your patience and understanding.	2025-08-22 17:24	System Issue
We are aware of the slowed system responsiveness this afternoon. We also note challenges with the referral print screen, which we expect to be resolved with server upgrades being made this evening	2025-08-21 16:37	System Issue
The system is currently under high demand and this is impacting on the responsiveness of the database. We are working on resolving the performance issues.	2025-08-20 12:03	System Issue
We are experiencing a high level of use of the Referral > Reports screen. We are currently investigating how to manage the usage, but in the meantime we recommend avoiding use of the screen unless necessary.	2025-08-18 14:59	System Issue
The system may become unavailable tonight from 10:15pm (AEST). If you intend to work around that time, make sure you're logged off by 10:10pm, and try again from 10:20pm.	2025-08-11 21:52	System Issue
Referrals sent since last Wednesday (23/07/2025) may not have had the follow up date automatically set. A fix has now been implemented. The follow up date now takes into account the multiple outcomes and will be set based on the sent status of all outcomes. Reach out to us at pmhcis.support@nwmphn.org.au if you have any questions.	2025-08-01 08:35	System Issue
You can now record sent and acceptance for each outcome of a referral. The help documentation has been updated, and communications have been sent to PHN and Intake leads. Please reach out to them or pmhcis.support@nwmphn.org.au if you have any questions.	2025-07-24 08:49	Deployment
The 'Feedback & Support' icon within the PMHCIS has now been moved to the menu bar in the top right and will be accessible on all pages of the webform. The		Deployment

Announcement	Time and Date	Category
'Request support' button will generate an email template that has a reminder not to include personally identifiable information and includes the referral link when generated from a specific referral.	2025-06-18 08:24	
To ensure you're accessing the most up-to-date version of the PMHCIS Intake Module, please update your bookmark to: pmhcis.intake.org.au.	2025-05-21 11:02	Deployment
The Head to Health intake system has been rebranded to the Primary Mental Health Care Information System (PMHCIS). Please update your bookmark to: pmhcis.intake.org.au. This change has only affected the visual display of the webform. There are no functionality changes, and all historical records are accessible as usual. More information is available here, or you can contact pmhcis.support@nwmphn.org.au if you have any queries.	2025-05-14 10:26	Deployment
The issue with access to a Site referral transferred from another PHN is now resolved. We're aware that when searching on those records, only the initials will appear in search results. However, the records can be accessed as expected. We're now working on this issue.	2025-02-10 16:30	Deployment
We are currently working to resolve a known issue where some intake staff may lose access to a referral. This only occurs if a referral was transferred from another PHN and is now referred to a Site. If this happens and you need access, please contact Head to Health Support at h2hsystemsupport@nwmphn.org.au. A fix to other reported issues was made on 6/2/2025.	2025-02-06 15:33	System Issue
We have made a change to the way that user account roles are managed. Roles are now set per each organisation assigned to the user account, rather than for all their organisations at once. See the Change Log for more information. Note that there may be referrals listed that are owned by another organisation. This is by design, because the change includes displaying referrals created in your organisation, not just those that are owned by your organisation. If you encounter an issue, notice a discrepancy, or need support managing these referrals, please report it to the Head to Health support team at h2hsystemsupport@nwmphn.org.au.	2025-01-29 11:57	Deployment
A new document titled 'Protecting PII in the Head to Health Data Management System' has been uploaded to the Head to Health Intake System under 'Document and Links'. It outlines essential 'Personally Identifiable Information' (PII) guidelines and protocols. Please read it and share it with your Head to Health teams.	2024-11-22 09:01	Deployment
Starting September 9th, the term 'Hub' has changed to 'Site' in the Referral outcome drop down box in the system. This is a text-only update and does not affect workflows. Please select 'Site' instead of 'Hub' in the Referral outcome when referring to a Pop-up, Satellite or MMHC. The Help document will be updated accordingly.	2024-09-09 09:34	Deployment
For people using email to receive their MFA notifications, please note that from 5th August 2024, the system sender email address will be changed to support@intake.org.au. Please check your spam if no notification is received or contact h2hsystemsupport@nwmphn.org.au for any issues.	2024-07-30 08:44	Deployment
A bug was identified this week that caused files added to Contact records to be removed. System-wide, this impacted about 50 records entered between 18/6/2024 and 24/6/2024. It did not impact on Contacts converted to Clients. Users who uploaded PDFs to Contact records during that timeframe are advised to check records and re-upload if needed. For further information or support please log a support request at h2hsystemsupport@nwmphn.org.au.	2024-06-27 07:29	System Issue
The Suggested consent wording has changed to include information about data linkage. Please review the updated wording.	2024-06-03 09:06	Deployment

Announcement	Time and Date	Category
The multiple referral function is now enabled. After a Referral Outcome (the primary outcome) is saved, you can add another, secondary, outcome. For more information about this function see the Help Documentation - Status of referrals/ referral timeline section.	2024-05-06 17:09	Deployment
Please note: as per the guidelines from DoHAC, we have revised the suggested wording for Consent 2 – to share de-identified data with DoHAC with effect from 1st May 2024. These changes are explained in more detail in the Help Documentation. Please familiarise yourself with the changes.	2024-04-30 16:58	Deployment
Update tonight: At 9:20pm (AEST) tonight the system will be updated, which will cause you to be logged out. We recommend you finish up your work at around 8:45pm. The update will take only a minute or so. When the update is done you will be able to log in as normal and this message will no longer appear.	2024-04-15 21:15	Deployment
A problem was discovered with the function to Show assigned referrals on the Incomplete referrals tab. It would incorrectly either show no assigned referrals or only one. This problem is now fixed. When you assign a staff member to a referral note, it will now correctly appear when the due date is past.	2024-03-19 16:56	System Issue
You can now add documentation to contacts. If converted to a client, files will automatically transfer to the referral record. For more information, click on the (?) icon next to the "Additional documentation" header on the Contact screen.	2023-12-20 09:13	Deployment
Users of the Microsoft Edge web browser are reporting they are unable to print a referral to a PDF file. The download hangs and a file named "unconfirmed nnnnn.crdownload" appears where the referral PDF normally would. The problem is not occurring with other browsers. Until the problem is resolved, we recommend you switch to another browser such as Google Chrome.	2023-12-12 15:33	System Issue
The layout of the print view of the Referral screen is now changed so that the IAR-DST domains are easier to read. Each domain and its notes now appear on a separate row.	2023-10-26 17:24	Deployment
A new option is now available for Gender: "Gender diverse". The location of the Intersex and Sexual orientation fields have been swapped around (so that Sexual orientation now comes after Date of birth).	2023-10-17 17:35	Deployment
Full name can now be displayed in lists. This is an option set at the team level. If your team would prefer to see the full name rather than first initial and surname, send your request to h2hsystemsupport@nwmphn.org.au.	2023-08-23 08:29	Deployment
Changes have been made to the Contact screen. As covered in the "Contacts" section in the Help Documentation, some changes are configurable, such as the Summary note type, which always appears at the top.	2023-08-07 08:32	Deployment
Some changes will be made to the Contact screen on Monday (7th August). The main change is to make the notes work as they do on the Referral screen. The "Contacts" section in the Help Documentation now includes the updates.	2023-08-03 09:07	Deployment
The wording for the consent questions is now updated. Click the Suggested consent wording box in the Consent section of the referral/IAR-DST screen. Also, a new consent wording prompt will appear on the new Contact screen.	2023-05-21 17:34	Deployment
There is now a new Abandon reason option available when you abandon a referral. The new option is: "Unable to contact client".	2023-05-04 09:01	Deployment
An important security patch is now available for Google Chrome. If you are using Chrome, you should update it now. To update, go to Chrome > Settings > About	2023-04-17 08:49	Deployment

Announcement	Time and Date	Category
Chrome. Wait for it to check for and install updates. Click the Restart button when it appears, to complete the process.		
The Suicide Referral field is now required before a referral record can be completed. Previously it had a default value of "Unknown". It will now be blank by default.	2023-03-27 08:44	Deployment
Administrators can now share IAR-DST comment templates with other PHNs from the Actions > Manage organisation screen.	2023-02-28 08:28	Deployment
In the Incomplete contacts list, the last note that was added to the Contact Notes table is now included. Look for the Most recent note column.	2023-02-25 10:13	Deployment
If you're getting your verification code by email when you log on, did you know you can choose a different method that is probably quicker? From your Profile details screen you can click the 2FA Settings button to set up getting your code by SMS or by an authenticator app on your phone.	2022-12-16 21:00	Deployment
Important: Multi Factor Authentication (MFA) will become mandatory at 5pm on Friday 9th December. You can set it up earlier by accessing your Profile details screen and clicking the button labelled Turn 2FA On. If you don't set it up before that time, then when you next log on you will be sent a verification code to your email address. You can change the verification method at any time from your Profile details screen.	2022-12-08 08:05	Deployment
Multi Factor Authentication (MFA) is now available. Use of MFA further protects client data by requiring an extra verification code when you log in. To activate MFA, go to your Profile details and click the button labelled Turn 2FA On.	2022-11-25 09:25	Deployment
The error with the Contact form is now resolved. We've reviewed the cause of the error and have taken steps to prevent it from happening again.	2022-11-16 17:59	Deployment
Multi-Factor Authentication (MFA) is now enabled in the System. You have the option to turn MFA on from your Profile details screen. Instructions are in the Help Documentation (look for the User profile settings section, or search on "MFA"). An email advising of this change and other security updates has been sent to all administrator users of the System.	2022-11-15 09:48	Deployment
A new referral note type is now available: Assessment. This for intake teams that would like to monitor time spent on assessments.	2022-11-10 13:27	Deployment
When emailing H2H System Support, please use the Referral URL or Client ID or Contact ID. Do not share personal or sensitive client information (even in a screenshot) as this is considered a data breach.	2022-11-02 15:28	Deployment
You can now search on phone numbers with the spaces removed. For example, you will be able to find a phone number of "0419 999 999" if your search is "041999". Don't forget that our main support email address is always available under the Feedback & support link on the right hand side of this screen (directly below). Use this address if you need support for a task that your PHN Admin isn't able to do.	2022-10-19 16:43	Deployment
The system now has the function to create reminders (referrals to be actioned). More information about this function is in the Help Documentation (refer to the Setting reminders and assigning to a staff member section).	2022-08-12 14:26	Deployment
On the referral Print view you now have more choice over which notes are included. You can choose to show or hide any combination of Clinical, Follow Up, and Documentation notes. By default, Clinical notes appear when you open the screen.	2022-07-15 13:14	Deployment
		Deployment

Announcement	Time and Date	Category
A new Directory function is now available from the Documents & Links menu. It has all the PHN intake teams around Australia and their phone numbers. It also lists the Head to Health centres, Hubs and Pop-ups.	2022-07-07 12:10	

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