IAR Frequently Asked Questions

phn NORTHERN QUEENSLAND
An Australian Government Initiative

Who developed the Initial Assessment and Referral Decision Support Tool (IAR-DST)?

An expert advisory group comprising of general practitioners (GPs), medical specialists, allied mental health clinicians, and individuals with lived experience, collaborated with The Department of Health, and consulted with a wide range of stakeholders to develop the IAR-DST. It represents a combination of the views from clinical practitioners from multiple disciplines, those with lived experience, and stakeholders from wide ranging backgrounds, and is informed by the current best evidence-based research.

The IAR-DST is based on recognising the increase in mental health problems, the wide treatment gap, the diagnostic challenges of mental health conditions, and the pressure on resources. In using the most recent evidence-based approaches it employs a stepped care model in both assessment and management. Importantly it recognises the value general practitioners bring to the health system and aims to support their clinical work. It does this with a holistic instrument comprising of eight domains. The medical and psychosocial aspects of a person's life are included by using Initial Assessment and Referral (IAR). This tool streamlines thinking, ensuring significant factors are not overlooked, and helps GPs with time constraints. It also improves communication with other health professionals through usage in common, ensures compliance, and is linked to an automatically generated management plan which helps GPs with time management.

The model of stepped care provides patients with the best level of care that is clinically indicated at that particular time. It allows care to be varied as the dynamic clinical situation demands. Provision of and accessibility to resources is optimised, and because the IAR-DST is a standardised accepted instrument, it offers GPs a protective framework in any underservicing (associated with poor patient outcomes), or overservicing (unnecessary burden on patients) dispute that may arise in the often lengthy and challenging history in treating patients with complex needs.

How long does it take to complete the IAR-DST?

The time taken to complete an assessment of a person (consumer/patient) is separate to the time it takes to complete the IAR-DST. The IAR-DST is not a new assessment tool or process. Anecdotally, it takes between two to ten minutes to complete the IAR-DST and generate a level of care. The time varies based on several factors including the user's familiarity with the tool and frequency of use.

Will the IAR-DST be integrated into GP clinical software?

The Department of Health and Aged Care (the Department) is currently developing user journeys to help define where the IAR-DST is best placed in GP workflows. From there a codesign process will commence with integration of IAR into GP clinical software planned for mid-2023.

I have completed the IAR-DST for my patient but I don't know any local services that align with the recommended level of care. What do I do now?

This scenario poses a problem with or without using the IAR-DST. Frequently GPs might be faced with a lack of options due to high demand, long wait lists or services not accepting referrals.

The recent General Practice Mental Health Standards Collaboration Report suggests that most GPs are confident in meeting the needs of patients with mental health concerns, however, only 13 per cent agreed there is sufficient access to other mental health services in their area. While this may be due to the lack of services in some areas, it may also suggest that GPs are unaware of the services on offer in their area or how to find them. CESPHN is working to map local services at all IAR levels and host this information within a user-friendly, accessible online directory. Further information to come.

In the interim GPs can:

- Consider bundling services (making several referrals) to achieve the intensity that is required.
- Consider services against an alternative level of care whilst waiting for the right services to become available (e.g., level two if level three is not available).
- Increase their contact with and monitoring of the patient, including with support from the practice nurse or other practitioners.
- Undertake advocacy with particular services or raise the issue for discussion within local advisory structures.

What happens if the service provider rejects the referral?

We understand that services can often have long waiting lists or closed for new referrals at certain times. At times there maybe issues with eligibility or access to services for other reasons. One of the benefits of IAR is it uses language and terminology that is increasingly understood across the sector, which is a great advantage compared to the current state. Using a nationally consistent approach will improve the ability for providers to prioritise patients and enable them to communicate about ineligibility or inappropriateness of referrals.

Who can use IAR-DST?

Clinicians who are suitably qualified and experienced to perform a mental health assessment.

This includes GPs, psychologists, credentialed mental health social workers or social workers who have completed additional training in mental health and referral skills and have access to mental health focused supervision, psychiatrists, credentialed mental health nurses or registered nurses who have completed additional training in mental health assessment and referral skills and have access to mental health focused supervision, and occupational therapists who are endorsed to provide the Better Access initiative.

Under supervision, it may be appropriate to engage non-clinical staff (for example, peer workers, youth workers, workers trained in the delivery of low intensity services) in undertaking components of the initial assessment. It is important to ensure that training has been provided in mental health

assessment and referral skills, suitably qualified and experienced mental health clinicians oversee decision-making by non-clinical staff. Key decision-making points during the IAR process include:

- Decisions about the rating on each of the domains.
- Decisions about the assignment of the level of care.
- Non-clinical staff have immediate access to supervision from a suitably qualified and experienced clinician (e.g., whenever it is needed, via telephone, or onsite supervision).

Why has the IAR-DST been developed?

One in five Australian adults (aged 16 to 85 years) will experience a mental illness each year and almost half will experience a mental disorder in their lifetime. In total, 10 million people, or about 38 per cent of the Australian community, have some level of mental health need.

NQPHN commissions a range of services across the stepped care spectrum to meet the mental health needs of our community.

These include low intensity services; psychological therapies; coordinated care for people with severe and complex mental health conditions; services for children and young people, including Headspace; psychosocial services for people with severe mental illness; Aboriginal and Torres Strait Islander mental health services; and suicide prevention services.

The IAR-DST is designed to assist the various parties involved in the assessment and referral process to ensure:

- Best use is made of the full range of options available to assist people in need in a way which targets resources where they are needed most.
- Patients are guided to the option which best meets their needs and has the least burden on them and the health system.

Should our team do the training together?

Some organisations may prefer to complete the training as a team or service to learn together, while others may prefer to register for training alongside other organisations in the open-registration sessions.