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GPMHSC stepped care guide

Delivering stepped care in general practice

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GPMHSC stepped care guide: Delivering stepped care in general practice

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Executive summary

A primary role of the General Practice Mental Health Standards Collaboration (GPMHSC) is the development of competencies related to the provision of mental health services. The GPMHSC identified that GPs in Australia need an easy-to-follow guide to the Stepped Care Model. Originally published in 2016, this is now the 2nd edition of the Stepped Care Guide and was redeveloped by the GPMHSC Stepped Care Working Group comprising Dr Michael Tam, Dr Caroline Johnson, Consumer Representative Heather Nowak and Carer Representative Peter Heggie.

This edition of the guide aims to:

- support the implementation of the Stepped Care Model
- encourage communication between general practice and Primary Health Networks (PHNs) to deliver stepped care
- encourage GPs to undertake shared decision-making with carers and consumers.

To do this, it includes the following:

- explanations of:
  - the Stepped Care Model
  - the role of the GP in stepped care
  - the role of the PHN in stepped care
- advice on:
  - empowering consumers and carers to use the model
  - using other services in your community to implement the Stepped Care Model
  - how to use the model for specific populations
  - how to use the model in telehealth
  - how to use the model in rural and remote areas.

Useful resources are located throughout the guide, and there is a new link you can use to identify your local PHN.

In developing this guide and ensuring its relevance to all professions involved in primary mental health care, the GPMHSC reached out to the following member organisations for comment: the Australian Psychological Society, the Australian Association of Social Workers, the Royal Australian and New Zealand College of Psychiatrists, Occupational Therapy Australia and the Australian College of Mental Health Nurses.

On behalf of the GPMHSC, I encourage you to refer to this guide to understand how to best use the Stepped Care Model in your own practice and in collaboration with your PHN.

Associate Professor Morton Rawlin
Chair, General Practice Mental Health Standards Collaboration

Acronyms and abbreviations

ACCHOs	Aboriginal community controlled health organisations
ADHD	Attention deficit hyperactivity disorder
AHWs	Aboriginal Health Workers
AOD	Alcohol and Other Drugs
ATSICHS	Aboriginal and Torres Strait Islander Community Health Service
CALD	Culturally and linguistically diverse
CEM	Clinical enhancement module
CATT	Crisis Assessment and Treatment Team
DoHDA	Department of Health, Disability and Ageing
DVA	Department of Veterans' Affairs
EAP	Employee assistance program
ED	Emergency department
FPS	Focussed Psychological Strategies
FPS CPD	FPS Continuing Professional Development
FPS ST	FPS Skills Training
GP	General practitioner
GPMHSC	General Practice Mental Health Standards Collaboration
IAR-DST	Initial Assessment and Referral Decision Support Tool
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and additional identities
MBS	Medicare Benefits Schedule
MH CPD	Mental Health Continuing Professional Development
MHST	Mental Health Skills Training
MHTP	Mental Health Treatment Plan
NACCHO	National Aboriginal Community Controlled Health Organisation
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
non-VR	Non-vocationally registered
OT	Occupational therapist
PHN	Primary Health Network
RFDS	Royal Flying Doctor Service

Introduction

Mental health has been the most common reason Australians visit their GP for several years, surpassing all other reasons for clinical presentations. According to the RACGP *Health of the Nation 2025 report*, 71%[1] of all GPs, and 75% of female GPs, identify mental health as a top reason for consumer visits, with anxiety and depression being the leading presentations. In addition, 57% of GPs view mental health as an emerging issue of concern for the future.

The scale of need is also reflected in other relevant data. For example, the Australian Bureau of Statistics (ABS) *National Study of Mental Health and Wellbeing* shows that:

- of Australians aged 16–85:
  - 42.9% have experienced a mental disorder in their lifetime[2]
  - 21.5%[3] (around 4.3 million people) experienced a mental disorder in the past 12 months, the most prevalent of which are anxiety disorders (17%) and affective disorders such as depression (8%)
- among people aged 16–24, the rate of people who had experienced a mental disorder in the past 12 months was even higher (38.8%), suggesting a youth mental health crisis.

These mental health trends highlight the importance of evidence-based, person-centred approaches that support early intervention, flexible care pathways and effective integration across services. Stepped care is one of these approaches.

The role of the GP

In 2024–25, Australians consulted GPs 167.2 million times[4], underscoring both the GP's role as the first, and often only, point of mental health support, and the critical role GPs have in addressing Australia's growing mental health needs. By providing whole-person care that includes detection, treatment, review and coordination, GPs can reduce the risk of people 'falling through the cracks'.

In addition, GPs are uniquely placed to provide continuity, coordinate multidisciplinary support and champion equity. This is particularly important for groups experiencing additional barriers, including people in rural and remote communities, culturally and linguistically diverse populations and Aboriginal and Torres Strait Islander peoples, who hold unique strengths, cultural knowledge and community-based support systems but have faced adversity through colonisation and intergenerational trauma.

The need to update the original Stepped Care Guide

Since the original Stepped Care Guide was published, substantial progress has been made in a number of areas, including telehealth, consumer and carer engagement and the use of targeted approaches for specific populations.

This updated guide has incorporated relevant changes to language, roles and care models, and also includes improved information and advice about how to:

- empower consumers and carers
- meet the needs of priority populations
- deliver care in rural and remote contexts
- use telehealth effectively
- measure outcomes.

It also clarifies the respective roles of GPs and PHNs and the use of the Initial Assessment and Referral Decision Support Tool (IAR-DST) and MHTPs to support the use of stepped care.

Basic principles of stepped care

Starting point: A consumer does not need to begin at the lowest level of intervention: instead, they need to be directly matched to the most appropriate level of care based on clinical presentation, risk, preference and functional impact[5]. Tools like the IAR can help you do this.

Non-linear/flexible movement: As stepped care aims to match the least intensive, most effective intervention to a consumer's current need, it might include non-linear steps (eg sideways, as well as up and down) as the consumer's circumstances change.

Continuity of care: Ideally, a consumer will predominantly use one GP (or one GP clinic), which will help to ensure continuity of care, including while they are receiving treatment from other health providers. As such, stepped care also means creating a meaningful, trusting relationship with your consumer so they feel comfortable to keep returning.

Variations: Because each PHN serves diverse populations and local contexts, including Aboriginal and Torres Strait Islander communities with distinct cultural strengths and locally led health structures such as ACCHOs, what they offer will vary across regions, based on community needs, service gaps and workforce availability.

Network of care: A consumer achieves the best outcomes when they have a network of care[6]: people such as their GP, support person or carer, family and so on, who are equally engaged alongside them in working towards their recovery. This means identifying the consumer's minimum sufficient network – the set of people, supports, services and interventions required to safely and effectively meet their needs at their current level of complexity and risk. However, if the consumer does not have a carer or support person, the GP *is* the support person.

Aims of the Stepped Care Model

The Stepped Care Model aims to:

- broaden the range of accessible, evidence-based care, while promoting affordability and equity
- offer a range of support options from low to high intensity, that can be matched to each consumer's current needs
- provide clear pathways between options as a consumer's needs change, thereby integrating services provided by GPs, allied health professionals, specialists, community organisations and digital supports
- improve collaboration and integration across local services, and improve connections to non-PHN options where appropriate
- uphold self-management principles (eg digital programs, brief GP interventions, community resources)
- achieve a sustainable system

Care provided under the Stepped Care Model can include:

- use of digital mental health tools and self-directed programs
- low-intensity or guided interventions initiated by a GP
- community-based psychosocial supports
- structured therapies of moderate intensity
- high-intensity clinical care that is coordinated and involves multiple professionals.

The levels of care in the Stepped Care Model

Before proceeding, please read the definitions of levels of care located here: https://docs.iar-dst.online/en/v1/level-of-care/index.html.

The stepped care process

The following steps explain how to implement the Stepped Care Model, as developed by the GPMHSC Stepped Care Working Group 2025.

1. A person experiencing mental health concerns presents to their GP.

2. The GP:
- builds relationship and trust with consumer
- identifies and assesses mental health care needs
- conducts a risk assessment together with the consumer
- develops a formulation/diagnosis.

3. The GP and consumer undertake shared decision-making and agree on appropriate treatment steps.

4. The GP may:
- assess and treat the consumer:
- use the IAR-DST to guide assessment
- document care using an MHTP
  - provide additional mental health care, appropriate to their level of competency (eg counselling, psychoeducation, FPS, social prescribing, psychotherapy)
  - prescribe medication
- support the consumer:
  - build rapport and trust
  - help the consumer problem-solve their issue
  - provide information about local services in the community and how to access them
- refer the consumer to PHN-commissioned services (if available), private services or community mental health services
- provide information about after-hours and crisis services

5. The local PHN may:
- provide access to commissioned services
- manage intake, and assess the consumer's eligibility for commissioned services
- support the consumer's navigation of the system and coordinate appointments and follow-ups
- connect consumers with relevant services.

6. Consumer receives the care from their GP and/or additional services.

7. PHN and/or other services provide feedback to the GP.

8. The GP:
- reviews progress, together with consumer
- monitors risk
- decides, in conjunction with the consumer and/or carer, to:
  - step up care
  - maintain care
  - change the care, while maintaining the same intensity of care (for example, changing from CBT to interpersonal therapy)
  - step down care
  - end care.

9. Repeat from Step 3.

Figure 1. How to provide stepped care, developed by the GPMHSC Stepped Care Working Group 2025

Stepped care matrix

The following table shows the assessment outcomes, possible interventions and referrals for each level (step) of care.

Intensity of care	Assessment examples (not an exhaustive list)	Possible interventions	Care options
Prevention/Early intervention	No diagnosable disorder Subthreshold symptoms	Psychoeducation Lifestyle advice Mental health literacy	Medicare mental health centres PHN digital wellbeing programs National Early Intervention Service (NEIS) e-mental health Social prescribing and other community-based activities such as yoga, church, gardening etc.
Low intensity/mild symptoms	Mild anxiety/depression Low distress Minimal functional impairment	MHTP development Guided self-help Digital CBT (literacy level and language to be considered) Brief GP follow up	MBS-funded digital mental health services Medicare mental health centres Online CBT program Social prescribing
Moderate symptoms	Moderate depression/ anxiety Functional impairment present No immediate risk	MHTP development Structured psychological treatment	Medicare mental health centres FPS trained GP Psychologist Psychiatrist PHN-commissioned services
Moderate to severe/complex	Severe symptoms Significant functional impairment	Multidisciplinary care Medication and psychotherapy Care coordination	Community mental health teams Psychologist Psychiatrist Local Crisis Assessment and Treatment Team (CATT) Emergency department (ED) Mental health triage
Long-term/high risk	Psychosis/mania/severe depression High psychosocial complexity	Ongoing multidisciplinary care Rehabilitation-orientated support	CATT ED Mental health triage

Figure 2. Stepped care matrix, developed by the GPMHSC Stepped Care Working Group 2025

Examples of the Stepped Care Model in action

The following examples show how the Stepped Care Model can be implemented for different levels of care. Note that these in no way provide a full picture of services that consumers can be offered.

Low intensity

- A consumer presents to their GP with mild symptoms. The consumer works full time, so is keen to explore online options. The GP creates an MHTP and uses eMHprac (or a similar resource) to provide the consumer with e-therapy information. The GP arranges follow-up with the consumer in four weeks' time.
- After six face-to-face counselling sessions with a mental health professional, a consumer's symptoms have improved considerably. They do not want to have any further sessions but, based on past history, they are at risk of relapse. The GP discusses online e-therapy options or refers them to PHN-commissioned low-acuity telephone-based care.

Moderate intensity

- A consumer has moderate symptoms and is keen to consider face-to-face psychological treatment. The GP creates an MHTP and refers the consumer to a private psychologist or a PHN-commissioned face-to-face psychological service for no-fee access.
- A consumer from a vulnerable demographic group describes moderate symptoms but has not previously engaged well with face-to-face psychological care. The GP creates an MHTP and refers the consumer to a PHN-commissioned stepped care service for an initial assessment to determine appropriate treatment and eligibility criteria. Appropriate treatment may include support from a range of service providers such as credentialled mental health clinicians, care coordinators and peer workers.
- A consumer describes moderate symptoms and requires disability support to aid in their recovery. The GP accesses disability and social support available through PHN-commissioned services, or if not available in that area/state, social workers, occupational therapists (OTs) and psychologists.

High intensity

- A consumer presents with severe and persistent mental health symptoms, significant functional impairment and escalating risk, requiring intensive and multidisciplinary support. The GP undertakes immediate risk assessment and management, creates (or reviews) an MHTP and refers the consumer to high-intensity services such as specialist mental health services, acute care teams, or PHN-commissioned high-intensity psychological therapies. Care may involve psychiatrists, clinical psychologists, mental health nurses, social workers and other allied health professionals, with active care coordination and regular GP follow-up to support continuity of care and safe transitions between services.

Examples of care coordination in action within the Stepped Care Model

The following examples show how GPs can coordinate a consumer's care while using the Stepped Care Model. Note that these in no way provide a full picture of how coordination can work.

Care coordination

- A child has learning disabilities and attention deficit hyperactivity disorder (ADHD) that significantly affect their schooling and family life. The child attends a public paediatrician, a children and youth mental health service, and an NDIS service. The child's family is somewhat chaotic and the child continues to miss appointments. The child's GP refers to PHN-commissioned stepped care services for care coordination.
- An Aboriginal man presents with depression. The GP creates a Social and Emotional Wellbeing template and works with the consumer to identify if psychological treatment is the best option for them. Recognising the importance of culturally safe, community-led care, the GP also works with the consumer to identify local cultural supports and refers to PHN-commissioned stepped care services, which may include care coordination in partnership with ACCHOs or Aboriginal Health Workers (AHWs).
- A young woman with an eating disorder and anxiety is seeing a private psychologist under an Eating

Disorder Treatment Plan (EDTP), as well as a dietitian, and intermittently attends the local hospital ED during crises. Communication between providers is limited, and there is no clear relapse plan. The GP refers to PHN-commissioned stepped care services for care coordination to align providers, clarify roles, develop a shared care plan and establish early warning and escalation pathways.

- An older man with chronic pain, depression and social isolation sees his GP regularly and has multiple medical specialists. He declines referral to psychology due to perceived stigma, but reports worsening mood and poor sleep. The GP links him with low-intensity psychological support, community social groups and pain self-management programs, while ensuring communication between services.

Implementing stepped care in general practice

The role of the GP in stepped care

As general practice is usually the first point of clinical contact for people seeking help with mental health concerns, this means GPs are often in a position where they can identify issues early and intervene preventively.[1] Even when a consumer presents for a non-mental-health request (eg a medical certificate), the GP can undertake an appropriate mental health assessment and clinical decision-making.

As a GP, you might be a referrer, care provider, care coordinator, or all of the above, based on the consumer's needs and the services that are available.

When implementing stepped care, you should aim to:

- identify mental health and psychosocial needs early
- provide an initial assessment that includes your routine physical health assessment, followed by mental health care such as counselling, psychoeducation and brief interventions, as well as ongoing care
- refer to appropriate stepped care services
- coordinate care provided by other providers
- maintain continuity of care
- *the GP–consumer therapeutic relationship is the most important factor in continuity of care and improved outcomes. In some Aboriginal community controlled health organisations (ACCHOs), consumers may see a different doctor each visit, so continuity of care requires adaptation for successful stepped care among rural and remote communities.*

The GP–consumer relationship

A GP's knowledge of a consumer's physical health, social circumstances and participation in work or education means they play a central role in understanding and managing the consumer's mental health needs[7]. In particular, the ongoing GP–consumer relationship creates opportunities for regular, low-threshold conversations about mental health, which can prevent relapse, reduce escalation, and interrupt the potential cycle of repeated crises.

Stepped care is a preventive and person-centred model, supporting GPs to work collaboratively with consumers to match a consumer's healthcare to their needs, and to adjust the care over time. For example, Mental Health Treatment Plans and referrals are most effective when completed by the consumer's usual GP or MyMedicare-registered practice, to maintain safe continuity and clinical oversight.

As continuity of care is fundamental to effective stepped care, you are encouraged to help consumers establish a single, trusted GP or usual practice where their mental health and physical health can be managed together. Although consumers value the efficiency, affordability and accessibility that can be achieved by using multiple services, it is also worth discussing with them that fragmented care can increase the risk of undiagnosed conditions, incomplete remission of symptoms and relapse.

Coordinating care provided by multiple services

An essential function of general practice is to coordinate and direct care across services, ranging from early intervention and low-intensity supports to higher-intensity, specialist, and coordinated care.

Duty of care

If a consumer is in immediate danger to themselves or others, call 000. If you have any concerns or questions about this issue, contact your medical defence provider, who can provide 24/7 expert medico-legal advice, ensuring you are able to act within legal boundaries.

You must always consider duty of care when managing consumers with severe mental illness. If responsibility for managing a particular individual's care is transferred between primary care and specialist services (whether state or privately funded), the service and the referring GP still have a duty of care to ensure that the receiving service has accepted care of the consumer and is aware of the consumer's needs. This is particularly important because of the potential vulnerability of consumers with mental health conditions.

When transferring care (which can often happen because of the episodic nature of some severe mental illnesses), it becomes particularly important for GPs to clearly define clinical responsibility, including:

- who is prescribing medication
- who is delivering treatment
- who is responsible for risk monitoring and review

The role of the PHN in stepped care

Australia's 31 PHNs have a coordination role in Australia's Stepped Care Model. Although they do not provide comprehensive clinical care themselves, nor replace general practice, they do:

- plan, commission, integrate and monitor services so that people can access the right level of care at the right time
- work in partnership with GPs, community providers, lived-experience organisations, hospitals and state services to strengthen local care pathways and improve consumers' ability to navigate health services.

As PHN services only account for a small part of the total mental health system, services delivered by other providers may better suit a consumer.

Commissioning of services

PHNs commission a range of services that may include:

- low-intensity and early-intervention supports
- digital and guided self-management programs
- community-based psychosocial services
- clinical interventions of moderate intensity
- Step Up/Step Down services (where commissioned). Step Up/Step Down refers to the coordinated system of services that offer short-term care when consumers are between inconsumer and community settings. They provide an alternative to (pre-acute) hospital admission and (post-acute) bridging support after the consumer is discharged from hospital. Services are usually delivered at staffed residential facilities or[8]

Different services at different PHNs

PHNs are responsible for understanding the mental health and psychosocial needs of their local catchment areas, by drawing on information such as:

- population data and epidemiology
- consumers' use of services and access to data
- local workforce capacity
- input based on community and lived experience.

As a result, each PHN provides or arranges different services. For example:

- some PHNs accept self-referrals from consumers, while others require referrals from a GP or other health professionals
- some PHNs conduct their own intake and assessment processes, while others use a service offered by another provider.

Communication between GPs and PHNs

Direct communication between you and your local PHN ensures that you fully understand the services the PHN offers and how the PHN can work with you to make sure that consumers are not 'lost' between services. This is particularly important when a consumer is moving from one step of care to another.

Signing up to your local PHN

Sign up to your PHN to receive regular communications from it. You can find your local PHN here.

Questions you could ask your PHN to work better together using stepped care

About their services

- What stepped care services are currently available in our area and who are they for?
- Who decides what service is offered and how is that determined?
- Which services are:
- low-intensity/early intervention?
- moderate-intensity clinical?
- psychosocial/functional recovery focused?
- Do you have a list of the services you recommend, for each level of intensity?
- Who provides the service?
- Are there services that accept same-day or rapid referrals?

Services for specific groups

- Are there services for specific populations (eg young people, perinatal, CALD, Aboriginal communities)?
- How do you reach those specific populations?
- Do you have an up-to-date profile on the specific populations in this area, what their needs are, and how do you commission services to meet those needs?
- For consumers with limited literacy, are services available in spoken/verbal formats as well as written materials?
- Are services available in languages other than English?

Accessing their services

- How does a GP or consumer access your services?
- Which consumers are suitable and/or eligible?
- Who isn't eligible, and why not?

Managing expectations

- What can I expect from you as my PHN?
- What do you need from me as a GP?

Clinical issues

- How does clinical handover occur between the GP and the service?
- How often is the person encouraged to make contact with their GP and how is the GP incorporated into the care plan?
- What feedback will I get after I refer (eg confirmation of acceptance, clinical updates, discharge summaries)?
- What is the process for reporting back to the referring GP?
- Do you have a referral navigation system you can share with me?
- Are there GP-priority pathways?
- How is the consumer reassessed at the end of a cycle of care?

Addressing concerns

- Who do I call if a referral stalls?
- Who does the GP or consumer contact if there are concerns about the service?

Using the stepped care services in your community

Maintain a good understanding of the mental health services in your area (eg mental health care providers, agencies, referral pathways). This will help you make better decisions about appropriate care for your consumers, including whether to step their level of care up or down.

Ideally, you should know and be familiar with:

- local mental health care providers and each one's eligibility criteria
- other mental health care agencies
- referral pathways
- evidence-based treatments
- workplace employee assistance programs (EAPs)
- services available at local organisations (eg schools, universities, councils, community groups, authorities).

As defined by the DoHDA, therapies and treatments not considered to be appropriate for a stepped care approach are those that:

- are not supported by empirical evidence
- fall outside the scope of primary mental health care, specifically:
  - services principally targeted at providing social support, with the exception of suicide prevention activities
  - bed-based services
- duplicate or replace existing services provided by other organisations, including state and territory government services
- are not supported by the funding guidelines for the primary mental health flexible funding pool.

Who is available to provide the stepped care services?

You need to be familiar with the roles of different health professionals in your area so that you can provide appropriate referrals. This also decreases the need for the consumer to explain their situation to multiple health professionals.

When referring a consumer:

- ensure that the training completed by the proposed service provider qualifies them to deliver the appropriate level of care (eg tele-coaches, GP providers of FPS, provisionally qualified psychologists, clinical psychologists and mental health workers have quite different qualifications)
- be aware of the responsibilities for escalation of care when you are sharing care with other providers, because you may need to quickly and effectively manage consumers who present with severe and persistent mental health symptoms.

Talking to your consumers about stepped care

While you might not talk to your consumers about the Stepped Care Model specifically, you should discuss the stepped care services that are available and might be effective options for them.

A basic principle of the Stepped Care Model is that you do not default to the same approach for mental health care (eg psychological services) when there are other services that would better suit the consumer's needs and circumstances.

As part of providing a consumer-centred service, your discussions with the consumer need to include:

- the information the consumer needs about their treatment options
- the treatments they feel most comfortable with
- the treatments that the consumer has the ability to access
- the role of the carer in the consumer's treatment and care.

When working with Aboriginal and Torres Strait Islander peoples, consider:

- yarning approaches
- community consultation
- culturally safe communication practices
- the importance of choice regarding AHWs or ACCHO involvement[9].

When stepped care services may not be appropriate

Depending on what is commissioned by the PHN, stepped care services may not be suitable for consumers with:

- acute psychosis or suicidality
- intellectual disability
- chronic illness or physical disability.

In these situations, use established referral pathways and networks to access the most appropriate care, based on the consumer's needs.

Using the Better Access initiative, MHTPs, CCMPs and the IAR-DST in stepped care

The two key GP planning tools are:

- MHTP (Mental Health Treatment Plan) – mental health-specific
- CCMP (Chronic Condition Management Plan) – broader, for chronic conditions (including mental illness)

These tools promote:

- holistic assessment
- goal-oriented care
- review and adjustment of treatment as required.

The Better Access initiative and Mental Health Treatment Plans

The Better Access initiative is generally appropriate for consumers with mild–moderate symptoms and is only one approach to deliver mental health care. For example, care coordination or disability support services might be appropriate for people with severe mental illness, and digital programs and self-help strategies might suit people with milder symptoms.

Eligibility for the Better Access initiative

For a consumer to be eligible for this scheme, they must have an MHTP with an MBS-stated eligibility requirement of a formulation/diagnosis, completed in consultation with a GP.

Interventions available under the Better Access initiative

Interventions the consumer may receive as part of their MHTP referral under the Better Access initiative include:

- face-to-face psychological therapy
- FPS delivered by a GP
- online therapy or another low-intensity service (for consumers with mild illness), accessed via a local PHN.

Benefits of developing an MHTP

An MHTP:

- provides a clear, simple and structured way to perform an early intervention as well as accurately assess and manage the consumer's illness and progress
- identifies holistic needs and provides appropriate referrals to allied mental health service providers
- enables the GP to talk to the consumer about the issues concerning them and understand the consumer's goals of treatment
- ensures that the consumer and, where possible, their carer(s) are actively involved in the consumer's treatment
- helps coordinate the consumer's care and can be provided to the consumer as a resource
- provides continuity and a 'cycle of care' for the consumer
- facilitates periodic reviews of the care plan and the consumer's progress with the consumer and carer(s).

How MHTPs are best used

Initial assessment and planning: These items fund the time needed for a comprehensive assessment and development of a tailored mental health care plan and are used for consumers with clinically diagnosable disorders who need a structured approach.

Provision of Better Access services: After the plan is created under one of these item numbers, the Better Access scheme enables consumers to access:

- up to 10 Medicare-rebated allied mental health sessions per year (eg with their GP, psychologists, social workers, OTs), and/or
- up to 10 group therapy sessions per year (eg with psychologists, social workers, OTs).

Referral documentation: The MHTP should clearly specify treatment goals and referrals, which also helps allied health providers claim rebates.

Chronic Condition Management Plans

In the context of the Better Access initiative, a GP may use a CCMP for consumers with chronic or complex mental disorders to support a coordinated, multidisciplinary approach to care. While an MHTP enables access to psychological therapy, the CCMP complements this by organising broader supports, such as allied health and other providers, helping ensure ongoing, holistic and consumer-centred management.

How CCMPs are best used

Consumer's symptoms: Create a CCMP when symptoms are persistent (≥ six months), cause functional impairment, and require ongoing GP involvement rather than episodic care. Mental illness can qualify as a chronic condition, and a consumer may have both a physical and mental condition.

Management of multiple services: These plans support team-based management across psychology, psychiatry, allied health and physical healthcare, which is particularly important when the consumer presents with comorbidities or psychosocial complexity.

Allied health access: The consumer can receive Medicare rebates for allied health services (commonly up to five sessions per year), such as those provided by:

- psychologists
- dietitians
- exercise physiologists
- OTs
- Aboriginal Mental Health Care trained clinicians

Follow-up: These plans enable planned follow-up, reviews of goals and adjustment of care over time, thereby reducing crisis-driven presentations and fragmented care.

See MBS Online for all Medicare item number information, including telehealth equivalents.

The Initial Assessment and Referral Decision Support Tool (IAR-DST)

The IAR-DST is a tool developed for Australian primary mental health care that is designed to:

- help clinicians assess psychological distress, functioning, risk and complexity
- support consistent referral decisions
- help GPs identify the level of care a consumer requires and deliver a recommended level of care that is aligned to stepped care principles.

The tool supports, but does not replace, clinical judgement. Use of this, or any other decision-support tool never replaces a GP's responsibility for diagnosis, treatment planning and review.

How the IAR-DST supports stepped care

By promoting a needs-based approach rather than diagnosis alone, the IAR-DST encourages you to consider the consumer's:

- symptom severity
- functional impairment
- risk factors
- psychosocial complexity.

As such, it can also inform your decisions based on an MHTP and provide documentation supporting your clinical reasoning about the level of care required.

It also supports:

- timely access to appropriate care
- more consistent referral pathways

Empowering your consumer and carer

Stepped care works best when the clinician and the consumer have a positive relationship[10], and the consumer and carer feel empowered.

What does it mean to empower your consumer?

An empowered consumer is one who is actively involved in choosing the care that suits them best. If they are unable to make an informed decision (eg minors or consumers with an intellectual disability), a carer is actively involved in making the decision on their behalf. (See What does it mean to empower the carer?)

How to empower a consumer

As success can look different to the consumer, their carer, and the clinical team, it's important that you:

- ask the consumer and carer what they want from care and what progress and recovery look like to them, rather than assuming goals on their behalf
- give them clear information about their care options, risks, and likely outcomes, so they can make decisions that suit their needs and values
- recognise that their idea of 'success' may differ from yours.

However, it's important that you balance 'dignity of risk' with safety and your duty of care. To achieve this, identify the minimal effective intervention that the consumer is willing to try that also maintains safety.

Empowerment also includes understanding the consumer's context, including who they are and how their environment and lifestyle impact their experiences of their mental health condition. This could mean learning about their support networks or lack thereof, and asking questions such as 'What can you do for yourself?'; 'What can other people do for you?'; and 'What can only I, as your GP, do?'

For Aboriginal and Torres Strait Islander peoples, this may include connection to Country, kinship structures, cultural obligations and community roles, which may influence care preferences and healing.

The goal is to develop a stepped care plan that works for the consumer and their carer, even if it differs from standard pathways.

Other ways you can empower the consumer and carer include:

- suggesting self-management resources that support personal responsibility for care, such as digital tools or guided programs
- using social prescribing to connect consumers with community, cultural, or wellbeing activities that align with what they find meaningful
- asking carers, with the consumer's consent:
  - how they define improvement
  - what changes they have seen
  - what challenges remain
  - what support they need in their caring role.

It is also recommended to:

- Explain to the consumer that the consumer journey is not linear and discuss what they should do if their symptoms worsen or if they experience a crisis. This should include a discussion of realistic expectations, what early warning signs might look like, their preferred supports, and clear actions for them, or others, to take in the event of a crisis. This helps consumers feel informed, confident and prepared throughout their care journey.
- Respond supportively if their condition regresses, including if they have returned to care only after their condition has worsened.

What does it mean to empower the carer?

It is equally important to empower the carer of a consumer with a mental illness. This starts with recognising the vital role they play in supporting the consumer's wellbeing, while also understanding that carers are people with their own needs.

Why empower carers?

For many carers, navigating the healthcare system can feel overwhelming, so a GP can help by providing clear information about the consumer's condition, treatment options, early warning signs and what to expect over time (always with the consumer's consent).

When carers understand the nature of the illness and the rationale behind treatment decisions, they are better equipped to provide safe, consistent support at home.

A key part of empowerment is inviting carers, with the consumer's consent, to share their perspective. They often see subtle changes in behaviour, mood or functioning before others do, and their insights can shape more effective care.

How to empower carers

Asking questions such as 'What does improvement look like to you?' and 'What support do you need in your caring role?' helps validate their experience and strengthens collaboration between carer, consumer and GP. This also sends the message that the carer is a partner in the consumer's care, not a passive observer.

You can also empower carers by connecting them with appropriate resources, such as carer support groups, psychoeducation programs, respite services and digital tools that help them monitor and manage their own wellbeing. Encouraging carers to look after themselves is essential because caring for someone with a mental illness can be emotionally demanding, and burnout reduces their ability to provide effective support.

By keeping carers informed, included and supported, you can help to build a stable environment for the consumer, and foster better outcomes for everyone involved.

Stepped care for specific populations

Stepped care can be challenging for a consumer who belongs to one or more specific populations. They might experience, for example, a language or literacy barrier, or feel uncomfortable immediately sharing their mental health concerns.

These, and other issues, can raise questions about access, equity and culturally safe healthcare. Many specific populations, however, including Aboriginal and Torres Strait Islander peoples, bring strong cultural practices, resilience and community-connected approaches that can support meaningful care.

As a GP, you can:

- listen non-judgementally and empathetically
- be aware of barriers to access
- be aware of your own biases.

You can also make sure that you:

- use culturally appropriate services where available
- avoid rigid application of tools that may cause harm
- be aware of western-orientated services (eg could consumers who don't return perhaps feel that the services are not culturally safe or culturally aware?)

There is not a lot of evidence about the use of stepped care for some population groups, so it's important to remember that its effectiveness and suitability may be different, depending on a consumer's cultural background, age, cognitive ability and social or environmental factors.

For example, approaches that are effective for adults may not translate well to children, those suitable for older people may not be effective for adolescents, and people from specific populations (such as the LGBTQIA+ and Aboriginal and Torres Strait Islander communities) may require approaches that differ from those that are effective in the general population. It's therefore important to not only appreciate these nuances but also to stay informed by reviewing reliable, up-to-date sources (such as clinical guidelines, peer-reviewed research and local mental health organisations) to understand how stepped care might apply to people from specific populations.

How best to provide stepped care for specific populations

Some generic ways you can provide stepped care to people from specific populations include:

- adapting stepped care tools for the population (eg working alongside Aboriginal and Torres Strait Islander peoples, communities, Elders and ACCHOs, culturally and linguistically diverse communities, and people with complex trauma, disability or social disadvantage)
- becoming familiar with the different issues each population may experience (eg minority stress, language and literacy barriers, stigma, past healthcare harm, intergenerational trauma)

- investigating and understanding the population-specific services that are available, and the mainstream services that can be adapted to specific populations
- expanding your knowledge of digital interventions that are specifically designed for cultural communities (eg https://www.healthtranslations.vic.gov.au/).

The following table outlines:

- the common barriers to care experienced by specific populations
- suggestions from Lived Experience groups and organisations on how you can adapt stepped care to overcome these barriers

Common barriers to care	Potential referral options	Adapting stepped care for this population
Aboriginal and Torres Strait Islander peoples		
Historical and ongoing impacts of colonisation and racism Experiences of culturally unsafe care Structural and geographic access barriers	ACCHOs Aboriginal Health Workers Cultural liaison	Recognise and build on cultural strengths, connection to Country, community leadership, kinship systems and cultural healing practices Adopt a social and emotional wellbeing approach Implement cultural safety Engage ACCHOs/AHWs if consent is given Work in partnership with community where appropriate Allow for longer consultations Consider intergenerational and systemic trauma
Culturally and Linguistically Diverse (CALD)		
Language barriers Stigma Low mental health literacy	Use professional interpreters Bicultural services Translated materials	Aim for culturally framed explanations of distress Adopt family inclusive approaches where appropriate Use bilingual clinicians/interpreters (do not rely on family) Allow for longer consultations
Children and adolescents		
Limited insight Parental or school barriers	Headspace Family-based therapy School collaboration	Use developmentally appropriate family-centred care Engage early via schools, youth services, Headspace Involve parents/caregivers, while respecting the young person's autonomy Lower the threshold for stepping up if self-harm or suicidal ideation is present Prioritise safety, school engagement and early intervention Allow for longer consultations

Common barriers to care	Potential referral options	Adapting stepped care for this population
LGBTQIA+ community		
Fear of discrimination Prior negative experiences Minority stress	LGBTQIA+-affirming GPs and psychologists Peer support services	Use inclusive language and visible safety signals, early peer supports, affirming psychoeducation Refer to LGBTQIA+-affirming clinicians Monitor suicidality during transitions Monitor impact of discrimination and isolation Allow for longer consultations
Veterans		
Stigma Reluctance to seek help Complex trauma	Open Arms – Veterans & Families Counselling DVA-funded services	Build trust Normalise help-seeking Integrate pain, sleep and AOD care early Advise of DVA pathways and veteran peer support Screen for post-traumatic stress disorder/moral injury and provide care as required Provide coordinated care (this is often needed) Allow for longer consultations
Refugees		
Trauma exposure Trust issues Language and settlement stress	Refugee health services Trauma-informed counselling Settlement services	Address practical needs first (housing, legal, income) Use interpreters and trauma-informed care Avoid premature exposure therapies Refer to specialist trauma services when needed Avoid rushing disclosure of trauma Allow for longer consultations
Older people		
Under-recognition Isolation Somatic presentation	Geriatric mental health services Social supports	Consider comorbid physical illness, cognition, grief, isolation Take it slowly, allow for longer consultations and avoid over-medicalisation Involve carers/family where appropriate Step care up or down, based on function and quality of life, not symptom scores alone
People with disability (including NDIS)		
Fragmented systems Access and cost barriers Possible systemic barriers and higher trauma exposure	Disability-aware providers NDIS psychosocial supports	Use accessible communication and allow longer consultations Actively avoid diagnostic overshadowing – a cognitive bias where health professionals misattribute a consumer's physical symptoms to a pre-existing psychiatric, intellectual or developmental condition (such as a disability) instead of investigating for an independent illness Involve carers/support workers with consent Be flexible about stepping care up and down to accommodate access needs

Common barriers to care	Potential referral options	Adapting stepped care for this population
People with alcohol and other drug use		
Shame Dual-diagnosis exclusion	Integrated mental health–AOD services	Be trained in trauma-informed care Use a non-judgemental harm-reduction approach Integrate mental health and AOD care at all steps Step up based on risk, dependence and functional impact Recognise the likelihood of non-linear progress Address withdrawal and safety early Allow for longer consultations
People experiencing homelessness		
Instability Competing priorities Mistrust of services	Outreach mental health services Homelessness health programs	Prioritise engagement, trust and continuity Treat housing, income and safety as mental health interventions Step up or down based on immediate needs and risk, not attendance Maintain care across transitions and services Allow for longer consultations
IPV (Intimate Partner Violence) survivors		
Fear Safety concerns Shame System navigation	Family violence services Trauma-informed counselling Legal supports	Use a trauma-informed, safety-first approach Allow for longer consultations Avoid couple therapy Respect autonomy and do not pressure disclosure Regularly reassess risk and safety Step care up or down in line with readiness and safety (not symptom severity) and recognise that a step up may be necessary, even if there are mild symptoms (eg if the risk of harm is significant) Integrate advocacy and legal supports alongside clinical care

Stepped care and telehealth

Benefits of using telehealth

Telehealth can reduce some common barriers to healthcare, such as travel, time, cost, stigma, disability and caring responsibilities. Consultations can be via phone or video, based on access and comfort, and both options mean that it is still possible to build and maintain good trust-driven relationships with consumers.

Challenges of using telehealth

Although telehealth offers advantages for many consumers and GPs, some consumers might experience the following access and equity issues:

- poor internet or low bandwidth, particularly in rural and remote areas
- difficulty finding a private and safe space for the consultation
- limited digital literacy or difficulty fulfilling the access criteria

Some consumers might also find telehealth clinically more challenging, particularly if they are in significant emotional distress. In such cases, you should carefully assess the suitability of telehealth for these consumers.

How to provide effective care using telehealth

- Before the session, take time to prepare (eg log on, check tech and internet is working).
- At the beginning of each session, confirm the consumer's privacy, location, and safety, and assure them that no one else near you can see or hear the conversation.
- For some consumers experiencing internet or privacy issues, and who are receiving low intensity services, suggest they consider having sessions in a practice or library with solid internet connection and private spaces.
- Combine telehealth with additional supports such as guided self-help programs and apps, online group programs or peer supports, social prescribing.
- Encourage the consumer to inform you if telehealth is not working for them.

Changes to telehealth from 1 November 2025

- From 1 November 2025, telehealth services under the Better Access initiative (including MHTP preparation, referrals and reviews) require an established clinical relationship.
- Medicare benefits are only payable if the consumer:
  - is registered with the GP's practice via MyMedicare, or
  - has seen the GP or another clinician at the same practice face-to-face in the preceding 12 months.
- Items specific to reviews of MHTPs and ongoing mental health telehealth were removed: GPs now use time-tiered general attendance items where appropriate.

More information about the 1 November 2025 changes can be found here.

Stepped care in rural and remote communities

A GP-led stepped care approach in rural and remote communities is critical because many of the challenges faced by consumers in rural and remote communities are different to those faced by consumers in metropolitan areas[11].

The particular importance of the GP's role in delivering stepped care in rural and remote communities

As GPs are often the only constant clinicians in these communities, they provide essential continuity in places where other service providers can change or rotate. For this reason, it's particularly important to understand that stepped care in rural and remote communities is centred on the GP, including the:

- GP and consumer relationship
- GP mental health treatment planning
- GP delivery of psychological interventions (Focussed Psychological Strategies in which the GP is trained)
- GP's role as coordinator of multiple fragmented services
- GP telehealth referrals (psychiatry, psychology).

The important role of telehealth in rural and remote communities

Telehealth plays an essential role in rural and remote communities, as it offers residents the ability to access services that might not be available locally.

Stepped care and early intervention is critical in rural and remote communities, because if the right level of care is not provided and the consumer's condition worsens, they may experience:

- long waitlists
- the need to travel hundreds of kilometres
- the need to rely on RFDS, retrieval services, or fly-in psychiatrists
- disruption to family, work and culture
- higher costs.

All of the following can be undertaken via telehealth:

- psychological therapy via video
- psychiatry assessment and review
- suicide risk follow-up
- digital mental health programs
- digital mental health coaching models.

Therefore, consider using telehealth across all steps (ie from low-intensity support to non-GP specialist input), or a blend of telehealth with face-to-face (which could include home visits, and consultations at community locations).

Challenges of telehealth in rural and remote communities

For some consumers, telehealth can also present challenges, if they have:

- limited or non-existent internet access
- lack of private spaces
- the need to ensure culturally safe, locally informed and community-led care, particularly for Aboriginal and Torres Strait Islander peoples
- a preference for face-to-face sessions in crisis or complex care needs
- fears about confidentiality and privacy in small communities where everyone knows everyone.

Providing stepped care in rural and remote areas

One of the major challenges of providing stepped care in rural and remote areas is achieving the right balance between these two competing principles:

- prioritising access and continuity over service availability
- basing a consumer's stepped care on their needs and risks, rather than what is locally available.

Consequently, you need to ensure that consumers receive timely and ongoing support from the resources that are available, while continuing to identify, or wait for, services that provide the level of support they require.

To help overcome this challenge:

- remain flexible:
  - consider adopting flexible pathways and varying the periods of time at each step
- proactively manage wait times for other services by providing the consumer with interim supports and check-ins, and conduct active follow-ups rather than just passive referrals
  - take a consumer to the next level of care (step up) by, for example, increasing the frequency and duration of sessions and/or referring them to other available service providers
- consider alternatives, such as telehealth, GP FPS sessions, evidence-based digital interventions, or referral to Rural Generalists with Mental Health Advanced Specialised Training
- use community-based options:
  - integrate allied health as necessary and partner with local services and communities
  - use community, peer, and informal supports
  - use shared care and case conferencing
- develop clear crisis escalation plans, particularly if the consumer lives a long way from acute services.

The risks of social isolation

When living in a rural or remote town, it's possible to feel quite separated from the larger society, and consequently, it's common for people to feel isolated or disconnected[12]. Loneliness and isolation affect approximately 35% of rural Australians[13], and social

isolation has been linked to poor health behaviours, mental illness, emotional distress, suicide, the development of dementia and premature death[14].

GPs who work in rural and remote areas are in a position to recognise social isolation early, and provide low-intensity and accessible supports.

If you are concerned that a consumer is facing social isolation, you could ask them about their:

- frequency of social contact
- how they maintain connection to family, community and Country
- support networks

You could also:

- provide psychoeducation about how social isolation affects health and wellbeing
- consider community-based and culturally led supports where appropriate
- refer to appropriate community and allied health supports if available
- book in regular follow-ups
- make sure the consumer understands what support and care is in place for them, what is going to happen next, and what follow-up appointments are needed.

Setting goals and measuring outcomes

To effectively measure outcomes, you need to set goals in the first conversation with the consumer, by asking them:

- 'What would improvement look like for you?'
- 'What do you want to be different in your life?'
- 'If you had a magic wand, what would you want to improve in your life?'
- 'What does doing better look like in your life?'

Goals and outcomes need to be:

- person-centred and meaningful to the consumer
- proportionate to the complexity of the problem
- SMART (specific, measurable, achievable, relevant, timely).

When to measure outcomes

This should be a shared, ongoing process and conversation between you, the consumer and (where appropriate and consented) their carer, rather than a single conversation that happens at a pre-determined interval.

Multiple factors can affect progress

Stepped care is only one factor that can affect a consumer's wellbeing, so it may not solely be the interventions you have provided or arranged that have led to progress, or the need to step up their care. Therefore, how you measure the outcomes of the stepped care will vary from consumer to consumer, and include consideration of other factors, such as changes in their circumstances.

Improvement might be reflected in lived experience, not just symptom scores. For example, the consumer might be experiencing:

- reduced distress
- improved functioning, relationships, housing or work stability
- increased sense of agency or confidence
- increased self-care
- participation in more social activities.

Similarly, if a consumer's condition worsens, this could be the result of external factors (eg breakdown of a relationship, loss of housing) rather than receiving the 'wrong' level of care.

Understanding what you're measuring/assessing

Before measuring an outcome, clarify the purpose of your review. Are you:

- measuring the consumer's progress (see Measuring a consumer's progress below)
- assessing whether a process of care (eg follow-up, engagement, access) is working (see Measuring process-based outcomes below)?

Measuring a consumer's progress

To measure the consumer's progress, ask them questions, such as:

- What does doing better look like for you?
- What does good look like?
- What have you learned from this experience?
- What has changed in your life recently?
- When did things start to feel different for you?
- What has been helpful for you?

Post-crisis question

- What did you do, even in a small way, that helped keep you safe or helped you get through the recent difficult time?

Obtaining consent to ask for a carer's perspective

Where appropriate, and with consent, carer perspectives can provide valuable insight. Ask for consent with a question such as:

- 'Is it okay if I ask your carer/support person if they have noticed any changes recently?'

Use of scales and tools

When choosing scales or tools to help measure outcomes, consider:

- the importance of clinical judgement
- the consumer's preference
- cultural suitability
- the feasibility of the tool for this consumer (eg can they use an app if they're not comfortable using a smart phone?)

Standardised tools can support your measurement of outcomes but should not be used in isolation or as the sole indicator of progress. One reason for this is because a person's score may stay the same (particularly over a short period of time) even when meaningful improvement has occurred.

Some commonly used scales and tools

- Kessler Psychological Distress Scale (K10)
- Depression Anxiety Stress Scales (DASS-21)
- Consumer Health Questionnaire-9 (PHQ-9)
  Edinburgh Postnatal Depression Scale (EPDS), which monitors emotional distress, but does not generate a diagnosis
- Positive and Negative Affect Schedule (PANAS)
- Audits in your practice, which aim to determine if the consumer has achieved goals of the MHTP

Consumer-centred scales and tools

In addition to the scales and tools listed above, you can also use:

- comments by the consumer about how their life has improved in other ways
- psychosocial progress (social, relationship, work, etc.)
- information about the consumer's self-care (eg participating in more social activities).

Measuring process-based outcomes

Some outcomes relate to how the care has been delivered by the practice and/or the health system, rather than changes in symptoms. For example, you may want to identify:

- whether follow-up occurred
- whether a planned review was offered or completed
- how the practice responds when a consumer does not return
- whether the service experienced was acceptable from the consumer's perspective.

Useful measures might include:

- the existence of a clear follow-up or 'check-in' step
- the existence of processes in the practice to identify and address missed appointments or disengagement.

Measuring process should be a simple and feasible task, and not an unnecessary administrative process.

GP education and training for stepped care

Mental Health Skills Training (MHST) Level 1

All GPs begin mental health training by completing GPMHSC-accredited MHST Level 1, which gives them the skills and knowledge to:

- assess, triage and refer consumers with mental illness
- prepare Mental Health Treatment Plans (MHTPs).

After completing MHST Level 1, GPs can:

- recognise and assess mental illness
- prepare and review evidence-based MHTPs
- monitor consumers' progress
- understand consumer and carer perspectives.

MBS items

After being accredited with Medicare, GPs can claim MBS items 2715 and 2717.

FPS Skills Training (FPS ST)

FPS ST gives GPs the skills and knowledge to provide treatment for mild mental illness and at-risk groups. GPs must complete MHST Level 1 before beginning FPS Skills Training.

After completing FPS ST, GPs can:

- deliver evidence-based FPS under an MHTP
- incorporate consumer and carer perspectives
- use local services to support safety and holistic care
- use relevant mental health MBS items
- engage in supervision and ongoing professional development.

MBS items

After completing FPS ST, GPs apply to the GPMHSC to register with Medicare as an FPS provider. After registration, they can claim item numbers 2725 and 2727.

Resources

Referral resources for stepped care

- Medicare Mental Health: Free service connecting people with mental health support www.medicarementalhealth.gov.au/
- Medicare Mental Health: Navigating mental health services www.medicarementalhealth.gov.au/finding-help/navigating-mental-health-services
- Medicare Mental Health: Crisis links and 24/7 support www.medicarementalhealth.gov.au/crisis-links
- Medicare Mental Health: Service finder www.medicarementalhealth.gov.au/service-finder-for-your-consumers
- healthdirect: Symptom checker and 24/7 health advice line (1800 022 222) www.healthdirect.gov.au/
- MindSpot GP: Online mental health referral service for GPs www.mindspot.org.au/mindspot-gp
- This Way Up: Online treatment programs for mental health https://thiswayup.org.au/
- headspace: Youth mental health support and centre locator https://headspace.org.au/
- Lifeline: 24/7 crisis support and suicide prevention www.lifeline.org.au/
- Beyond Blue: Mental health support, information and the free wellbeing app www.beyondblue.org.au/
- ReachOut: Online mental health support for young people, parents and schools https://au.reachout.com/
- SANE: Free digital and telehealth support for adults, their carers and families www.sane.org/get-support/sane-support-services

PHN stepped care resources

- Department of Health, Disability and Ageing (DoHDA): Overview of Australia's 31 PHNs www.health.gov.au/our-work/primary-health-networks
- DoHDA: PHN locator map www.health.gov.au/resources/apps-and-tools/primary-health-network-locator/app
- Gold Coast PHN: Summary of funded services by level of care https://gcphn.org.au/wp-content/uploads/2025/03/GCPHN-Mental-Health-Funded-Services-A3-Summary.pdf
- DoHDA: Resources for PHNs implementing primary mental health care reform www.health.gov.au/resources/collections/primary-health-networks-phn-collection-of-primary-mental-health-care-resources
- Eastern Melbourne PHN: Overview of commissioned mental health stepped care services https://emphn.org.au/our-work/mental-health-services-overview/stepped-care-mental-health/
- North Western Melbourne PHN: Service overview of the mental health system of care https://nwmphn.org.au/news/north-western-melbourne-primary-health-network-service-in-depth-mental-health-system-of-care/

Resources on models of care

- GPMHSC: IAR-DST Resource Hub https://mentalhealth.racgp.org.au/Info/Detail/15801373-2fbb-4e02-8510-ce17b2a67cea
- GPMHSC: GP Mental Health Treatment Plan templates https://gpmhsc.org.au/Info/Detail/8a218292-d2d3-47c0-b8a8-43ab7eddeb04
- MBS Online: Medicare Benefits Schedule and item number information www.mbsonline.gov.au/
- Eastern Melbourne PHN: Link-me+ model of care https://emphn.org.au/for-health-professionals/general-practice/introducing-link-me/
- Australian Commission on Safety and Quality in Health Care: Developing a model of care for a digital mental health service (fact sheet)
- www.safetyandquality.gov.au/resources/developing-model-care-digital-mental-health-service-fact-sheet-0
- Orygen: New and refined youth mental health models of care www.orygen.org.au/Policy-Centre/Youth-Mental-Health-Models-Of-Care
- Mental Health Online: Model of Care (March 2022) https://action.mentalhealthonline.org.au/sites/default/files/2022-06/MHO%20Model%20of%20Care%20March%202022.pdf

Resources related to empowering your consumer and carer

- Carers Australia: Advocacy, programs and support services www.carersaustralia.com.au/
- Victorian Department of Health: Guideline on working together with families and carers in mental health care www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers
- National Mental Health Commission: Consumer and Carer Engagement: a Practical Guide www.mentalhealthcommission.gov.au/lived-experience/consumer-and-carers/consumer-and-carer-engagement-%281%29

- Western Australian Department of Health: Working with Consumers and Carers Toolkit www.health.wa.gov.au/articles/u_z/working-with-consumers-and-carers-toolkit
- Lived Experience Australia: Consumer and carer inclusion training www.livedexperienceaustralia.com.au/staff-training
- Canberra Health Services/ACT Government: Consumer and Carer Research Partner Toolkit www.canberrahealthservices.act.gov.au/__data/assets/pdf_file/0011/3037493/Consumer-and-Carer-Research-Partner-Toolkit.pdf
- Emerging Minds: Checklist for consumer and carer (lived experience) participation https://emergingminds.com.au/resources/checklist-consumer-carer-lived-experience-participation/
- SA Health: Consumer, carer and community engagement www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/consumer+carer+and+community+engagement/consumer+carer+and+community+engagement
- Australian Commission on Safety and Quality in Health Care: Partnering with Consumers guide www.safetyandquality.gov.au/your-health-service/partnering-consumers
- Health Consumers' Council WA: Resources for people with disability and their carers www.hconc.org.au/empowering-consumers-with-a-disability/
- Safer Care Victoria: Partnering with consumers – frameworks and guides www.safercare.vic.gov.au/best-practice-improvement/partnering-with-consumers
- Northern NSW Local Health District: Guidance on partnering with consumers https://healthliteracy.nnswlhd.health.nsw.gov.au/partnering-with-consumers/
- Mind Australia: Support for carers – strategies, legal guidance and respite information www.mindaustralia.org.au/support-carers
- Mental Health Carers NSW: Carer Advocacy Toolkit www.mentalhealthcarersnsw.org/resources/carer-advocacy-toolkit/

Resources on stepped care for specific populations

- GPMHSC: Specific Populations resources to assist GPs https://gpmhsc.org.au/resourcesection/index/efead48b-5006-46f1-aebe-027ed4b4a0a3/specific-populations-resource-hub
- RACGP/NACCHO: Preventive healthcare for Aboriginal and Torres Strait Islander people www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/national-guide
- Health Translations: Multilingual health and wellbeing information www.healthtranslations.vic.gov.au/
- Embrace Multicultural Mental Health: Resources, service links and translated information https://embracementalhealth.org.au/
- Yilabara: Indigenous Mental Health First Aid training program https://yilabara.org.au/programs/aboriginal-mental-health-first-aid/
- Mental Health Foundation Australia: Mental health education, support groups and psychological services www.mhfa.org.au/
- The Australian Indigenous Doctors' Association: Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and Consumers (position paper) https://aida.org.au/wp-content/uploads/2026/04/Cultural_Safety.pdf
- Menzies School of Health Research: Stay Strong Care Plan template www.menzies.edu.au/icms_docs/338899_Digital_Stay_Strong_Plan.pdf
- WellMob: Social, emotional and cultural wellbeing online resources for Aboriginal and Torres Strait Islander people https://wellmob.org.au/
- RACGP: Abuse and violence: working with our consumers in general practice (the White Book, 5th edition) www.racgp.org.au/getattachment/4ab6102c-67d9-4440-9398-a3ae759164ef/Abuse-and-violence-Working-with-our-consumers-in-general-practice.aspx

Resources related to using telehealth for stepped care

- Telehealth Professional Development: Peer group activity resources https://telehealthprofessionaldevelopment.com/
- MBS Online: Fact sheets on Better Access initiative changes www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Current

- RACGP: Guide to providing telephone and video consultations www.racgp.org.au/running-a-practice/technology/clinical-technology/telehealth/guide-to-providing-telephone-and-video-consultatio/principles-for-conducting-telehealth-consultations
- RACGP: Telehealth and supervision www.racgp.org.au/running-a-practice/technology/clinical-technology/telehealth/telehealth-and-supervision-a-guide-for-gps-in-trai/introduction
- GPMHSC: Resources that support GPs using telehealth for mental health consultations https://gpmhsc.org.au/guidelinessection/index/f82abc8e-df8b-4309-a066-8a59fb15c2b8/telepartnerships
- Australian College of Rural and Remote Medicine (ACRRM): Framework and Guidelines for Telehealth Services www.acrrm.org.au/docs/default-source/all-files/telehealth-framework-and-guidelines.pdf
- Medical Indemnity Protection Society: Telehealth checklist for healthcare providers https://support.mips.com.au/home/comprehensive-telehealth-checklist
- Victorian Department of Health: Resources for health services implementing virtual care www.health.vic.gov.au/consumer-care/telehealth

Resources relating to stepped care in rural and remote communities

- PLOS ONE: Scoping review protocol – barriers and facilitators to accessing mental health services in regional, rural and remote Australia (2022) https://pmc.ncbi.nlm.nih.gov/articles/PMC9733872/
- National Mental Health Commission: National Lived Experience (Peer) Workforce Development Guidelines www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines/national-lived-experience-%28peer%29-workforce-develop/from-commitment-to-co-production-employing-the-liv/chapter-5-development-in-regional%2C-rural-and-remot
- National Rural Health Alliance: Factsheet on mental health in rural and remote Australia www.ruralhealth.org.au/wp-content/uploads/2024/05/nrha-mental-health-factsheet-july2021.pdf
- General Practice Supervision Australia: FAQ on telehealth for Aboriginal and Torres Strait Islander consumers https://gpsa.org.au/wp-content/uploads/2023/06/FAQ_telehealth-ATSI_V3.pdf

Resources to measure outcomes in your practice

- Australian Medical Association: Measuring Clinical Outcomes in General Practice www.ama.com.au/sites/default/files/2021-12/Final%20Measuring%20Clinical%20Outcomes%20in%20General%20Practice%202021.pdf
- Australian Commission on Safety and Quality in Health Care: *Consumer-Reported Outcome Measures* www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/consumer-reported-outcome-measures
- Victorian Department of Health: Measuring consumer outcomes – practice guide for clinicians www.health.vic.gov.au/consumer-outcomes-in-mental-health-services/measuring-outcomes-practice-guide-clinicians
- DoHDA: Overview and guide to choosing outcome measures for the National Best Practice Framework for Early Childhood Intervention www.health.gov.au/sites/default/files/2025-09/the-national-best-practice-framework-for-early-childhood-intervention-measurement-overview-choosing-and-using-outcome-measures.pdf
- Emerging Minds: Understanding and supporting children's mental health: Measuring Outcomes tool examples https://emergingminds.com.au/resources/understanding-and-supporting-childrens-mental-health-measuring-outcomes-tool-examples/

Resources about mental health education for GPs

- GPMHSC: Mental health training standards 2026–28: a guide for GPs https://gpmhsc.org.au/Info/Detail/68017c4a-37af-429d-a971-abd6fa01a54c
- GPMHSC: Mental Health Skills Training and Focussed Psychological Strategies Training information https://gpmhsc.org.au/InfoSection/Index/78cb509e-c80e-441d-ac4b-82b414ba2c44

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