NATIONAL   
GUIDANCE

Initial assessment and referral (IAR)  
for mental healthcare – Older Adults (Consultation Draft)

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Foreword

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

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

**Stage 1**

In stage 1 of the project, the Department of Health formed an Expert Advisory Group and Project Steering Committee. The Department of Health commissioned a literature review and completed a PHN survey to understand the progress of stepped care and initial assessment and referral activity.

**Stage 2**

During stage 2 of the project, the Department of Health developed and released a draft of the IAR Guidance for consultation with PHNs and other key stakeholders. In March 2019, the Department of Health officially released the first version of the IAR Guidance.

**Stage 3**

During this project stage, the Department of Health developed and disseminated an Initial Assessment and Referral in Stepped Care Systems Resource Toolkit. The Toolkit includes:

* A brief implementation guide for PHNs
* Clinical governance resources
* Learning resources (including vignettes and workshop slides).

**Stage 4**

The Department of Health facilitated an Implementation Review to examine the validity and utility of the IAR Guidance. The University of Melbourne completed the Implementation Review, which involved 9 PHNs. The Nine PHNs were selected to complete a small-scale implementation test of the IAR Guidance. The University of Melbourne authored a report on the findings.

**Stage 5**

During this project stage, the Department of Health worked closely with the Expert Advisory Group and Working Groups to develop IAR Guidance for children (aged 5-11) and adolescents (aged 12-17), including an extensive consultation opportunity.

**Stage 6**

During this project stage, the Department of Health worked closely with the Expert Advisory Group and Working Groups to develop IAR Guidance for older adults.

Table of Contents

[Section 1 – Introduction 7](#_Toc100593089)

[Overview 7](#_Toc100593090)

[Scope 7](#_Toc100593091)

[Background 9](#_Toc100593092)

[Development of the IAR Guidance 12](#_Toc100593093)

[Guiding Principles 14](#_Toc100593094)

[Workforce capabilities and IAR 15](#_Toc100593095)

[Section 2 – Older Adult Lift Out 16](#_Toc100593096)

[The initial assessment domains – Older Adults 16](#_Toc100593097)

[Glossary for rating the initial assessment domains – Older Adults 18](#_Toc100593098)

[Levels of Care – Older Adults 31](#_Toc100593099)

[Care Type 31](#_Toc100593100)

[Care appropriateness 32](#_Toc100593101)

[The Decision Support Tool – Older Adults 38](#_Toc100593102)

[Interpreting Standard Assessment Tools to Guide Initial Assessments with older people 41](#_Toc100593103)

[Section 3 – Progress Monitoring 44](#_Toc100593104)

# Section 1 – Introduction

## Overview

In 2015 the Australian Government released its response to the Review of Mental Health Programmes and Services. The Response set a new stepped care approach to mental health service design and delivery.

In a stepped care approach, a person presenting to the health system is matched to the least intensive level of care that most suits their current treatment need, considering the balance between intended benefits and potential risks. A secondary and critical feature of stepped care is ongoing outcome and experience measurement to provide close to real-time feedback on outcomes allowing treatment intensity to be adjusted (stepping up or stepping down) as necessary. To achieve this, an initial assessment is required. The initial assessment is undertaken in partnership with the individual to determine suitable and appropriate treatment choices/options.

This Guidance focuses on the initial response to requests for mental health assistance in primary care settings. The IAR Guidance assists the various parties involved in the initial assessment and referral process. Without a consistent national approach, referrers and providers will inevitably assess and recommend levels of care inconsistently, resulting in discrepancies in the type of care provided across regions for similar clinical presentations. This Guidance supports nationally consistent evidence-informed initial assessment and referral processes. The Department of Health will refine the IAR Guidance as new evidence emerges.

It is expected that mental health services will use the IAR Guidance to:

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

## Scope

This Guidance focuses on the initial response to requests for mental health assistance in primary care settings. The IAR Guidance assists the various parties involved in the initial assessment and referral process, including:

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

#### Issues the IAR Guidance seeks to address

The IAR Guidance provides:

* A description of the different levels of care for consistent use by stakeholders.
* Criteria to assist referrers and mental health services with the initial assessment and selection of an initial level of care.
* A description of the evidence-based services likely to meet the clinical and recovery needs to be based on the level of care identified.
* Guidance relating to clinical governance within initial assessment and referral systems.

#### Issues that are not covered

The IAR Guidance does not provide:

* Information about treatment guidelines
* Information or advice about medication
* Information about more detailed and comprehensive psychological or diagnostic assessments.

While this Guidance refers to the critical interface between primary mental health care and acute and specialist mental health settings, this Guidance does not replace emergency mental health triage tools. Specialist and acute mental health services may use the IAR Decision Support Tool to inform decisions about onwards referral to primary mental healthcare services.

#### Target population

The IAR Guidance includes information and advice about initial assessment and referral for adults ([National Guidance](https://www.health.gov.au/resources/publications/primary-health-networks-phn-mental-health-care-guidance-initial-assessment-and-referral-for-mental-health-care)). The Department of Health has developed IAR-Guidance and an IAR-DST for children, adolescents, and older adults. However, the Department of Health has not yet commenced the processes necessary to ensure the IAR Guidance is appropriate for some population groups. These groups include:

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

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

#### Expectations

The IAR Guidance does not endorse or recommend a specific mechanism for intake (e.g., centralised or de-centralised intake systems). The mechanism for referral systems is a decision that is based on the service model and other contextual factors. The IAR Guidance can be applied irrespective of the intake mechanism.

The IAR Guidance represents the Department of Health's expectations regarding the standards providers uphold and the initial assessment requirements. Providers have scope to build in additional requirements to suit local circumstances.

The IAR Guidance outlines a list of core services recommended for each level of care. Availability of the recommended core services will vary from region to region depending on various factors (e.g., funding, workforce availability). The intervention recommendations included in the IAR Guidance may be delivered by community-managed organisations, state and territory mental health services, private providers, general practice, etc.

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

#### Clinical Judgement and Consumer Choice

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

## Background

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

#### Prevalence of Mental Illness and Community Need

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

One in five Australian adults (aged 16 to 85 years) will experience a mental illness each year. Almost half will experience a mental disorder in their lifetime.0F[[1]](#footnote-1) Anxiety disorders, and affective (mood) disorders are the most common, affecting approximately 14% and 6%, respectively, of the adult population each year, with these conditions often co-occurring. In addition, almost one in seven (14%) young people (aged 4 to 17 years) are estimated to have experienced a mental illness in the previous year.1F[[2]](#footnote-2)

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

People with mild mental illnesses, estimated at 2.3 million people, and those with moderately severe mental illness, with around 1.1 million people, represent the next largest group. People with mild to moderately severe illnesses are predominantly supported in the primary mental health system. Most services are provided through general practice and the Medicare Better Access initiative. Again, this layer of service responsibility rests with the Commonwealth.

At the highest end of the spectrum of need, approximately 775,000 people live with severe mental illness. For this group, the Commonwealth, states, and private hospitals share responsibility for clinical service provision. The National Disability Insurance Scheme supports eligible individuals experiencing the most significant disability associated with severe mental illness. Figure 1 summarises the estimated prevalence, graded according to levels of need.

*Figure 1: Estimated prevalence of mental health conditions and stepped care levels of need based on severity.*

P156#yIS1

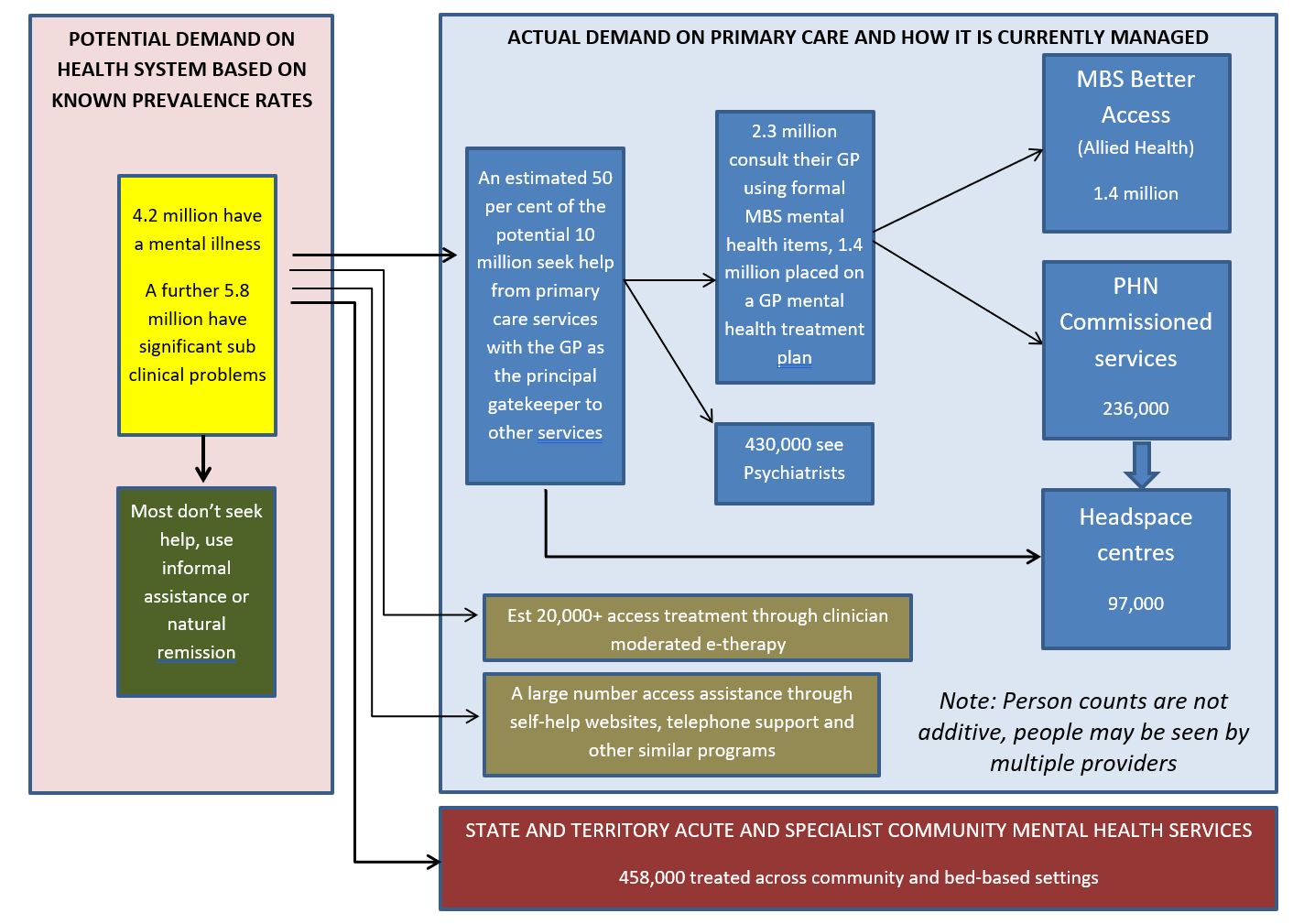
Source: Adapted from Figure 8, COAG Health Council (2017), *The Fifth National Mental Health and Suicide Prevention Plan*, Commonwealth on Australia, updated to 2018 population

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

#### High-Level View of how The Primary Mental Health Care System meets current Demand

Figure 2 provides a summary view of the current role of primary mental health care in responding to community need for mental health care.

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



## Development of the IAR Guidance

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

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

#### Literature Review

The Department of Health funded the Australian Psychological Society (APS) to review the literature to identify critical features of international and national approaches to initial assessment and referral within a stepped care framework. The review included grey literature and a scoping review of the peer-reviewed literature. A total of 21 documents were identified, including the results of randomised controlled trials and guidelines about stepped care approaches. The APS obtained results from a total of 13 countries.

It was evident from the literature review that internationally there is a wide range of approaches to initial assessment and referral within stepped care frameworks in mental health care settings.

#### PHN Summary Report

A national PHN survey (Survey 1) was undertaken throughout November and December 2017 to inform the development of the IAR Guidance. The PHN Summary Report was made available to PHNs via SharePoint. The survey took the form of a structured interview with pre-determined questions designed to elicit consistent information from across the PHN network.

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

The PHN Summary Report confirmed four typical intake and referral mechanisms in place across PHNs. These include:

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

Since this initial survey, additional surveys have confirmed that these continue as the four typical intake and referral mechanisms across PHNs.

The process of developing the older adult version of the National IAR Guidance has incorporated the following steps:

* The Working Group for older adults was convened and comprised significant clinical expertise in mental health for older adults.
* A Version Development Framework for older adults was developed for the working group, incorporating evidence and critical considerations to guide working group meeting discussions.
* Four working group meetings were facilitated alongside significant out-of-session input from members.
* The Expert Advisory Group met to review drafts and recommend the version for broader consultation following the development phase.

Members of the IAR Working Group (Older Adults), who provided invaluable expertise and input into the development of this Guidance, included:

| Member | Position, Organisation |
| --- | --- |
| Dr Caroline Johnson (Chair) | General Practitioner, Senior Lecturer, University of Melbourne |
| Angela Scarfe | Representative, Australian Association of Social Workers |
| Dr Dimity Pond | Representative, Royal Australian College of General Practitioners |
| Dr David Lie | Acting Medical Director, Addiction and Mental Health Services, Metro South Health Service (Queensland) |
| Norm Wotherspoon | Lived experience representative (consumer) |
| Susan Adams | Lived experience representative (carer) |
| Assoc. Prof. Michael Murray | Divisional Medical Director, Continuing Care, Director of Geriatric Medicine, Austin Health |
| Dr Linda De George-Walker | Representative, Australian Psychological Society |
| Kylie Coventry | Representative, Australian Psychological Society |
| Bill Buckingham | Principal, Buckingham Consulting  Former Technical Advisor (Mental Health), Australian Government Department of Health |

## Guiding Principles

The following principles underpin the IAR Guidance and help inform high-quality initial assessment and referral systems.

#### Supported decision-making to support consumer choice

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

The [Australian Healthcare Charter of Rights](https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights) emphasises the rights all people have, including the right to a genuine partnership with their healthcare providers and:

* Ask questions and be involved in open and honest communication
* Make decisions with their healthcare provider to the extent that they choose and are able to
* Include the people that they want in planning and decision-making.

Users of the IAR Guidance and IAR-DST are expected to protect and uphold the individual's right to express a choice and preference in their healthcare and be active partners in decision-making.

#### Trauma-informed initial assessment and referral practices

Trauma-informed care is an approach to service delivery based on an understanding of the ways trauma affects people’s lives and their treatment needs. Trauma-informed care incorporates the principles of safety, supported decision-making (choice, control, empowerment) and trust into all parts of a service. Through a trauma-informed approach to initial assessment and referral, safety is the priority and re-traumatisation is avoided. An essential requirement for effective and appropriate initial assessment and referral activities is to understand trauma's psychological, social, and physical effects.

#### Least treatment burden but is most likely to result in the best outcome

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

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

#### Accessible care options

An individual is more likely to engage in an intervention that is simple to access, flexible and affordable. The advice in this Guidance is dependent on initial assessment and referral that are sensitive to the participation needs of the consumer. For example, if a person cannot commit to appointments within business hours, after-hours, online, or telephone interventions may be warranted if clinically appropriate. It is also essential to understand (through respectful and discreet enquiries) the person's capacity to fund the intervention.

#### Responsive and flexible

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

#### Effective clinical governance

A high-performing initial assessment and referral system is underpinned by robust clinical governance. The IAR Guidance is underpinned by the National Safety and Quality Health Services Standards and the National Standards for Mental Health Services. PHNs are responsible for ensuring effective mechanisms for monitoring and managing the quality of care to meet or exceed the national standards.

#### Safe services

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

## Workforce capabilities and IAR

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

* General Practitioners (GPs) and other health/medical specialists
* Psychologists
* Credentialed mental health social workers or social workers who have completed additional training in mental health assessment and referral skills and have access to mental health focussed supervision
* Aboriginal and Torres Strait Islander mental health workers who have completed additional training in mental health assessment and referral skills and have access to mental health focussed supervision
* Psychiatrists
* Credentialed mental health nurses or registered nurses who have completed additional training in mental health assessment and referral skills and have access to mental health focussed supervision
* Occupational therapists endorsed to provide Better Access to Mental Healthcare or occupational therapists who have completed additional training in mental health assessment and referral skills and have access to mental health focussed supervision

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

* Non-clinical staff are adequately trained 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, and
  + the decision about 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).

The IAR-DST should not be used without clinical oversight and guides but does not replace clinical judgement. Systems and processes for initial assessment and referral should consider the unique and personal circumstances of the individual, including other health or social issues, their preferences and choices, and any risk or safety issues.

Clinicians using the IAR Guidance and Decision Support Tool should have existing core competencies relating to best practice engagement and mental health assessment of older adults. Clinicians are encouraged to utilise the resources available regarding best practice assessment (e.g., [The Royal Australian College of General Practitioners Silver Book](https://www.racgp.org.au/getattachment/97c45a13-6af2-429e-b691-4132b8bbdd3e/Mental-health.aspx) Part A, Mental Health and [A Practical Guide for Working with Carers of People with Mental Illness](https://www.workingwithfamiliesandcarers.com.au/)).

PRACTICE POINT

Services must be confident that intake and referral systems are operated by professionals who have the ability to build rapport and trust. The initial assessment outcome will lose validity if the person is reluctant to provide or disclose information. Developing trust and rapport may help to reduce attitudinal barriers to help-seeking that exist among some older adults. These attitudinal barriers include reluctance to talk about their mental health experiences, a fear of stigma, stoicism, a lack of trust and a fear of institutionalisation or hospitalisation. Carers, family members, and significant others may also be of significant value when actively engaged and encouraged to reduce any reluctance and support the person and clinician to gain a supportive and trusting relationship.

# Section 2 – Older Adult Lift Out

The IAR Guidance and Decision Support Tool (DST) – Older Adult Version assists general practitioners and clinicians in recommending the most appropriate level of care for an older adult seeking or requiring mental health support. In addition to the older adult version, the following versions are also available for use:

* IAR Guidance and Decision Support Tool (children aged 5 – 11).
* IAR Guidance and Decision Support Tool (adolescents aged 12 – 17).
* IAR Guidance and Decision Support Tool (adults aged 18 and over).

Whilst the IAR Guidance uses age to indicate the overall appropriateness of each tool, the final decision about the most appropriate version is based on the clinical judgment of the user, taking into account contextual and other considerations.

The IAR is an initiative of the Australian Government Department of Health. It brings together information from various sources, including Australian and international evidence and advice from leading experts. The IAR assists the various parties involved in the assessment and referral process in recommending a level of care for a person seeking mental health support. Each level of care is based on the least intensive and least intrusive evidence-based intervention that will likely lead to the most significant possible gain.

## The initial assessment domains – Older Adults

The initial assessment process recommended in this Guidance identifies eight domains that are assessed when determining the next steps in the referral process for an older adult referred to a mental health service. The eight domains fall into two categories:

* *Primary Assessment Domains (Domains 1 to 4):* These domains cover symptom severity and distress, risk of harm, functioning, and impact of co-existing conditions. The Primary Assessment Domains represent the basic areas for an initial assessment that have direct implications for decisions about the selection of a level of care.
* *Contextual Domains (Domains 5 to 8):* These domains cover service use and response history, social and environmental stressors, family and other supports, and engagement and motivation. Assessment on these domains provides essential context to moderate decisions indicated by the primary domains.

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

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

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

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

*Table 1 – The primary and contextual initial assessment domains – older adults*

| DOMAIN 1 Symptom severity and distress | * Current and past symptoms and duration. * Level of distress attributable to a mental health issue. * Experience of a mental health condition. * Are symptoms improving/worsening, is distress improving/worsening, and are new symptoms emerging? |
| --- | --- |
| DOMAIN 2 Risk of harm | * Suicidality – current and past suicidal ideation and attempts. * Intentional, non-suicidal self-harm – current and past. * Impulsive, dangerous, or risky behaviours with the potential for harm to self or others (including risks associated with the use of alcohol and other drugs). * The harm caused by abuse, exploitation, or neglect by others. * Unintentional harm to self or others arising from severe symptoms or self-neglect. |
| DOMAIN 3 Functioning | * Ability to fulfil usual roles/responsibilities appropriate to their age and cultural background. * Functioning within the family or home environment, vocational settings, with friends or peers, and in the community. * Ability to undertake basic activities of daily living appropriate to their age (e.g., self-care, mobility, toileting, nutrition, and personal hygiene). |
| DOMAIN 4 Impact of co-existing conditions | * Physical health conditions. * Cognitive impairment, intellectual disability, learning and communication disorders. * Substance use/misuse. |
| DOMAIN 5 Service use and response history | * Whether the older adult has previously sought help from or referred to mental health services and related supports (including specialist or mental health inpatient services). * If the older adult is currently engaged with services and support. * Their progress or benefit from past or current services and support. |
| DOMAIN 6 Social and environmental stressors | * Assessment on this domain should consider the degree to which any or all the following factors are relevant to the person's current circumstances and the referral decision: significant transitions, trauma or victimisation, family or household stress, socio-economic disadvantage, performance-related pressure, and legal issues. |
| DOMAIN 7 Family and other supports | * Whether personal supports, including emotionally nurturing relationships, practical support, and social support, are present in the environment. * Their potential to contribute to improved mental health and participation in treatment. |
| DOMAIN 8 Engagement and motivation | * The person's awareness of the mental health issue. * The person's capacity and willingness to engage in or accept assistance. |

## Glossary for rating the initial assessment domains – Older Adults

The Glossary includes a hierarchical ranking of factors relevant to each domain to guide judgements about problem severity.

The Glossary provides a rating system that grades each domain on a 5-point rating scale of severity, where:

0 = No problem

1 = Mild problem

2 = Moderate problem

3 = Severe problem

4 = Very severe problem

The Glossary outlines specific criteria for assessing each domain, designed to serve as a checklist of factors to consider when judging the extent to which a problem is present.

#### General Instructions for Rating the Domains

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

#### Overarching Rules and Guide to Ratings

* If more than one descriptor applies to the person within each domain, the descriptor with the highest rating should be selected.
  + Example one: if 3-b and 3-c apply, but 4-a is also present, the rating selected is 4.
  + Example two: if 2-a and 2-b apply, but 3-c is also present, the rating selected is 3.
* Unless stated otherwise, rate the person's current situation, defined as their most typical over the past month. This recognises that personal and social circumstances can change.
* Use all available information in making your rating. This should include clinical interviews and information gathered from the person, the person's family, referrers, or other informants. Consider all reliable perspectives when selecting a rating (e.g., including information provided by the person, family, or referrer).
* While terms vary, the rating scale for each domain follows the general format:

0 = No problem

1 = Mild problem

2 = Moderate problem

3 = Severe problem

4 = Very severe problem

* The coding of ratings as numerals is not intended to imply that an overall composite score can be used for making decisions about the person's service needs. The numbers should be regarded as just shorthand for summarising severity.
* Guidance is given for each domain on examples of problems that should be considered for specific ratings (the 'descriptors'). Consider these as examples only rather than an exhaustive list of all factors relevant to the domain. Therefore, referring to the underlying rating format at times may be helpful.
* If there is uncertainty in the ratings, do not use the IAR-DST. Seek additional information that will allow you to rate with certainty. Where uncertainty remains even after the additional information is obtained, the older adult should be supported to access an appropriate clinician for a comprehensive assessment.
* The IAR-DST should not be used without clinical oversight and guides but does not replace clinical judgement. Systems and processes for initial assessment and referral should consider the unique and personal circumstances of the individual, including other health or social issues, their preferences and choices, and any risk or safety issues.
* IAR should not be used as a screening tool because it cannot be used without some form of personalised assessment.

#### Domain 1 – Symptom severity and distress

The severity of current symptoms and associated levels of distress are important factors in recommending a level of care and making a referral decision.

This domain considers symptoms to include both internalised (emotional) problems experienced by the older adult (e.g., anxiety and depressive symptoms) as well as externalised behaviours observable by or impacting others (e.g., anger or aggressive outbursts). Symptoms may be associated with distress, but this is not always the case. Symptoms may indicate a particular diagnostic condition, but a diagnosis is not required.

Assessment of an older adult on this domain should consider:

* Current and past symptoms and duration.
* Level of distress attributable to mental health issues.
* Previous experience of a mental health condition.
* Are symptoms improving/worsening, is distress improving/worsening, and are new symptoms emerging?

**Practice point – Delirium**

Acute changes (typically hours to days) in an older adult's mood, behaviour, cognition, perception, or general mental state may indicate delirium. Delirium is often a medical emergency. Most people with delirium present with:

1. Acute onset mental state changes with a fluctuating course and

2. Problems with attention and concentration, plus either

3. Disorganised thought processes, or an altered level of consciousness

Reference: <https://www.safetyandquality.gov.au/sites/default/files/2021-11/delirium_clinical_care_standard_2021.pdf>

Delirium can trigger the highest possible ratings (rating = 4) on several primary domains classified as 'red flags' and trigger a referral to a specialist and acute mental health service (level 5). It is inappropriate to send a person with delirium to a mental health service. IAR-DST users should be familiar with their local delirium screening and assessment pathway. Contact the GP or hospital for urgent care instructions in the absence of a defined local pathway. If the presentation seems atypical or symptoms persist despite mental health intervention, review and input from a psycho-geriatrician or psychogeriatric service should be considered (especially for frail or patients experiencing medical complexity.

**Practice point – Dementia**

Dementia describes a group of conditions characterised by the gradual impairment of brain function.

People with dementia may present for mental health assistance in all primary health care settings. While specific exclusions exist within MBS guidelines for services provided through the Better Access program, these do not limit the use of the IAR Guidance and IAR-DST. A diagnosis of dementia does not exclude an older adult from seeking mental health assistance but may impact on referral and treatment options. Dementia may co-exist with treatable mental health issues.

The IAR Guidance and IAR-DST are focused on individuals who present for mental health services and assist with determining the intensity of the mental health response required. This focus is applicable broadly and irrespective of the factors that cause or contribute to the person's mental health experience.

**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)**

1. Mild anxiety-related symptoms (e.g., worry, difficulty concentrating).
2. Mild mood-related symptoms (e.g., sadness, fatigue, apathy, some reluctance to participate in previously enjoyed activities, irritability, occasional disrupted sleep).
3. Mild behavioural symptoms (e.g., occasional aggressive outbursts, disinhibited behaviour, interpersonal difficulties).
4. Currently experiencing other 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)**

1. Moderate anxiety-related symptoms (e.g., excessive worry, panic, avoidant behaviour, unexplained somatic complaints).
2. Moderate mood-related symptoms (e.g., excessive sadness, exhaustion, frequent irritability, loss of interest and pleasure, frequent reluctance to participate in previously enjoyed activities, apathy, feelings of guilt or worthlessness, frequent sleep disturbance).
3. Moderate behavioural symptoms (e.g., regular aggressive outbursts, frequently disinhibited behaviour, significant interpersonal difficulties).
4. Currently experiencing a mental health condition associated with moderate levels of distress or moderate reduction in quality of life.

**3 = Severe**

1. Severe anxiety-related symptoms are present most of the time.
2. Severe mood-related symptoms are present most of the time.
3. Significant behavioural symptoms that cause substantial disruption and distress and are often uncontrollable.
4. Currently experiencing a mental health condition (e.g., the impact of complex trauma, obsessive-compulsive disorder) where the symptoms are associated with high levels of distress, a significant reduction in quality of life, are present most of the time or are difficult to control. Symptoms may be ongoing or of more recent or sudden onset.
5. Symptoms of an early form of a severe mental health condition (e.g., abnormal perceptions, suspicious thinking, rapid mood swings, a substantial decrease in the need for sleep).
6. Has been treated by a specialist community mental health service or admitted to hospital for a mental health condition in the previous twelve months.

**4 = Very severe**

1. Very severe and pervasive anxiety symptoms are present virtually all the time and are poorly controlled.
2. Very severe and pervasive mood-related symptoms are present virtually all the time and are poorly controlled.
3. Extreme behavioural symptoms are present in most activities and are rarely capable of being controlled.
4. Currently experiencing a mental health condition (e.g., disordered thinking, extreme mood variation, obsessions, extreme avoidant behaviour, extreme interpersonal difficulties) and symptoms are very severe, present virtually all the time and are poorly controlled. Symptoms may be ongoing or of more recent or sudden onset.
5. 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.

#### Domain 2 – Risk of Harm

This domain considers the older adult's potential to harm themselves or others or be harmed by others.

Practice point – Risk of harm

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

Recent Australian and international evidence indicates that suicide risk prediction is a flawed, imprecise, and misleading activity in mental healthcare that contributes to over and underprediction of suicide risk.

This domain is not about predicting the older adults that are likely to attempt or die by suicide or undertake other forms of harm but instead should be used to guide the evaluation of current risk to inform the most appropriate response and referral. This domain is focused on examining:

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

*The IAR adaptation for older adults includes the* ***risk of 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 risk of 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 risk of harm arising from those stressors is rated separately at Domain 2.*

Practice point – Elder abuse

The World Health Organisation defines elder abuse as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.' Elder abuse includes financial, physical, psychological, emotional, and sexual abuse or neglect. Users of the IAR Guidance and decision support tool for older adults must understand and be aware of elder abuse, understand and be aware of elder abuse, and what to do if an older adult discloses elder abuse (or if elder abuse is suspected). More information about elder abuse is available through the [Australian Human Rights Commission](https://humanrights.gov.au/elderabuse)

1800 ELDERHelp (1800 353 374) is a free call number that automatically redirects callers seeking information and advice on elder abuse with the existing phone line service in their jurisdiction.

**0 = No identified risk in this domain**

**1 = Low risk of harm**

1. No current suicidal ideation, but has experienced ideation, intent, plans, or attempts in the past unrelated to the current episode or current life stressors
2. Occasional non-suicidal self-injurious acts in the recent past and not requiring any medical treatment.
3. May have engaged in past behaviours that posed a risk to self or others, but no current or recent instances.
4. Currently at low risk of harm from abuse, exploitation, or neglect by others.

**2 = Moderate risk of harm**

1. Current suicidal ideation, without plan or intent but may have had intent, plans, or attempts in the past unrelated to the current episode or current life stressors.
2. Frequent non-suicidal self-injurious acts in the recent past and not requiring any medical treatment.
3. Current or recent behaviours that pose a non-life-threatening risk to self or others.
4. Currently at some risk of harm from abuse, exploitation, or neglect by others.
5. Intermittent lapses in self-care that may lead to harm.

**3 = High risk of harm**

1. Current suicidal ideation with intent. May have history of, or recent, suicide attempt. 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.
2. Recent suicide attempt (within past 12 months) but no current intent, plan, or ideation.
3. Frequent non-suicidal self-injurious acts in the recent past and requiring medical treatment.
4. Recent or current dangerous or risky behaviours to self or others that have had or are likely to have a serious impact.
5. Significant risk of, or recent experience of, abuse, exploitation, or neglect by others.
6. Clearly compromised self-care ability that is ongoing to the extent that indirect or unintentional harm to self is likely.

**4 = Very high risk of harm**

1. Recent suicide attempt or current suicidal intention with plan and means to carry out. Few or no protective factors.
2. Current suicidal ideation with intent and plan. Few or no protective factors.
3. History of life-threatening self-injurious acts that are prominent in the current presentation.
4. 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.
5. 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.
6. Other signs or indicators of imminent risk of serious harm to themselves or others.

#### Domain 3 – Functioning

This domain considers functional impairment caused by or exacerbated by mental health issues. While some types of illnesses and disabilities experienced by the older adult may play a role in determining what types of support services may be required, they should not be considered in determining mental health service **intensity** within a stepped care continuum.

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).

**Practice point – Functional decline in later life**

Some gradual functional decline can be expected in later life, particularly beyond the age of 80 or for older adults with multiple co-occurring issues. A reduction in function can be associated with illness, a decline in physical health, and the older person's environment, among other factors. This domain is concerned with functional impairment caused or exacerbated by mental health issues.

Understanding the timeline and trajectory of functional change from baseline (i.e., what is usual for the person) is necessary for accurately rating this domain.

If there is uncertainty about the factors contributing to functional impairment (e.g., underlying medical causes of functional decline) a comprehensive assessment is recommended.

**0 = No problems in this domain**

**1 = Mild impact**

1. 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.
2. Mental health issues contribute to brief and transient disruptions in one or more areas of functioning.

**2 = Moderate impact**

1. 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.
2. Mental health issues contribute to occasional difficulties with basic activities of daily living but without threat to health.

**3 = Severe impact**

1. Significant difficulties with functioning, resulting in disruption to many areas of the person's life most of the time (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.
2. Mental health issues contribute to difficulties with basic self-care (e.g., hygiene, eating, appearance) on a frequent, consistent basis but without threat to health.

**4 = Very severe to extreme impact**

1. Profound difficulties with functioning, resulting in major 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).
2. Mental health issues contribute to severe and persistent self-neglect that poses a threat to health.

#### Domain 4 – Impact of co-existing conditions

Increasingly, individuals are experiencing and managing multi-morbidity (coexistence of multiple conditions, including chronic disease). This domain considers the extent to which other conditions contribute to (or have the potential to contribute to) increased severity of the mental health issue or compromise the person's ability to participate in the recommended services and support.

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

* Physical health conditions (consider all physical health issues and be mindful of age-related conditions like incontinence, hearing problems, loss of sight).
* Cognitive impairment, intellectual disability, or learning and communication disorder.
* Substance use/misuse

Practice point – Definitions of intellectual disability, cognitive impairment, and learning and communication disorders

The terms intellectual disability and cognitive impairment have no universally agreed definitions. For this Guidance, the below definitions will apply:

Cognitive impairment – A description of a person's current functioning regarding learning, communication, attention, memory, thinking and problem-solving. Cognitive impairment can be temporary or permanent, mild, moderate, or severe. Cognitive impairment can affect what the person can understand and how they relate to others and interpret the environment.

Intellectual disability – A disability characterised by significant intellectual functioning and adaptive behaviour limitations, covering many everyday social and practical skills. This disability originates before the age of 18. Genetic factors cause most intellectual disabilities. However, there are other causes of intellectual disabilities, such as brain injury or being born prematurely.

Learning and communication disorders – learning and communication disorders may affect how an older adult comprehends, recalls, understands and/or expresses information. These disorders are often dynamic and can improve over time. The impairment caused by these disorders might be minimal or significant and vary from person to person.

**0 = No problem in this domain**

**1 = Minor impact**

1. Physical health condition(s) present but are stable and have no or a minor impact on the person's mental health.
2. Cognitive impairment, intellectual disability, or neurological disorder present but has no or a minor impact on the person's mental health and capacity to participate in services.
3. 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**

1. Physical health condition(s) present and significantly impact the person's mental health or ability to participate in services.
2. Mild cognitive impairment, intellectual disability, or neurological disorder present with the potential to impact the person's mental health or their ability to participate in services.
3. Occasional substance use impacts on or with the potential to impact the person's mental health.
4. Overuse or misuse of prescription medications impact or have the potential to impact the person's mental health.

**3 = Severe impact**

1. Physical health condition(s) present, require intensive medical monitoring and seriously compromise the person's mental health (e.g., worsened symptoms, heightened distress).
2. Cognitive impairment, intellectual disability, or neurological disorder significantly impact the person's mental health and impede the person's ability to participate in services.
3. Frequent substance use poses a threat to health or represents a barrier to mental health-related recovery.
4. Overuse or misuse of prescription medications impacts significantly on the person's mental health or presents a barrier to mental health-related recovery.

**4 = Very severe impact**

1. 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.
2. Severe cognitive impairment, intellectual disability or neurological disorder present significantly impacts the person's mental health and impedes their ability to participate in services.
3. Regular and uncontrolled substance use poses a severe threat to health.

#### Domain 5 – Service use and response history

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).
* If the person is currently engaged with services and support.
* 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, culturally appropriate, evidence-informed mental health, health and/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.

**0 = No problem in this domain – no descriptors apply**

1. Has not previously sought help from or required a referral for a mental health issue.
2. In a current service arrangement that is appropriate and of benefit to the person.

**1 = Excellent progress from previous service use**

1. Previously sought help for earlier mental health issues and experienced benefit with no need for ongoing services.

**2 = Moderate progress from previous service use**

1. Previously accessed services and was generally able to achieve and maintain benefit from the service with some need for ongoing services.

**3 = Minor progress from previous or current service use**

1. Previously accessed services with only minor benefit.
2. Previously accessed intermittent specialist supports (e.g., psychiatry services, state, and territory specialist mental health services, or dementia or other psychogeriatric services) for the current or previous episode but a limited response.
3. Currently accessing services but is not experiencing the expected response despite intensive and structured supports delivered over a typical course of treatment.

**4 = Negligible progress with previous or current service use**

1. Previously accessed services with negligible or no benefit despite intensive, structured, and specialist supports delivered over an extended period.
2. Currently accessing services but is deteriorating despite intensive, structured, and specialist supports (e.g., psychiatry services, state and territory specialist mental health services, dementia, or other psychogeriatric services) delivered over an extended period.

#### Domain 6 – Social and environmental stressors

This domain considers the extent and severity of a range of factors in the older adult's environment that might contribute to the onset or continuation of the mental health issue. Significant environmental stressors and adversity can lead to increased symptom severity and compromise the capacity of the person to participate in or benefit from the recommended resources and services. Furthermore, understanding the complexities the older adult is experiencing (or has experienced) may alter the type of service offered or indicate that additional service referrals are required (e.g., a referral to a social support service).

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

* Significant losses (e.g., job loss, relationship breakdown, illness, or death of a loved one).
* Significant change and transitions (e.g., the transition from gainful employment to retirement, a change in living environment, uncertainty about future care arrangements, changes in independence, managing an illness, refugee or asylum-seeking experiences).
* 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., human rights abuses, discrimination, racial abuse, financial abuse, victim of crime).
* Family or household stress (e.g., household drug or alcohol abuse, parent or family member with an illness or disability, access to children/grandchildren).
* Socioeconomic disadvantage (e.g., poverty, unemployment, unstable or insecure housing).
* Performance-related pressure (e.g., unrealistic role expectations and caregiving responsibilities).
* Loneliness or isolation.

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

**0 = No problem in this domain**

**1 = Mildly stressful environment**

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

**2 = Moderately stressful environment**

1. 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**

1. The person is experiencing (or has experienced) one or more stressors that are currently having or are likely to significantly impact their mental health.

**4 = Extremely stressful environment**

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

#### Domain 7 – Family and other supports

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. Personal 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.

**0 = Highly supported**

1. Personal supports are highly supportive and meet the older adult's emotional, practical, and social needs.

**1 = Well supported**

1. A few supports seen as useful by the older adult are available, willing to, and capable of providing emotional, practical, and social support.

**2 = Limited supports**

1. 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.

**3 = Minimal supports**

1. Very few actual or potential useful sources of support are available, willing to and capable of providing emotional, practical, or social support
2. Despite the older adult requiring them, a substitute decision-maker has not facilitated access to services and support in the past.

**4 = No supports**

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

#### Domain 8 – Engagement and motivation

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:

* Understanding of the symptoms, condition, and impact.
* Ability and capacity to manage the condition.
* Motivation to access necessary supports (particularly important 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, it is important for the initial assessment and referral process to include support people, caregivers, and family members in discussions and decision-making where appropriate.

Practice point – Checking in when engagement or motivation is low

A follow-up check-in helps determine if the recommended information, resources, and services are being utilised and perceived as helpful. Proactively "checking in" or encouraging the person to "check back" is essential when engagement or motivation is low. A plan for check-in should be made at the point of referral and documented.

The check-in should explore the following questions:

1. Is the person engaging with the recommended information, resources, and services? If the person is not engaging, it is essential to re-examine motivation and explore reasons for the lack of engagement (domain 8).

2. Does the person think that the recommended information, resources, and services are/were helpful?

3. Is there evidence of deterioration or changing risk of suicide or harm to self or others?

4. Is the person experiencing new or worsening social and environmental stressors?

6. Discuss and document the next steps determined in collaboration with the person. The next steps might include:

- Continue existing service arrangements

- Build-in additional supports

- Initiate a referral to a different level of care

**0 = Optimal**

1. The person is motivated to participate in the recommended services and support.
2. The person is capable of taking an active role in managing the condition.

**1 = Positive**

1. The person is mostly willing to accept and participate in the recommended services and support.
2. The person is mostly capable of taking an active role in managing the condition.

**2 = Limited**

1. The person is hesitant to accept and participate in the recommended services and support.
2. The person has limited ability to take an active role in managing the condition.

**3 = Minimal**

1. The person is very reluctant to accept or participate in services and support.
2. 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**

1. The person refuses to accept or participate in the recommended services and support.
2. The person has minimal ability to take an active role in managing the condition.

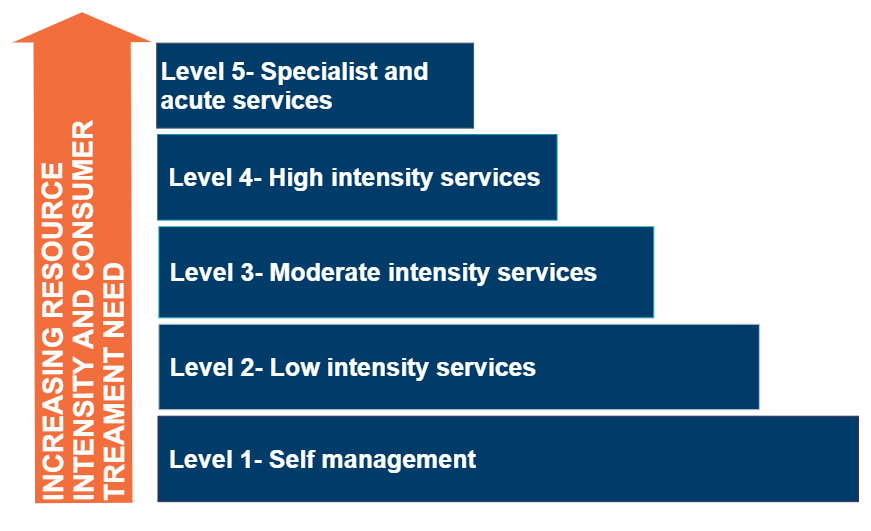
## Levels of Care – Older Adults

This section describes the different levels of care. The information gathered through the initial assessment is used to recommend a level of care and inform a referral decision. The levels of care do not replace individualised assessment and care - instead, providing information to guide decision-making.

It is important to emphasise that the referral criteria are offered only to guide judgements about the recommended level of care. Each presenting older adult will have unique requirements that must always take precedence in decision making.

There are five levels of care (depicted in Figure 3). Each level of care is differentiated based on the intensity of the mental healthcare available at each level of care. There may be a gap in services available at some or all levels of care. The determined level of care applies irrespective of service availability. Referrers may need to take a flexible approach (e.g., telehealth services or bundling services as part of a care package) to achieve the required service intensity.

*Figure 3 – The 5 Levels of Care*



### Care Type

An important additional consideration is the type and appropriateness of the resources or services recommended. Users of the Decision Support Tool should actively consider and incorporate decisions about resource or service type and appropriateness when considering resource or service options that are personalised to each person's unique needs.

When making a resource recommendation or referral decision at any level of care, consider the type of resources and/or service options that account for the perspectives and preferences of the person, such as:

* Culturally appropriate and safe services (such as social and emotional wellbeing services available through Aboriginal Community Controlled Health Organisations).
* Developmentally appropriate services.
* Services specific to the person's diagnosis (where applicable).
* Specialist sexuality and gender diversity resources and services.
* If the person has multiple service needs, consider options for integrated services and service models.
* Services that can sensitively incorporate social and environmental supports (e.g., specialist family violence services).

### Care appropriateness

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

* Readiness of the person.
* The priorities of the person.
* Cost.
* Location.
* Availability of in-language, interpreter, and translator services.
* Literacy of the person (including digital literacy).
* The availability of technology (e.g., internet connection, telephone).
* The practical and emotional support needs of the person.

Practice point – Supported decision-making

Supported decision-making strategies for initial assessment and referral:

* Ensure the person is provided with information using their preferred way of receiving information (e.g., written/verbal/visual, English/other languages, with/without a support person). Take care to provide information that is developmentally and culturally appropriate.
* Ensure the person is provided with information about the range of services and support available (including the option of no service) and encourage the person to contribute their options, ideas, solutions, and expectations. This might include culturally important activities or self-care strategies.
* Ensure the person can express any concerns or fears about the options (e.g., cost, travel, previous positive or negative experiences).
* Be prepared to talk about the pros and cons of each option (e.g., intensity, length of service engagement, commitment required, waiting periods, and the potential impact on symptoms).
* Check-in to ensure the person has understood the information provided and ensure enough time for any questions.

For more information and advice about supported decision-making, visit: <http://media.healthdirect.org.au/publications/Guidelines-for-Supported-Decision-Making-in-Mental-Health-Services.pdf>

#### Level 1 - Self-Management

**Definition:** This level of care generally involves evidence-informed, appropriate, and culturally safe online resources and other forms of self-help. A summary of the evidence-based online mental health resources and self-help services is available through the [Head to Health website](https://www.headtohealth.gov.au/supporting-yourself/support-for/aged-and-elderly). An older adult may require assistance, prompting and encouragement from a support person, caregiver, or family member to engage with and understand self-management recommendations (supported self-management).

**Care environment:** Resources are easily accessible and available online, via telephone or in the community. Resources may also be available in integrated settings (e.g., community centres, pharmacies, aged care services, and general practice).

**Core clinical services:**This level of care focuses on resources that can be accessed and self-managed by the older adult but may also include support from another person (e.g., a support person). Clinical services are generally not required; however, where they are involved, they should include:

* Psychoeducation (written and verbal forms), social prescribing, and information via a GP. The GP may also consider developing a MHTP (if consistent with Medicare Benefits Schedule eligibility requirements).
* Wellbeing and preventative programs within an aged care service or community setting.
* Be focussed on monitoring, with the capability to step up into a higher level of care if required.
* A comprehensive physical health assessment and ongoing management of physical health issues via a GP.

**Other clinical services that may be required:**

* Lifestyle supports (e.g., sleep hygiene, social exercise programs).

**Support services:**

* Specific community, social, and recreational supports relevant to wellbeing.
* Peer support.
* Services and support focussed on connections with community and culture.
* Care coordination services (if more than two services provide care and support to the person).

Additional services, if needed, are focused on advocating for and coordinating additional services and support required and relevant to the person's wellbeing, including community-based, housing, legal, financial, aged care, health, and other supports.

**Referral criteria:**

An older person suitable for this level of care typically has low, or no risk factors are usually experiencing mild symptoms/low levels of distress. Where present, distress is likely to be in response to a stressful environment. Symptoms have typically been present for a short time (less than six months, but this may vary). The person is generally functioning well. Where the person has accessed services before, they are likely to have had a moderate to excellent response to the previous service experience.

A person experiencing a lack of motivation/engagement should not be referred to this level of care because these problems will work against involvement in self-management strategies. Additionally, Level 1 care is unlikely to be suitable for those with severe problems in their treatment/recovery history or very severe environmental stressors.

#### Level 2 - Low-Intensity Services

**Definition:** Low-intensity services are designed to be accessed quickly (without the need for a formal referral, e.g., through a third-party service or provider), easily (through a range of modalities including face-to-face, group work, telephone, and online services) and typically involve few or short sessions. In contrast to Level 1, low-intensity services usually require some direct, individually tailored engagement with a mental health professional.

**Care environment:** Services are easily accessible and available online, over the telephone or in the community. Services may also be available in integrated settings (e.g., community centres, pharmacies, aged care services, and general practice).

**Core clinical services:**

* Psychoeducation (written and verbal forms) and information via a GP. The GP may also consider developing a MHTP (if consistent with Medicare Benefits Schedule eligibility requirements).
* Evidence-informed, appropriate, and culturally safe low-intensity services (including online, telephone and face-to-face low-intensity psychological services, or brief service engagement delivered by mental health professionals). Includes both individual and group work.
* A comprehensive physical health assessment and ongoing management of physical health issues via a GP.

**Other clinical services that may be required:**

* Lifestyle supports (e.g., sleep hygiene, social exercise programs).
* Wellbeing programs.

**Support services:**

* Specific community, social, recreational, aged care, and health supports.
* Peer support.
* Services and support focussed on connections with community and culture.
* Care coordination services (if more than two services provide care and support).

Additional services, if needed, are focused on advocating for and coordinating additional services and support required and relevant to the person's wellbeing, including community-based, housing, legal, financial, aged care, health, and other supports.

**Referral criteria:**

A person suitable for this level of care typically has low or no risk factors and is usually experiencing mild symptoms/low levels of distress. Where present, this is likely to be in response to a stressful environment. Symptoms have typically been present for a short time (less than six months, but this may vary). The person is generally functioning well but may have problems with motivation or engagement.

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

#### Level 3 – Moderate-Intensity Services

**Definition:** Moderate-intensity services generally provide structured, reasonably frequent, and individually tailored service delivery (e.g., a defined number of psychological sessions delivered regularly).

**Care environment:** Typically, community locations (e.g., consulting rooms, outreach into aged care facilities) or if appropriate, via telephone or videoconference (e.g., for people in remote communities), and clinician assisted e-therapies. Services may also be available in integrated settings (e.g., community centres, aged care services, and general practice).

**Core clinical services:** A comprehensive biopsychosocial assessment (if not already undertaken) is required for all people suited to this level of care.

* GP mental health assessment (and development of a MHTP).
* Evidence-informed, appropriate, and culturally safe psychological services.
* Diagnosis specific services where indicated.
* Supports to minimise functional impairment and maximise functional recovery.
* A comprehensive physical health assessment and ongoing management of physical health issues via a GP.

**Other clinical services that may be required:**

* Lifestyle supports (e.g., sleep hygiene, social exercise programs).
* Wellbeing programs.
* Community psychiatry - psychiatrist opinion and management plan

**Support services:** Additional services are likely to be needed and may include:

* Specific community, social, recreational, and living supports relevant to the person's well-being.
* Peer support.
* Services and support focussed on connections with community and culture.
* Care coordination services (if more than two services provide care and support).

Additional services, if needed, are focused on advocating for and coordinating additional services and support required and relevant to the person's wellbeing, including community-based, housing, legal, financial, aged care, health, and other supports.

**Referral criteria:**

A person requiring this level of care is likely to be experiencing mild to moderate symptoms/distress (that would meet the criteria for a diagnosis). Symptoms have typically been present for six months or more (but this may vary). The initial assessment would usually indicate problems present in risk of harm, functioning or impact of co-existing conditions but not at very severe levels, which should trigger consideration of a referral to Level 5. People experiencing moderate to severe symptoms with mild to moderate problems associated with Risk, Functioning and Impact of Co-existing Conditions are usually suitable for this level of care.

#### Level 4 - High-Intensity Services

**Definition:** High-intensity services, including periods of intensive service that usually involve multi-disciplinary support and care coordination as multiple services are likely to be involved. Level 4 is usually designed to support people experiencing severe symptoms, significant functional impairment, or risk factors.

**Care environment:** Typically, face-to-face services in community locations (e.g., consulting rooms, aged care services) or outreach to the older adult within their home or another environment).

**Core clinical services:** A comprehensive biopsychosocial assessment (if not already undertaken) is required for a person suited to this level of care.

* GP mental health assessment (and development of a MHTP).
* Evidence-informed, appropriate, and culturally safe psychological services provided by a mental health professional.
* Community psychiatry - psychiatrist opinion, referral, management plan and treatment.
* Diagnosis specific services where indicated.
* Support to minimise functional impairment and maximise functional recovery.
* Active involvement and input from a psycho-geriatrician or psychogeriatric service.
* A comprehensive physical health assessment and ongoing management of physical health issues via a GP.

**Other clinical services that may be required:**

* Lifestyle supports (e.g., sleep hygiene, social exercise programs).
* Wellbeing programs.

**Support services:** Additional services are likely to be needed and may include:

* Specific community, social, recreational, and living support.
* Peer support.
* Services and support focussed on connections with community and culture.
* Care coordination services (if more than two services provide care and support).

Additional services, if needed, are focused on advocating for and coordinating additional services and support required and relevant to the person's wellbeing, including community-based, housing, legal, financial, aged care, health, and other supports.

**Referral criteria:**

An older adult requiring this level of care usually has significant symptoms. An older adult with a severe presentation is likely to be experiencing moderate or higher problems associated with Risk of Harm, Functioning, and Impact of Co-existing Conditions. Where problems are assessed as very severe in Symptom, Risk of Harm or Functioning domains, a referral to Level 5 care should be considered.

#### Level 5 - Acute and Specialist Community Mental Health Services

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

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

**Core clinical services:** For this level of care, the older adult is likely to benefit from psychiatric assessment and care, specialist behavioural programs, crisis management, and therapeutic services using pro-active engagement strategies provided by a multi-disciplinary specialist team with outreach capability. A comprehensive physical health assessment and ongoing management of physical health issues via a GP.

**Support services:** Additional services are likely to be needed and may include:

* Specific community, social, recreational, and living supports relevant to well-being.
* Peer support.
* Services and support focussed on connections with community and culture.
* Wellbeing programs.
* Care coordination services (if more than two services provide care and support).

Additional services, if needed, are focused on advocating for and coordinating additional services and support required and relevant to the person's wellbeing, including community-based, housing, legal, financial, aged care, health, and other supports.

**Referral criteria:**

A person requiring this level of care usually has 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) 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 consequences.

## The Decision Support Tool – Older Adults

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

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

Assessment on the eight domains provides the starting point. The next step is to define levels of care based on different levels of resource intensity. This Guidance outlines the schema for conceptualising resource intensity based on five levels of care. The model guides thinking about referral options rather than a picture-perfect reflection of the mental health service system.

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

A person's presenting issues on each domain can interact in different ways. As an example, a person presenting with mild to moderate symptoms (Domain 1) but no significant problems on any of the contextual domains (domains 5-8) is likely to require a different level of care from a person with mild to moderate symptoms but extensive social and environmental stressors or a history of poor response to previous treatment. The challenge for referral decision making is portrayed in Figure 4.

Figure 4: Mapping assessments on eight interactive domains to 5 levels of care

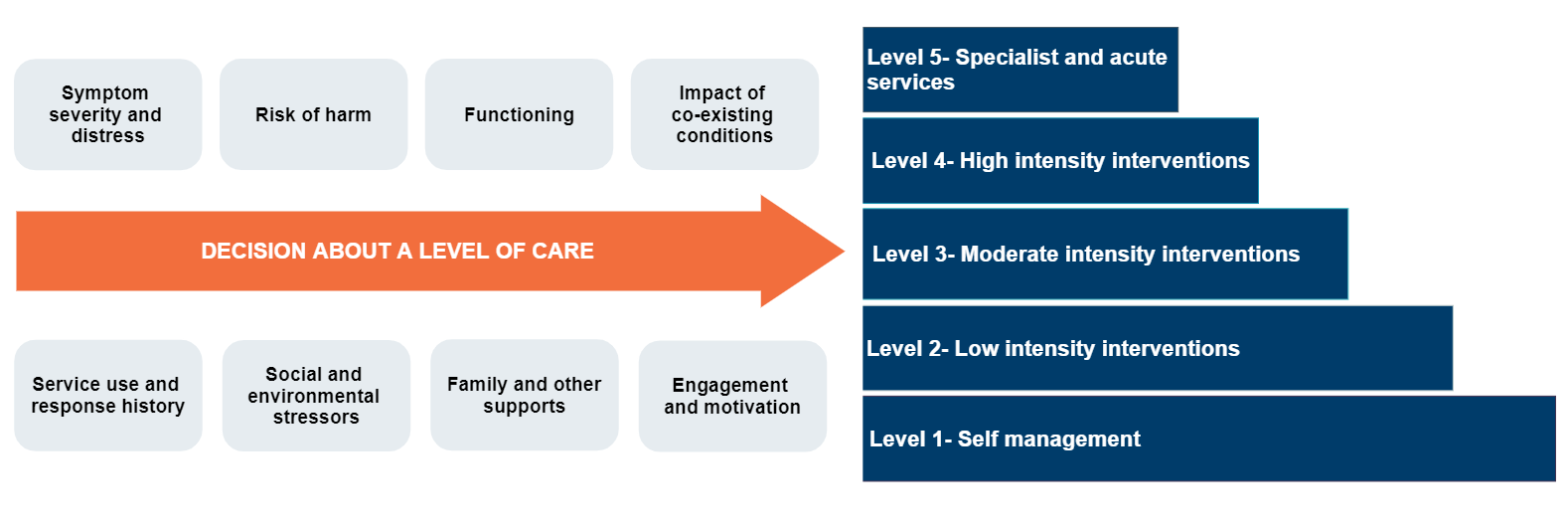


Figure 5 summarises the logic that underpins the decision support tool. It shows how ratings of the domains using the glossary rating guide, and interactions between the domains, can be applied to guide referral decisions.

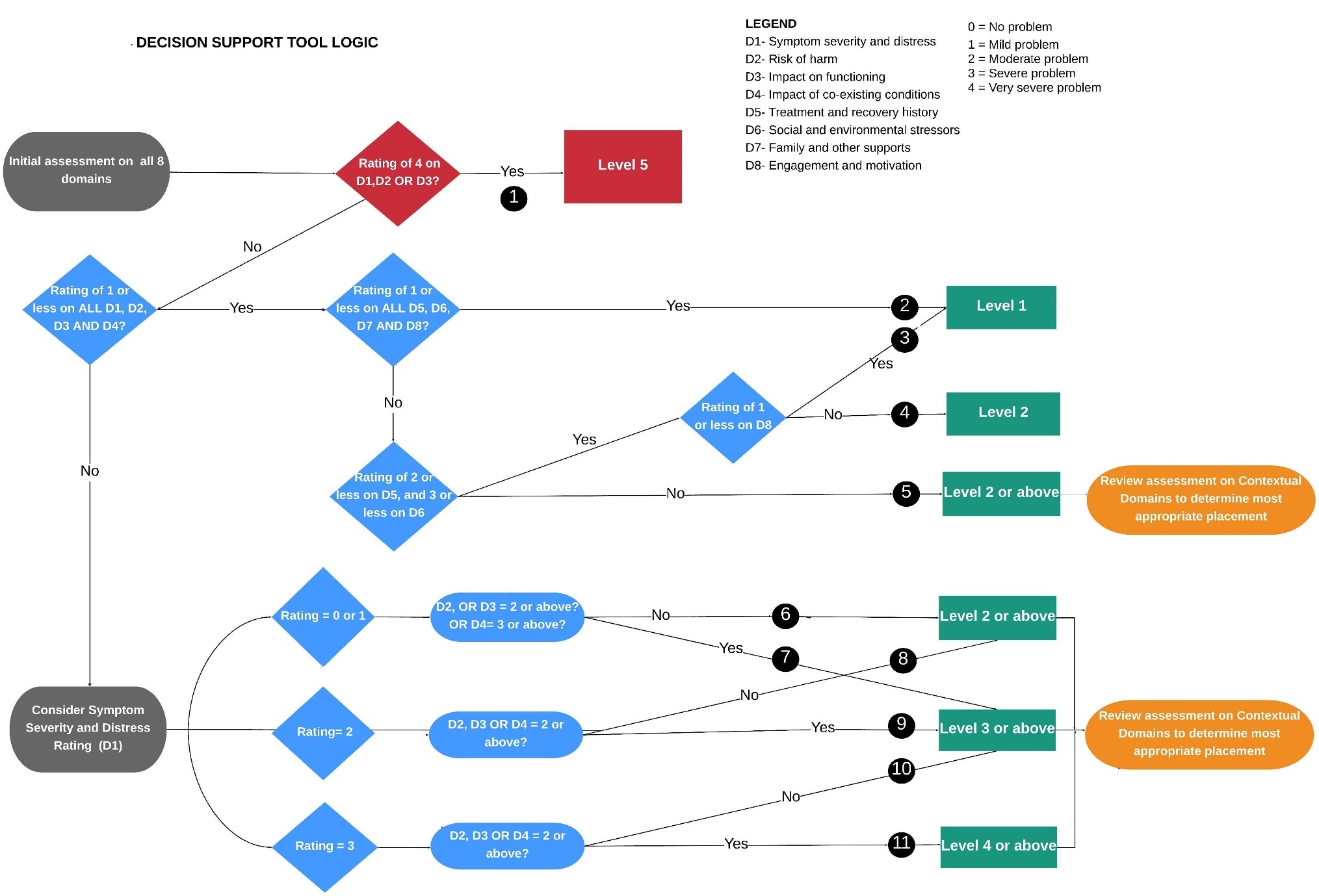
Like most decision support tools that aim to describe complex relationships, the initial impression for many who examine the logic may be that it is complex or difficult to fathom at first glance. However, there is an underlying simplicity to the approach to guiding decision-making described below by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

There are five levels of care and 11 possible pathways into the five levels of care. The 11 pathways are referenced using the black numbered circle.

**Pathway 1:** 'red flag' items are identified that would usually warrant referral to Level 5 care, including acute and specialist community mental health services (primarily state and territory services). These include very severe ratings on symptoms, risk, and functioning domains. 'Red flag' items act as independent criteria that automatically place an individual in a specific level of care, regardless of their assessment on other domains.

**Pathways 2 – 5:** targets people with relatively low ratings on primary domains. Decisions about this group are guided using treatment history (D5) and other contextual domains into (mostly) Level 1 or 2 care.

**Pathways 6 – 11:** There is considerable complexity in this potentially large group. Presentations in this group are classified initially based on symptom/distress severity, then on other complexity in the other primary domains. Levels of care are recommended for this group based on contextual domains which are unmapped. Most of this group are expected to be referred to Level 2 or above.

*Figure 5- The Decision Support Logic*

## Interpreting Standard Assessment Tools to Guide Initial Assessments with older adults

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

**Practice point – Standard assessment tools and adults**

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

**Significant discordance between clinician assessment and scores on standard assessment measures is an indicator that a comprehensive assessment is required.**

Kessler-10+ (K10+)

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

*Table 1 – Thresholds for the K10+*

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

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

It is essential to note that these thresholds are based on the distribution of K10+ scores in the **general population**, derived from general household surveys, and **do not reflect clinical samples** – that is, people who present for assistance with mental health problems. In general, people presenting for help have significantly increased K10+ scores compared with the general population. For example, based on PMHC MDS data, 84% of clients receiving mental health services commissioned by PHNs have K-10 scores in the High or Very high categories (Score 22+) compared with 13% of the general population; 58% report distress in the Very high (score 30+) range compared with 4% of the general population. These findings highlight that the K10+ scores, when used alone, should not be interpreted as aligning directly with Domain 1 rating levels (e.g., a rating of 4 'Very severe' on Domain 1 is not simply equivalent to a K10+ score of 30+). Remember that the K10+ identifies **non-specific** distress and that high levels might be attributable to factors other than mental health problems.

Kessler-5 (K-5)

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

*Table 2 – Thresholds for the K-5*

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

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

Patient Health Questionnaire 9 (PHQ-9)

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

*Table 3 – Thresholds for the PHQ-9*

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

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

Generalised Anxiety Disorder Scale (GAD-7)

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

*Table 4 – Thresholds for the GAD-7*

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

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

Work and Social Adjustment Scale (WSAS)

The WSAS is a measure of functional impairment pertaining to work and social functioning. WSAS is a 5-item self-report scale.

*Table 6 – Thresholds of the WSAS*

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

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

# Section 3 – Progress Monitoring

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

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

#### Who should monitor progress?

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

#### How should progress monitoring occur?

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

Practice point – Reviewing progress

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

#### How often should progress monitoring occur?

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

#### When should a step-up be considered?

A step-up should be considered when:

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

Practice point – Indicators of deterioration

The [Australian Commission of Quality and Safety in Health Care](https://www.safetyandquality.gov.au/wp-content/uploads/2017/08/National-Consensus-Statement-Essential-elements-for-recognising-and-responding-to-deterioration-in-a-person%E2%80%99s-mental-state-July-2017.pdf) lists 5 indicators of deterioration, including (1) clinician, consumer or carer reported change; (2) distress; (3) loss of touch with reality or consequences of behaviours; (4) loss of function; (5) elevated risk to self, others or property.

#### When should a step-down be considered?

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

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

Practice point – Using outcome and experience measures to monitor progress

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

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

* Waiting periods are avoided or eliminated.
* Involve a facilitated and "warm" referral. A warm referral typically involves a supported introduction to the new service (e.g., supporting the individual to make the initial contact with the new service or provider) and (with the individual's consent) providing relevant written reports or notes.
* Include a clear and documented handover of duty of care.

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1. Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing 2007: Summary of Results, ABS cat. no. 4326.0, Canberra, ABS. [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)