JC JoyAge

Operational Manual for
DECC + ICCMW
Collaborative Stepped Care

July 2020

Contents

Overview & General Guidelines

1. Collaborative Stepped Care Model

The JC JoyAge adopted a collaborative stepped care approach between District Elderly Community Centre (DECC) and Integrated Community Centre for Mental Wellness (ICCMW) to elderly depression. In the collaborative stepped care model, older persons are matched to the intervention module that most suits their current needs. The person does not have to start at the lowest level of intervention to progress to the next 'step'. Rather, they enter the service with the intervention level aligned to their needs.

	Indicated Prevention for Mild Depression	Clinical Intervention for Moderate Depression	Intensive Clinical Intervention for Moderately Severe Depression
Intervention goal	To reduce depressive symptom level to normal level, enhance resilience	To reduce depressive symptom level to mild depression or below	To reduce depressive symptom level to moderate depression or below
Key intervention mode	Psychoeducation on a specific topic (insomnia, pain, stress, and anxiety), or low-intensity psychotherapy	High-intensity psychotherapy	High-intensity psychotherapy
Principal team	DECC	DECC and ICCMW*	ICCMW

*Principal team will be decided based on the scoring on item 2 in PHQ-9

1.1. Case Management

The JoyAge Project Social Worker (Project Social Worker) who conducted the first consultation (intake) will be the Key Worker, who will follow up the person throughout the service period (i.e., until discharge); except that

Step Up:

- In the event of stepping up from "Moderate Depression" intervention to "Moderately Severe Depression" intervention (i.e., the person's mental state has significantly deteriorated), a Key Worker from ICCMW should be assigned, who will follow up the person from this point onward throughout the service period (i.e., until discharge)
- Whenever an older person from DECC is stepping up to receive ICCMW service, a handover session between the person, the DECC Key Worker, and the Project Social Worker working in ICCMW is recommended to be conducted within five working days* upon the step-up notice is issued. The ICCMW Project Social Worker will become the Key Worker once the client agrees to be transferred in the handover session. DECC Worker needs to pass Case Summary and all previous assessment of the client to ICCMW Case Worker. A First Consultation led by the ICCMW Key Worker will then be conducted within five working days after the handover session.

Step Down:

- After the standard course of intervention, if the person's condition remains at or has decreased to "Mild Depression" state and further follow-up at DECC is needed (i.e., the person's mental state has significantly improved but still requires low-intensity intervention), a Key Worker from DECC should be assigned, who will follow up the person from this point onward throughout the service period (i.e., until discharge)
- Whenever a person from ICCMW is stepping down to receive DECC service, a handover session between the person, the DECC Project Social Worker, and the ICCMW Key Worker is recommended to be conducted within ten working days* upon the step-down notice is issued. The DECC Project Social Worker will be the Key Worker once the client agrees to be transferred in the handover session. ICMMW Worker needs to pass Case Summary and all previous assessment of the client to DECC Case Worker. A First Consultation led by the DECC Key Worker will be conducted within ten working days after the handover session.

*To facilitate this arrangement, a fixed session each week between DECC and ICCMW Project Workers for joint consultation is recommended.

1.2. Exit Plan

In the Progress Review session, when a person is assessed to be meeting the discharge criteria, a 2-month Exit Plan involving a Peer Supporter follow-up should be invoked.

- In the review session, the Key Worker will work with the client to develop a 6- to 8-week Mental Health Wellness Plan (e.g., Activity Scheduling, WRAP®) to further improve or consolidate the protective factors. Specific, Measurable, Attainable, Realistic, and Timely (SMART) goals will be set and agreed upon between the Key Worker and the client.
- During the Exit period, the same Peer Supporter will meet the person regularly and follow up on the Mental Health Wellness Plan and SMART goals.
- By the end of the Exit period, the Key Worker will conduct another review:
  - If the exit criteria are continually met, conduct a Full Review with the aim of relapse prevention, complete Form D and Case Summary Form (Appendix: Form D, Case Summary), and discharge.
  - If the exit criteria are not met, review and revise SMART goals prescription with Peer Supporter follow-up for another month, and conduct the review again afterwards; consider referring the case to other services as well (routine ICCMW, DECC, NEC services, etc.)

1.3. Suggested Frequency of Contact by Key Social Workers and Peer Supporters

During Active Intervention Period:

	Indicated Prevention for Mild Depression	Clinical Intervention for Moderate Depression	Intensive Clinical Intervention for Moderately Severe Depression
Key Social Worker Contacts (Minimal)	Once every 2 weeks	Once every 1–2 weeks	Once every 1 weeks
Peer Supporter Contacts (Minimal)	Once every 1–2 weeks (approx. 0.5 hours)	Once every 1–2 weeks (0.5 to 1 hour)	Once every 1–2 weeks (0.5 to 1 hour)

During Exit Plan Period:

	Exit Period 6 weeks – 2 months	Extended Exit Period 1 month
Key Social Worker Contacts (Minimal)	• 1 Progress Review session to set goals and the Mental Health Wellness Plan • 1 End of the Exit Plan Period review session • 1 Discharge session	• 1 Discharge session
Peer Supporter Contacts (Minimal)	• Case-by-case basis with the principle of gradually decrease in frequency • Complete the Mental Health Wellness Plan with the client • Connect the client to DECC, NEC, or other social services and join at least one activity at the centre; or expand the client's social network (added one social support); or add one meaningful activity to the daily routine	• Further work on the goal in the Mental Health Wellness Plan • Connect the client to DECC, NEC, or other social services

1.4. Referral for People with Moderately Severe Depression and Acute Suicidal Risk

At any time of the service, if there are any concerns about the person's suicidal risk, or if the person is assessed to have a moderate or higher risk of suicide, referral should be made to a hospital or Fast Track Clinic (FTC) for Elderly Suicide Prevention Programme (ESPP). The Project Social Worker should also follow his or her organisation protocol for risk management and obtain support from their service supervisor or the responsible staff.

If a moderate or higher risk of suicide is suspected in a person receiving DECC case management, support from the district ICCMW team should be solicited for a joint risk assessment session. This joint assessment session should be arranged as soon as possible and within two days after receiving the notification. A referral plan should be made, or if the suicidal risk is assessed to be manageable within the project scope, a management plan will be co-formulated between the DECC and ICCMW teams.

2. Service Eligibility

*2.1. Inclusion Criteria**

- Age 60 years or above; and
- Reside in the centre's catchment area; and
- Have depressive symptoms at a mild level or above (i.e., PHQ-9 score ≥ 5)

2.2. Exclusion Criteria

- Known history of autism, intellectual disability, schizophrenia-spectrum disorder, bipolar disorder, Parkinson's disease, or major neurocognitive disorders
- (temporary exclusion criteria) Acute suicidal risk

2.3. Discharge Criteria

- Depressive symptom level within the normal range (i.e., PHQ-9 score ≤ 4, item 1 and 2 score < 2); and
- Achievement in recovery orientated goals (i.e., achieve at least one personal recovery goal); and
- Improvement in protective factors:
  - Improvement in life engagement (i.e., add at least one meaningful activity on a Typical Day); or
  - Improvement in social support network (i.e., connect with DECC, NEC, or other social services; or add at least one name to Name Generator)
  - Reduction in loneliness to normal range (i.e., UCLA Loneliness Scale score < 3)

*Any persons meeting the inclusion criteria are eligible to receive JC JoyAge service, regardless of other interventions or services (e.g., Hospital Authority) they are currently receiving.

3. Case Identification

3.1. Open Referral

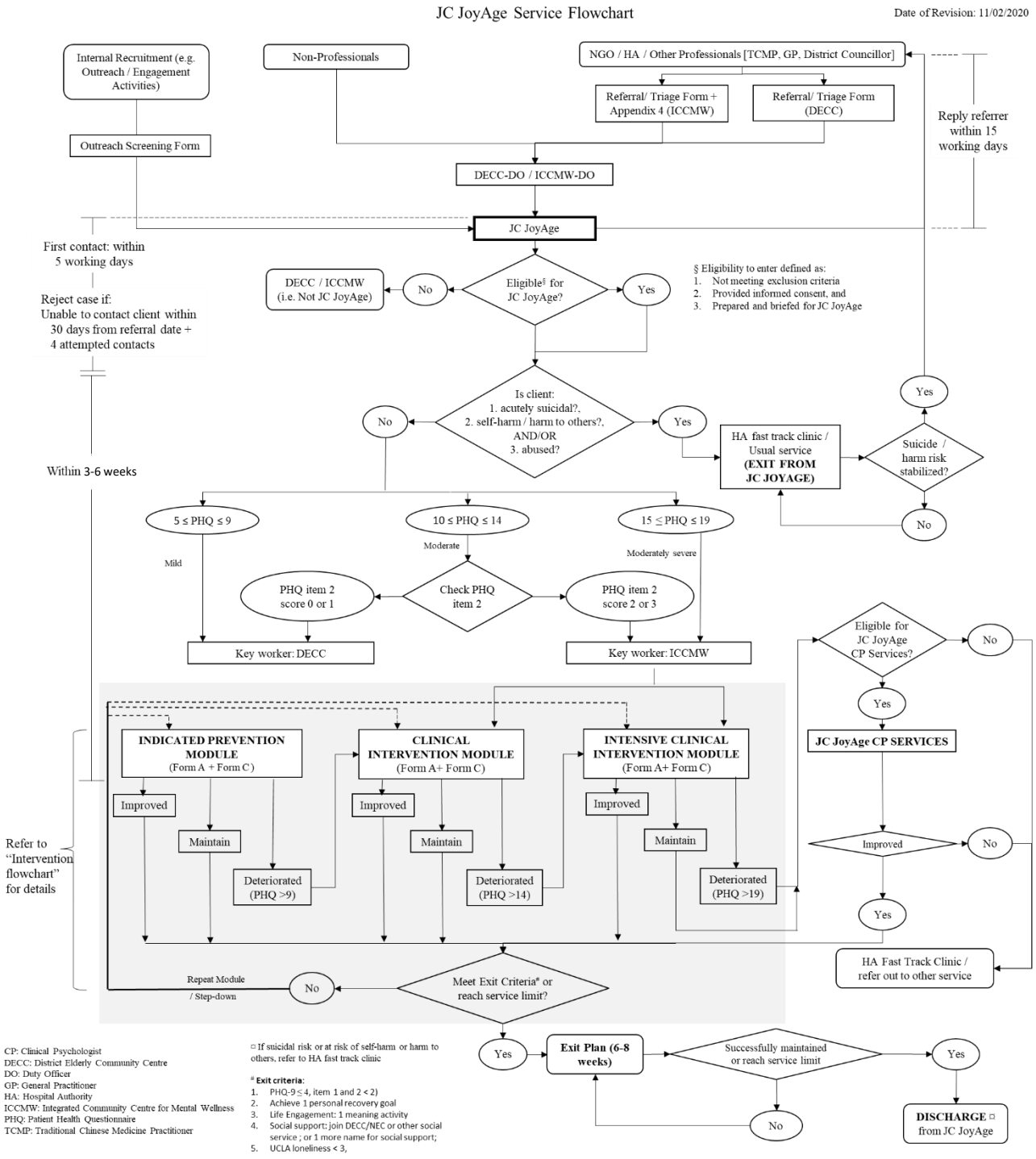
- Referring parties assess eligibility (Appendix: Referral Form); the older persons are eligible when
  - the assessment result is suggestive of mild depressive symptoms or above (PHQ-9 score ³ 5)

3.2. Outreach (e.g., street booth, talks, home visit)

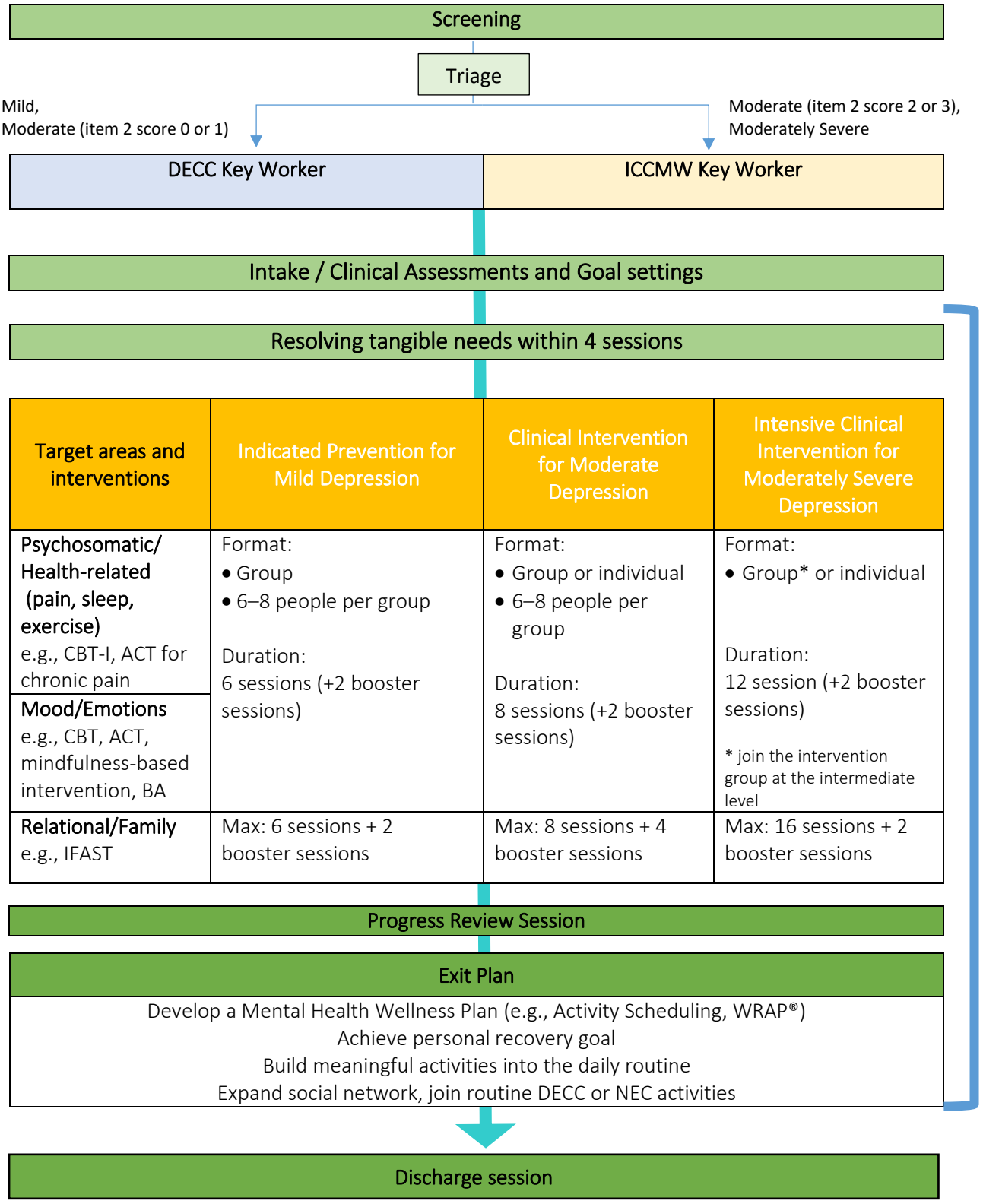
- Project Social Workers or Peer Supporters assess eligibility (Appendix: Outreach Screening Form); the older persons are eligible when
  - the assessment result is suggestive of mild depressive symptoms or above (PHQ-9 score ³ 5)

4. JC JoyAge Flowchart

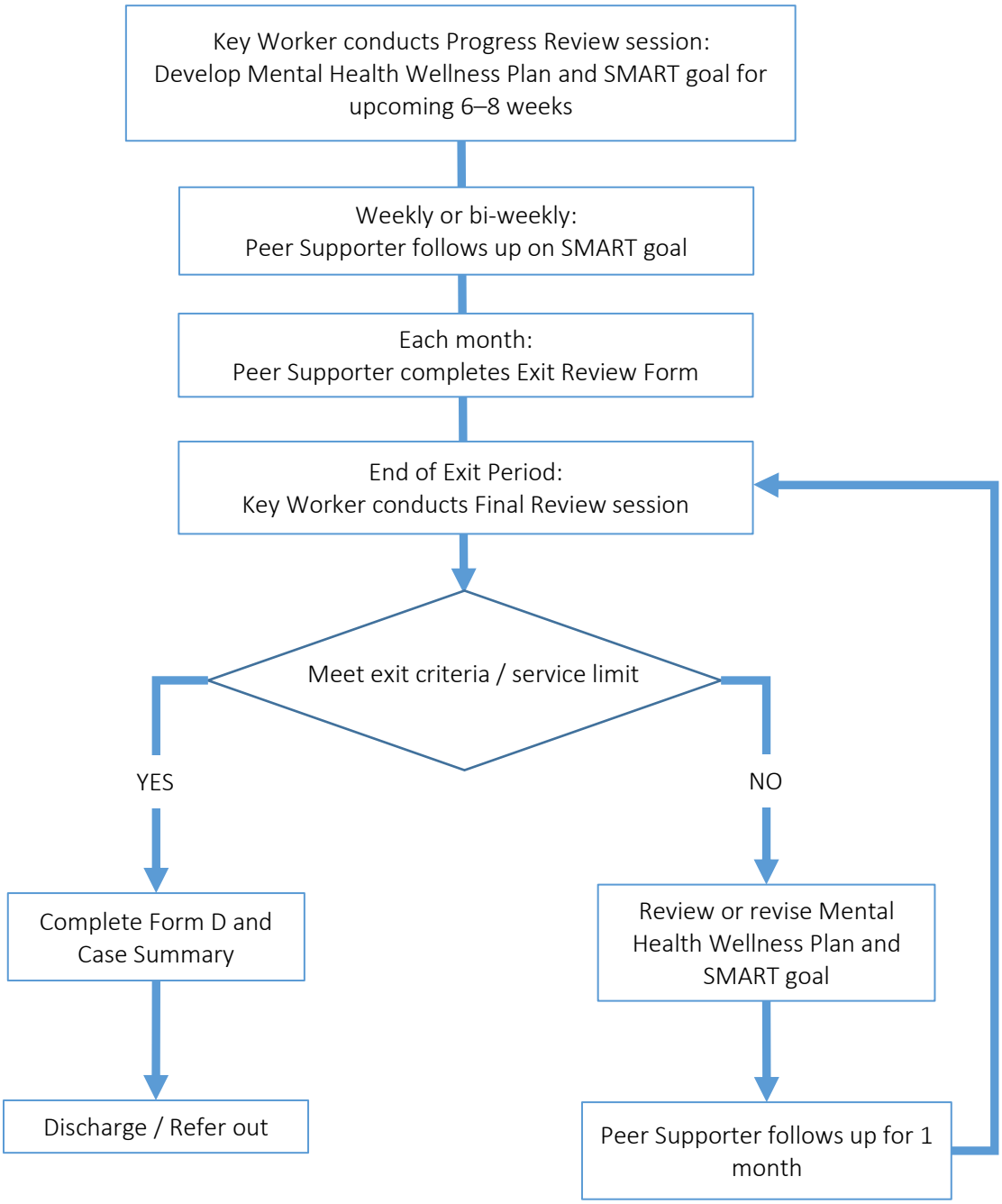
4.1. Service Flowchart



4.2. Overview of Intervention flow



4.3 Exit Period Flowchart



Module 1: Indicated Prevention for "Mild Depression" Group

1. Target Participants & Step-up/Step-down Criteria

1.1. Target Participants

- PHQ-9 score of 5 to 9
- Client will be followed up by DECC Key Worker

1.2. When to Step Up to ICCMW

- The older person should be stepped up to Clinical Intervention for Moderate Depression population when the person shows
  - increased PHQ-9 score to ≥10; and
  - increase in depressive mood (i.e., PHQ-9 item 2 score ≥ 2)
  - (optional and decide on a case-by-case basis) no improvement after the standard course of intervention (see Intervention in Module 1)

1.3. When to Exit, or Refer Out

- Exit Plan should be invoked when the person meets the discharge criteria
- Key Worker should consider referring the person out to other appropriate services (e.g., DECC, IMHP) when the person shows no improvement after the standard course of intervention (see Intervention in Module 1)

2. Assessment and Form

2.1. Form, Measurement Tools and Schedule

Domains	Measurement	Assessor		1st Consultation		Before & after group	Review/Discharge	
		SW	PS	New	Step-down		SW	PS
Depression	PHQ-9	ü		Form A	ü	ü	Form D + Case Summary	ü
Suicidal Risk	Suicidal Risk	ü			ü			
Anxiety	GAD-7	ü				ü		
Loneliness	UCLA Loneliness	ü				ü		
Social Support	Name Generator	ü						
Quality of Life	EQ-5D	ü						
Cognition	MoCA-5	ü						
Recovery goal	GAS				ü			
Clinical Intake (Form C)		ü		ü				
Service use	CSRI	ü						
Recovery	RAS	ü						
Daily Activities & Life Engagement	Typical Days	ü	ü	ü		ü		ü
Sleep*	ISI	ü	ü			ü	ü	
Pain*	FPS-R	ü	ü			ü	ü	
Frailty*	FRAIL	ü	ü			ü	ü	

PHQ-9 = Patient Health Questionnaire-9; GAD-7 = General Anxiety Disorder-7; EQ-5D-5L = EQ-5D five-level; MoCA-5 = Montreal Cognitive Assessment 5-Minute Protocol; GAS = Goal Attainment Scale; CSRI = Client Service Receipt Inventory; RAS = Recovery Assessment Scale; ISI = Insomnia Severity Index; FPS-R = Faces Pain Scale – Revised; FRAIL = 5-item FRAIL Scale.
*Assessed only where indicated.

Note: Whenever appropriate, explore and record if the person is having or interested in medical treatment on top of the project programmes. Provide information and other support if needed.

3. Intervention

3.1. Core Elements & Principles

3.1.1. Targeting Specific Stressors, Coping and Personal Recovery Goal

- Intervention goal: to reduce depressive symptom level to < Mild Depression, enhance resilience
- Target specific stressors, coping strategies, and negative cognition
- Work on client's personal recovery goal

3.1.2. Matching Intervention Strategy to Personal Recovery Gaol, Needs and Readiness

- **Low-intensity psychotherapy groups such as CBT** can be used as a first-line intervention for older persons whose main complaints involve low mood and negative thoughts (i.e., scored on PHQ-9 items 2 and 6) may have greater needs or readiness.
- **Low-intensity psychotherapy groups targeting specific concerns** can be used as a first-line intervention for those whose chief concerns are somatic (e.g., sleep, pain).
- **Relational approach** can be considered for those whose chief concerns are relationship issue.

3.2. Intervention Format

3.2.1. Low-intensity Psychotherapy

- Objective: to improve mood using brief psychotherapy
- First-line intervention approach: psychotherapy group (target on mood in general or somatic symptoms)
    - Topics: mood, pain, sleep, stress, behavioural activation
    - Duration: 6–8 group sessions (include two individual booster sessions where indicated)
    - Group size: up to 6 persons (max. 8) per worker
- Other treatment approaches for consideration: individual/relational approach
    - When the client's main concern is relationship issue or where an individual approach is more suitable
    - Possible approaches:
        - Individual psychotherapy (CBT, ACT)
        - Behavioural activation
        - Problem-solving therapy
        - Relational or family therapy
    - Duration: 6–10 sessions

3.3. Intervention Flow

If more than one intervention within this category is needed, possible intervention sequences include:

- 1st Psychotherapy group è 2nd psychotherapy group (on other topics)
- 1st Psychotherapy group è Individual/relational approach
- Individual/relational approach è psychotherapy group (on other topics)

Note: Parallel provision of intervention is **not** encouraged

For persons receiving low-intensity psychotherapy group as the first-line intervention:

Step		Goal	Key Worker Tasks	PS Tasks
1	1st consultation	To assess, build rapport, and formulate a strategy	1. Low-intensity Clinical Assessment and service matching 2. Set personal recovery goal	Nil
2	Engagement & resolving tangle needs (new case only)	To engage, assess, build rapport, and provide resources	1. Motivational interview 2. Rapport building, 3. Resource building/ welfare referral 4. Engage and prepare the client for low-intensity psychotherapy	1. Engagement 2. Assess Typical Days and life engagement
3	Low-intensity psychotherapy session	To increase coping skills, resilience, awareness of mental health, improve mood	Deliver low-intensity psychotherapy (group or individual) on 1. Mood; or 2. Specific somatic issues; or 3. Relational issue Note: The group can be held by social workers other than the Key Worker	Assist the person to engage in group and tasks
4	Last psychotherapy session	To evaluate mood changes and further needs	Done by SW who holds the group (may not be the Key SW): 1. Wrap up/consolidate or highlight mental health elements 2. Post-Group Evaluation	Assess Typical Days and life engagement
5	Progress Review session	To determine the next step: • step-down; • step-up; • initiate the exit process; or • plan for referring out	1. Discuss with the client on the progress of personal recovery goal and PHQ-9 2. Plan the next action and engage clients in the next steps 3. Arrange handover session and case summary for stepping up if needed	Accompany the person for step-down, step-up, or outside service if needed
If Progress review suggests the older person's condition • improves and meets the exit criteria, develop the Mental Health Wellness Plan for exit period (go to Step 6) • improves but not meeting exit criteria: repeat steps 3–4 ONCE (consider different topics, add individual booster sessions or change to a different approach); ▪ **Upon reaching the service limit (i.e., two rounds or nine months of intervention), if the older person shows no improvement, consider referring out (go to Step 6)** • deteriorates and/or requires more intensive intervention: arrange step-up				
6	Exit Plan	To further improve or consolidate protective factors	Regular meeting with Peer Supporters on client's progress	1. Regular follow-up for 6–8 weeks 2. Reinforce a Mental Health Wellness Plan

				3. Complete PS Exit Review Form monthly
7	Full Review session	To plan for discharge or referring out; and consolidate coping, resilience, and protective factors	1. Discuss with the client on the progress of A. Mental Health Wellness Plan B. SMART goals 2. Complete Form D and Case Summary	Nil

Module 2: Clinical Intervention for "Moderate Depression" Group

1. Target Participants & Step-up/Step-down Criteria

1.1. Target Participants

- PHQ-9 score of 10–14 (with item 2 scoring 0 or 1), client will be followed up by DECC Key Worker
- PHQ-9 score of 10–14 (with item 2 scoring 2 or 3), client will be followed up by ICCMW Key Worker

1.2. When to Step Up or Refer Out

- DECC Key Worker should consider stepping the older person up to ICCMW if the person shows
  - an increased PHQ-9 score to ≥15; or
  - prominent suicidal risk
- Key Worker should consider referring the person out to other appropriate services (e.g., IMHP, ESPP) if the person shows
  - no improvement after the standard course of intervention (see Intervention in Module 2), or
  - deterioration in mental health (i.e., PHQ-9 score ≥ 20), or
  - acute suicidal risk

1.3. When to Step Down, Exit

- The older person should be stepped down to Mild Depression (consider using a psychoeducation group as the intervention principle) if PHQ-9 score decreases to between 5 and 9
- Exit Plan should be invoked when the person meets the discharge criteria

2. Assessment and Form

2.1. Form, Measurement Tools and Schedule

Domains	Measurement	Assessor		1st Consultation		Before & after group	Review/Discharge	
		SW	PS	New	Step-up		SW	PS
Depression	PHQ-9	ü		Form A	ü	ü	Form D + Case Summary	ü
Suicidal Risk	Suicidal Risk	ü			ü			
Anxiety	GAD-7	ü				ü		
Loneliness	UCLA Loneliness	ü				ü		
Social Support	Name Generator	ü						
Quality of Life	EQ-5D	ü						
Cognition	MoCA-5	ü						
Recovery goal	GAS				ü			
Clinical Intake (Form C)		ü		ü				
Service use	CSRI	ü						
Recovery	RAS	ü						
Daily Activities & Life Engagement	Typical Days	ü	ü	ü		ü		ü
Sleep*	ISI	ü	ü			ü	ü	
Pain*	FPS-R	ü	ü			ü	ü	
Frailty*	FRAIL	ü	ü			ü	ü	

PHQ-9 = Patient Health Questionnaire-9; GAD-7 = General Anxiety Disorder-7; EQ-5D-5L = EQ-5D five-level; MoCA-5 = Montreal Cognitive Assessment 5-Minute Protocol; GAS = Goal Attainment Scale;

CSRI = Client Service Receipt Inventory; RAS = Recovery Assessment Scale; ISI = Insomnia Severity Index; FPS-R = Faces Pain Scale – Revised; FRAIL = 5-item FRAIL Scale.
*Assessed only where indicated.

Note: Whenever appropriate, explore and record if the person is having or interested in medical treatment on top of project programmes. Provide information and other support if needed.

3. Intervention

3.1. Core Elements & Principles

- *Evidence-based Psychotherapy*
  - Evidence-based psychotherapy (e.g., CBT) will be used in this clinical population.
  - The goal is to improve depressive symptoms to a normal level and facilitate the achievement of the personal recovery goal
  - For cases who had received similar psychotherapy elsewhere, repeating the therapy can still be beneficial.
- *Choosing Strategy According to Potential Benefits/Effectiveness*
  - Group sessions may be considered for those who may benefit from group dynamics and support when involved in a mild group. In doing so, workers need to consider the client's willingness, his or her mental state, risk level, ability to engage in a group setting to decide the suitability.
  - Individual sessions may be appropriate when symptom level is high and/or the person's condition involves complex issues.
  - Relational approach may be considered if the client's major concern is relationship issue.

3.2. Risk Assessment and Management

- Frequent and regular risk assessment is recommended.

3.3. Intervention Format

- *Approaches*
  - Cognitive Behavioural Therapy
  - Behavioural activation
  - Problem-solving therapy
  - Acceptance and Commitment Therapy
  - Mindfulness-Based Intervention
  - Relational/family approaches
- *Format*
  - Individual/relational approach: 8–12 sessions; or
  - Group: 8 sessions (plus two individual booster sessions where indicated)

3.4. Intervention Flow

If more than one intervention within this category is needed, possible intervention sequences include:

- 1st Psychotherapy group è 2nd psychotherapy group (on other topics)
- 1st Psychotherapy group è Individual/relational approach
- Individual/relational approach è psychotherapy group

Note: Parallel provision of intervention is **not** encouraged

Step		Goal	Key Worker Tasks	PS Tasks
1	1st consultation	To assess, build rapport, and formulate a strategy	1. Low-intensity Clinical Assessment and service matching 2. Set personal recovery goal	Nil
2	Engagement & resolving tangle needs (new case only)	To engage, assess, build rapport, and provide resources	1. Motivational interview 2. Rapport building, 3. Resource building/ welfare referral 4. Engage and prepare the client to psychotherapy	1. Engagement 2. Assess Typical Days and life engagement
3	Psychotherapy session (group/ individual)	To improve mood and/or relationship	Deliver low-intensity psychotherapy	Assist the person to complete homework if needed
4	Last psychotherapy session	To evaluate mood changes and plan relapse prevention	1. Wrap up 2. Assess mood 3. Relapse prevention	Assess Typical Days and life engagement
5	Progress Review session	To determine the next step: • step-down; • step-up; or • plan for referring out	1. Discuss with the client on the progress of personal recovery goal and PHQ-9 2. Plan the next action and engage clients in the next steps 3. Arrange handover session and case summary for stepping up if needed	Accompany the person for step-down, step-up, or outside service if needed
If Progress review suggests the older person's condition • improves and meets the exit criteria, develop a Mental Health Wellness Plan for exit period (go to Step 6) • improves but not meeting the exit criteria, consider conducting a (group/individual-based) booster session, or, with special consideration, provide a second round of intervention (e.g., psychotherapy group on specific topics; relational approach) ○ **Upon reaching the service limit (i.e., two rounds or nine months of intervention), if the older person shows deterioration, consider increasing intervention intensity, changing intervention focus, or referring out (go to Step 6)** • deteriorates and/or requires more intensive intervention, arrange step-up				
6	Exit Plan	To further improve or consolidate the protective factors	Regular meeting with Peer Supporters on client's progress	1. Regular follow-up for 6–8 weeks 2. Reinforce a Mental Health Wellness Plan

				3. Complete PS Exit Review Form monthly
7	Full Review session	To plan for discharge or referring out; and consolidate coping, resilience, and protective factors	1. Discuss with the client on the progress of A. Mental Health Wellness Plan B. SMART goals 2. Complete Form D and Case Summary	Nil

Module 3: Intensive Clinical Intervention for "Moderately Severe Depression" Group

1. Target Participants & Step-up/Step-down Criteria

1.1. Target Participants

- PHQ-9 score of 15 to 19;
- Client will be followed up by ICCMW Key Worker

1.2. When to Refer Out

- Key Worker should consider referring the person to other appropriate services (e.g., IMHP, ESPP) if the person shows
  - no improvement after the standard course of intervention (see Intervention in Module 3), or
  - deterioration in mental health (i.e., PHQ-9 score ≥ 20), or
  - acute risk of suicide

1.3. When to Step Down, Exit

- The person should be stepped down to Mild Depression Module (consider using psychoeducation group as intervention principle for these clients) if the person's PHQ-9 score decreases to between 5 and 9
- Exit Plan should be evoked when the person meets the discharge criteria

2. Assessment and Form

2.1. Form, Measurement Tools and Schedule

<table>
<tr><th rowspan="2">Domains</th><th rowspan="2">Measurement</th><th colspan="2">Assessor</th><th colspan="2">1st Consultation</th><th colspan="2">Review/Discharge</th></tr>
<tr><th>SW</th><th>PS</th><th>New</th><th>Step-up</th><th>SW</th><th>PS</th></tr>
<tr><td>Depression</td><td>PHQ-9</td><td>ü</td><td></td><td rowspan="8">Form A</td><td>ü</td><td rowspan="9">Form D + Case Summary</td><td>ü</td></tr>
<tr><td>Suicidal Risk</td><td>Suicidal Risk</td><td>ü</td><td></td><td>ü</td><td></td></tr>
<tr><td>Anxiety</td><td>GAD-7</td><td>ü</td><td></td><td></td><td></td></tr>
<tr><td>Loneliness</td><td>UCLA Loneliness</td><td>ü</td><td></td><td></td><td></td></tr>
<tr><td>Social Support</td><td>Name Generator</td><td>ü</td><td></td><td></td><td></td></tr>
<tr><td>Quality of Life</td><td>EQ-5D</td><td>ü</td><td></td><td></td><td></td></tr>
<tr><td>Cognition</td><td>MoCA-5</td><td>ü</td><td></td><td></td><td></td></tr>
<tr><td>Recovery goal</td><td>GAS</td><td>ü</td><td></td><td></td><td>ü</td><td></td></tr>
<tr><td colspan="2">Clinical Intake (Form C)</td><td>ü</td><td></td><td>ü</td><td></td><td></td><td></td></tr>
<tr><td>Service use</td><td>CSRI</td><td>ü</td><td></td><td></td><td></td><td>ü</td><td></td></tr>
<tr><td>Recovery</td><td>RAS</td><td>ü</td><td>ü</td><td></td><td></td><td></td><td>ü</td></tr>
<tr><td>Daily Activities & Life Engagement</td><td>Typical Days</td><td>ü</td><td>ü</td><td>ü</td><td></td><td></td><td>ü</td></tr>
</table>

PHQ-9 = Patient Health Questionnaire-9; GAD-7 = General Anxiety Disorder-7; EQ-5D-5L = EQ-5D five-level; MoCA-5 = Montreal Cognitive Assessment 5-Minute Protocol; GAS = Goal Attainment Scale; CSRI = Client Service Receipt Inventory; RAS = Recovery Assessment Scale.

Note: Whenever appropriate, explore and record if the person is having or interested in medical treatment on top of project programmes. Provide information and other support if needed.

3. Intervention

3.1. Core Elements & Principles

3.1.3. Evidence-based Psychotherapy

- Evidence-based high-intensity psychotherapy (e.g., CBT) will be used for this clinical population.
- The goal is to improve depressive symptoms to a subclinical or normal level.
- For cases who had received similar psychotherapy elsewhere, repeating the therapy can still be beneficial.

3.1.4. Choosing Strategy According to Potential Benefits/Effectiveness

- **Individual sessions** may be appropriate when symptom level is high and/or the person's condition involves complex issues.
- **Group sessions** may be considered for less severe cases who may benefit from group dynamics and support when involved in a mild group. Careful consideration is needed to ensure the client is suitable and can have meaningful participation in a group setting.
- **Relational approach** may be considered if the client's major concern is relationship issue.

3.1.5. Risk Assessment and Management

Frequent and regular risk assessment is recommended.

3.2. Intervention Format

3.2.3. Approaches

- Cognitive Behavioural Therapy
- Problem-solving therapy
- Acceptance and Commitment Therapy
- Mindfulness-Based Intervention
- Relational/family approaches

3.2.4. Format

- Individual/Relational approach: 12–16 sessions; or
- Group: join the group at intermediate level (plus two to four individual booster sessions where indicated)

3.3. Intervention Flow

If more than one intervention within this category is needed, possible intervention sequences may include:

- Individual/relational approach è psychotherapy group (on other topics)
- 1st Psychotherapy group è Individual/relational approach
- 1st Psychotherapy group è 2nd psychotherapy group (on other topics)

Note: Parallel provision of intervention is **not** encouraged

Step		Goal	Key Worker Tasks	Peer Supporter Tasks
1	1st consultation	To assess, build rapport, and formulate a strategy	1. Low-intensity Clinical Assessment and service matching 2. Set personal recovery goal	Nil
2	Engagement & resolving tangle needs (new case only)	To engage, assess, build rapport, and provide resources	1. Motivational interview 2. Rapport building,	1. Engagement 2. Assess Typical Days and life engagement

			3. Resource building/ welfare referral 4. Engage and prepare the client to high-intensity psychotherapy	
3	Psychotherapy session (group/ individual)	To improve mood and/or relationship	Deliver high-intensity psychotherapy	Assist the person to complete homework if needed
4	Last psychotherapy session	To evaluate mood changes and plan relapse prevention	1. Wrap up 2. Assess mood 3. Relapse prevention	Assess Typical Days and life engagement
5	Progress Review session	To determine the next step: • step-down; • step-up; or • plan for referring out	1. Discuss with the client on the progress of personal recovery goal and PHQ-9 2. Plan the next action and engage clients in the next steps 3. Arrange handover session and case summary for step down if needed	Accompany the person for step-down, step-up, or outside service if needed
If Progress review suggests the older person's condition • improves and meets exit criteria, develop Mental Health Wellness Plan for exit period (go to Step 6) • improves but not meeting exit criteria, consider conducting a (group/individual-based) booster session, or, with special consideration, providing a second round of intervention (e.g., psychotherapy group on specific topics; relational approach) ○ Upon reaching service limit (i.e., two rounds or nine months of intervention), if the older person ▪ shows deterioration, consider increasing intervention intensity, changing intervention focus, or referring out (go to Step 6) ▪ remains at Mild Depression level (i.e., PHQ-9 = 5–9), step down to JoyAge DECC service • deteriorates and/or requires more intensive intervention, arrange step-up				
6	Exit Plan	To further improve or consolidate protective factors	Regular meeting with Peer Supporters on client's progress	1. Regular follow-up for 6–8 weeks 2. Reinforce a Mental Health Wellness Plan 3. Complete PS Exit Review Form monthly
7	Full Review session	To plan for discharge or referring out; and consolidate coping, resilience, and protective factors	1. Discuss with the client on the progress of A. Mental Health Wellness Plan B. SMART goals 2. Complete Form D and Case Summary	Nil