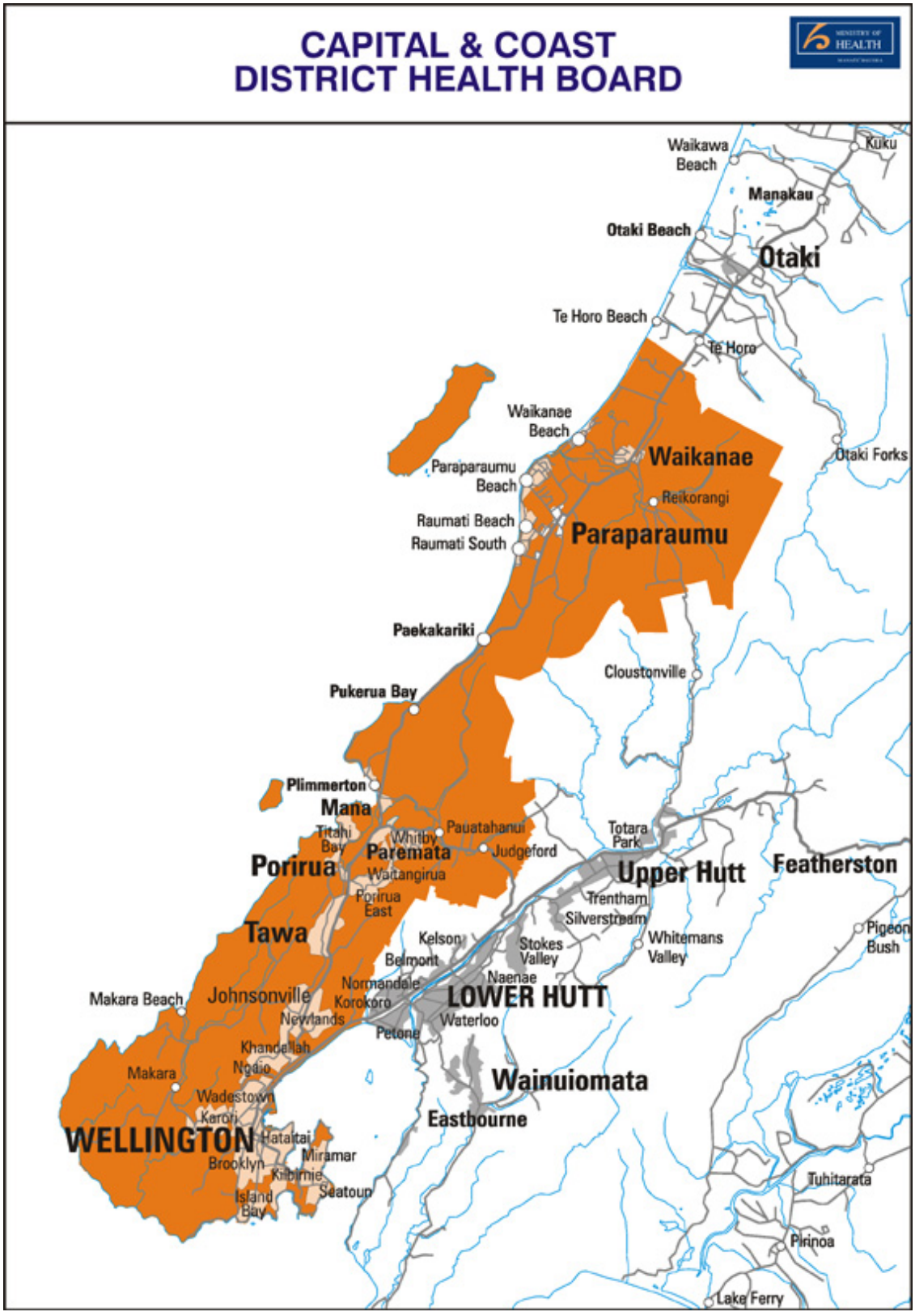
CENTRAL REGION'S MENTAL HEALTH NEEDS ASSESSMENT & SERVICE COORDINATION SERVICES

Capital & Coast DHB	Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA
Hawkes Bay DHB	HAWKE'S BAY District Health Board
Hutt Valley DHB	HUTT VALLEY DHB
Mid Central DHB	MidCentral District Health Board Te Pae Hauora o Ruahine o Tararua
Wairarapa DHB	Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa
Whanganui DHB	WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui

A resource for Staff

Contents

Capital & Coast DHB Map



DHB Population Base: **288,100** (https://en.wikipedia.org/wiki/District_health_board)

Capital & Coast DHB Mental Health NASC Services

Contact Details	Te-Upoko-me-te-Whatu-o-Te-Ika Mental Health, Addictions and Intellectual Disability Service (3DHB) Level 8, BNZ Tower, 14 Hartham Place, Porirua P O Box 50-215, Porirua Telephone: (04) 381 1600 Mobile: 027275 8913 Facsimile: (04) 381 1640
Team Profile	0.5 FTE Clinical Team Leader 5.0 FTE Clinical currently consisting of a mix of service coordinators (nurses, occupational therapists and social workers). 1.5 Administration
Access	18 years and over with some flexibility for those aged 16-18years. Referrals from any source. Referrals must meet the following eligibility criteria: 1. Mental Health and/ or Addiction diagnosis from secondary/tertiary mental health provider; and 2. Support needs that are driven by mental health and/or addiction issues.  Te Ara Pai Referral to Services - digital v
Approach	All of the providers of services for Capital & Coast DHB Mental Health have a bulk funding arrangement. This includes residential and community support.

Needs Assessment

Complex

Assessments are completed by NASC. Complex is described as a person with multiple areas of need who may have a number of clinicians and services involved in their care.

Needs Assessment Document (Complex)

Te Ara Pai Personalised Plan V5

Non Complex

Assessments completed by Navigators. Navigators are community based. (In locations outside of the Capital & Coast DHB geographical area, the Navigator role is similar to that of a support worker.)

Service Coordination

Completed in a personalised plan that is part of the Needs Assessment.

Services

Purchase Code	Descriptor	Provider/s	Service Name	Volume	Comments
MHA20D	Adult community support services – Non-clinical staff	Pathways	Navigation	31 FTE	Navigators work alongside people to develop their personalised plan, set goals, define actions and access relevant community services. Support hours are defined by actions in plan.
		Richmond			
MHA20E	Adult community support services - Cultural staff	Te Waka Whaiora	Navigation	7 FTE	Kaupapa Maori
		Vaka Tautua		4 FTE	Pacific
MHA20DH	Adult community support services- Non-Clinical Staff-UoM hour	Pathways	Home Based Support Services.	43000 hours	Support staff work with people to live independently at home – this support is to assist with developing skills in daily planning, cooking, cleaning, taking medication, attending appointments, developing exercise programs from home.
		Richmond			

			Te Waka Whaiora			This service is 7 days per week from 0700-2200. Hours of support are allocated based upon identified needs.
	MHA20C	Adult community support services – Nurses & allied health staff	Pathways	Health and Wellbeing Team	5 clinical FTE – 3 nurses and 2 Occupational Therapists.	Staff work alongside Te Ara Pai and Housing and Recovery Providers to support people to develop and implement plans that address health issues that may be a barrier to achieving recovery goals.
	MHA22D	Vocational support service - Non-clinical staff	Workwise	Occupation Services	5 FTE	1 Education consultant and 4 Employment/Occupation consultants. Support people into occupation or assist people to retain occupation.
	MHA23D	Housing coordination service- non clinical staff	Pathways	Keys Housing Facilitation Service	4 FTE	Support people to find and maintain tenancies. Develop networks with housing providers to enhance accessibility.
	MHA24	Housing and recovery services day time/awake night support	Pathways	Whitiora	16 beds	Mix of single, double and 3 bedroom units. Based in Titahi Bay.
			MASH Ribbonwood	11 beds (Mix of MHA24 & 25 on same site)	Mix of single, double and 3 bedroom units. Based in Ranui Heights. Provider also has contract for 11 beds for disability services.	
			Timata Hou Hillcrest	19 beds (16 bulk funded – 3 fee for service)	6 houses on one site in Raumati South. 5 additional beds available Registered Nursing through the day	

			Richmond Henry Street	12 beds	Mainly older adults in 3 houses on one site in Kilbernie	
			Richmond King Street	8 beds (Mix of MHA24 & 25 on same site)	4 townhouses on one site collocated with a further 2 houses that have youth crisis respite and the office. Service is for under 25, and length of stay is maximum 2 years.	
			MASH Mapuia	5	Shared houses on three separate sites.	
			MASH Mirimar	7	Mirimar is 2 town houses on same site.	
			MASH Wellington Road	5		
	MHA25	Housing and recovery services day time/responsive night support	MASH	Baffin	6	Shared houses on separate sites.
				Blakey	6	
			Te Menenga Pai	Newtown	12 beds	Shared house, meals provided, Kaupapa Maori. 2 additional beds in house that are rented to tenants.
	MHW68D	Family whānau support education, information and advocacy service – Non-clinical staff	Atareira	Offices based in central Wellington, but each field worker is linked to a local area.	6 family field workers. 1.0 FTE – cultural – Specifically Maori and Pacific. 1.0 FTE counsellor for family members.	Community based service that provides support, education, information and advocacy to the family and whānau of mental health Service Users at the place they prefer. The service is flexible in its hours to allow contact with family and whānau who work during the day. Flexi fund for family respite options.

	MHA07	Sub-acute extended care - Inpatient beds	Pathways	Tumanako	6 Beds	Based in Linden, community setting. 2 staff on duty throughout waking hours.
	Provider Arm	Inpatient Rehabilitation Service	CCDHB	Te Korowai Whariki: The service provides both longer-term care (Tawhirimatea Unit) and intensive rehabilitation (Tane Mahuta) within both secure and open settings.	65 Beds (20 are Capital and Coast DHB funded beds)	The service's focus is on recovery and rehabilitation through providing people with the opportunity to learn new skills, as well as gain independence and empowerment for community living. Both units provide clients with individualised recovery, treatment plans in both a safe care and open setting. Rehabilitation length of stay is individual but anticipated to not be longer than 2 years.
Review Process	Community Services are reviewed by the provider, clinical team and client 3 monthly or earlier if required. NASC included in review for complex cases Housing and Recovery services reviewed 6 monthly. Review meeting includes NASC, provider and client. Regional Rehab Services are reviewed every 6 weeks as part of the multidisciplinary team meeting					
InterNASC Process	Transfers in and out of the area are coordinated by the NASC. Assessment and referral completed by NASC. Risk Assessment and other clinical assessments completed by clinical mental health team					
Process for clients with dual or multiple needs	Contact made with relevant NASC i.e. Care Coordination (Older Persons Health NASC) or Capital Support (DSS client group) to discuss best process, and possible joint visit for assessment Monthly meeting with Care Coordination. Monthly meeting with Capital Support.					

Information supplied by Kym Park, Capital and Coast DHB
Updated Dec 2015 by Helene Dore, FOCUS

Capital & Coast Referral form

Te Ara Pai Services: Stepping Stones to Wellness

Referrals should be sent to - tearapaihub@ccdhb.org.nz

Eligibility: *for full information, see Te Ara Pai Services Guidelines*

Date:	NHI:	DOB:	Gender:	Ethnicity:
Surname		Given Name:		
Address:				
Home Phone:		Mobile/Other Phone:		
Mental Health Diagnosis:				
Clinical Care Provider (name & contact details):	Name: CMHT/Organisation: Telephone No:			
Referrer (name & contact details):	Name: CMHT/Organisation: Telephone			
If CCDHB referrer:	Current HONOS: ☐ Wellness Plan attached: ☐ MH Assessment & latest Review attached: ☐			

REFERRAL OPTIONS *(tick checkboxes to select)*

OCCUPATION	☐ Employment Support ☐ Education Support ☐ Skills Development
HEALTH AND WELLBEING FACILITATION	☐ Access to Primary Care ☐ Support with Plans ☐ Complex Health Issues ☐ Smoking Cessation
PERSONAL CONNECTIONS AND SKILLS FOR LIFE	☐ PeerZone ☐ Concrete Jungle
FAMILY/WHĀNAU	☐ Family/Whānau Support ☐ General ☐ Cultural Support Māori ☐ Cultural Support Pasifika ☐ Child and Youth
HOME BASED SUPPORT	☐ Medication support *start date* ☐ Cooking ☐ Household tasks ☐ Personal cares
Chosen Home Based Support Service Provider	☐ Emerge Aotearoa ☐ Pathways Health Ltd ☐ Te Waka Whaiora ☐ Unknown/Unsure
NAVIGATION	☐ Personal planning ☐ Mental health (Hinengaro) ☐ Relationships, Family/Whānau
Chosen Navigation Service Provider	

HOUSING FACILITATION

☐ Tenancy support

☐ Finding a house

If finding a house is selected – *the Housing Facilitation team (as required by Wellington City Council) need the following documents before the initial meeting:*

☐ Current bank statement

☐ 52 week statement of income from Work and Income

☐ Proof of identity – **EITHER:**

One of the following:

☐ Current passport

☐ Refugee card

or -

Two of the following:

☐ Birth certificate

☐ Marriage certificate

☐ Current NZ driver's license

☐ Current photo credit card ID

☐ Current student photo ID

☐ Community services card

	☐ Money & Finances	☐ Emerge Aotearoa
	☐ Spirituality (Wairua)	☐ Pathways Health Ltd
	☐ Physical health (Tīnana)	☐ Te Waka Whaiora
	☐ Education, Training, Work	☐ Vaka Tautua
	☐ Activity	☐ Unknown/Unsure

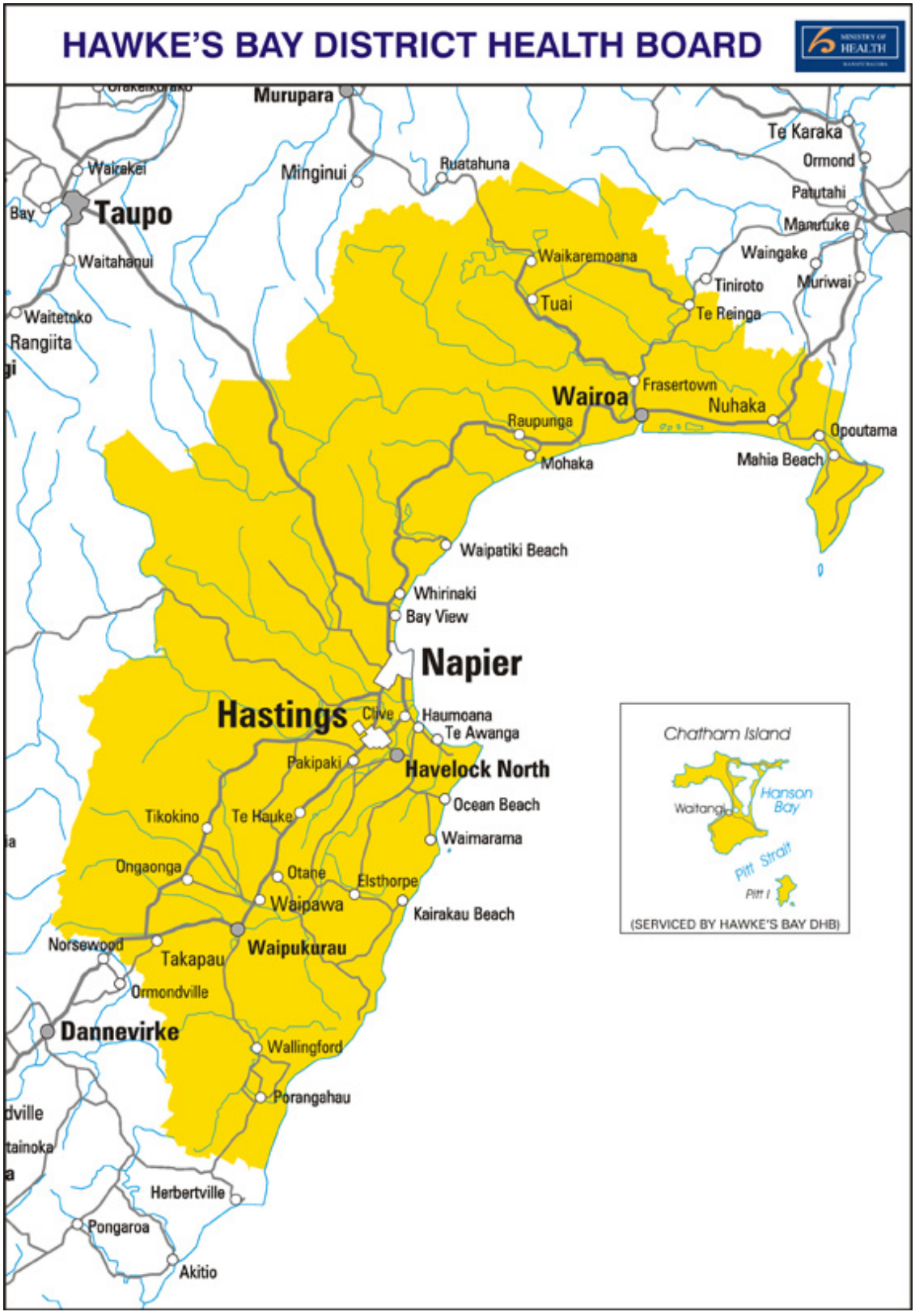
Are there any specific staff requirements (eg gender, ethnicity, age) that we need to be aware of?

If goals are known, please complete this section

Goals	**Hours per week**
Any other comments:	
For CCDHB referrers: If NASC involvement is required, please state reasons:	

Is the person aware of this referral?	YES/NO

Hawkes Bay DHB Map



DHB Population Base 153,900 (https://en.wikipedia.org/wiki/District_health_board)

Hawkes Bay DHB NASC Services

Contact Details	Needs Assessment Service Coordination Mental Health and Addiction Service Hawkes Bay District Health Board (DHB) Private Bag 9014 Hastings, New Zealand Telephone 06 878 8109 (ask for mental health NASC) Duty phone: 027 231 1465 Fax: 06 878 1686
Team Profile	4 FTE Team Leader (Occupational Therapist 1 FTE) Registered Nurse (1 FTE) Support Workers (2 FTE)
Access	All Ages (Eligibility: service and enduring mental health needs as determined by Mental Health secondary services) 1. Referral by key worker or clinician within Mental Health secondary services. Must be current service user of Hawkes Bay DHB Mental Health & Addiction secondary services. Person can continue to be a NASC client after they have been discharged from clinical secondary services. 2. Access to Maternal Mental Health is by referral from key worker. Staff on inpatient ward may refer to key worker if required to access this.  HawkesBayNASC Form updatedApr 201 Attach form core documentation: (or equivalent) • Comprehensive assessment of history • Risk alerts form • Recovery plan

Approach

Residential service providers have a bulk funded arrangement.

Household Management and Personal Care Support have a fee for service arrangement.

Community Support Worker Service has a capacity funding arrangement.

Te Taiwhenua O Herteonga is a separate Kaupapa service that includes:

- Clinical Service
- Community Support Worker for social support
- Residential Care (3 houses in Flaxmere)
- Recovery Centre with a day programme
- Medication Support
- People accessing this service do not require NASC

Needs Assessment

Functions completed by Mental Health NASC Team member with consultation with relevant clinicians.

Needs Assessment Document (Complex)

Hawkes Bay NASC template.dot

Non-complex clients do not require a Needs Assessment form to be completed. Non-complex support is up to 4 hours per week with only 1-2 providers

Service Coordination

No separate template. Combined in electronic clinical application (ECA). ECA is a Shared Care Record detailing NASC process information including the referral, needs assessment, service provision, goals and plan of review.

Services

Purchase Code	Descriptor	Provider/s	Service Name	Volume	Comments
MHA19	Adult Community support services – RNs and non-clinical staff	Access Home health	Home Based Support Services	Fee for service	Support staff work with people to live independently at home – this support is to assist with household management tasks and personal cares. Support hours are defined by individualised Recovery Plan.

		Adult community medication services. Non-clinical with oversight from RN.	Te Taiwhenua O Heretaunga	Medication support	Bulk funded	Support staff provides medication support as per need identified by clinical team: phone/text reminders; weekly drop off; daily delivery medication to people in their own homes. 7 days per week
		Adult Community support services –Non-clinical staff	Healthcare NZ	Home Based Support Services	Fee for service	Support staff work with people to live independently at home – this support is to assist with household management tasks and personal cares. Support hours are defined by individualised Recovery Plan.
		Maternal Mental Health. Karitane nurses. Managed by RN.	Karitane	Home based wrap around service and support for Mother and Baby	Fee for service	Support and advice in the community regarding mother craft skills. Support hours. are defined by individualised Recovery Plan
		Residential Services. Non-clinical staff.	Whatever It Takes	Matariki House	3 bedroomed shared house	Support for people who have mental health and A&D issues. Community support has been tried and failed. Meals and med support provided. Staffed from 5pm to 8am. CSW support provided at times during day.

	MHA25 MHA20D MHF	Adult enhanced community support service. Non clinical staff	Centre care Community Trust	Home Based Support Services including medication support. Access to Day Programme	15 bed capacity	Support staff work with people to live independently at home. Provision of Day Programme during weekdays; medication support service provided 7 days week; breakfast and hot lunchtime meal provided weekdays. On call phone service provided out of hours.
	PH1018 PH1019	Adult community medication services. Non clinical with oversight from pharmacist	Glenn's Pharmacy	Medication support	Bulk funded	Support staff provide medication support as per need identified by clinical team: phone/text reminders; weekly drop off; daily delivery medication to people in their own homes. 7 days per week
	IDF	Inpatient Regional Rehabilitation Service	Capital & Coast DHB	Te Korowai Whariki- The service provides both longer term care (Tawhirimatea) and intensive rehabilitation (Tane Mahuta) within both secure and open settings	4 beds; 1 exception	Provide specialist inpatient rehabilitation programme according to individual needs. Timeframe variable according to individual needs – expectation is 2 years minimum.
	MHA17	Planned respite service. Non-clinical staff	Richmond NZ – now Emerge Aotearoa Ltd	Respite for MHS consumers – not for those in crisis	3 beds	Service is provided in shared house with staff on hand to meet and greet plus some call in support; on call service overnight. Staff not on site 24/7.

	MHA20D	Community Support Worker service. Non-clinical staff	Richmond NZ – now Emerge Aotearoa Ltd	Home based support services	Bulk funded	Support staff work alongside people to develop their personalised plan, set goals, define actions and access relevant community services. Supports are defined by individualised Recovery Plans.
	MHW68D	Family Advocacy Services. Non-clinical staff	Richmond NZ – now Emerge Aotearoa Ltd	Richmond Family/whānau services. Advocacy for consumers, families, parents	Bulk funded	Advocates work with people and their families to provide support and education.
	MH147	Planned Respite for youth. Registered Health Professional has oversight of non-clinical staff.	Richmond NZ – now Emerge Aotearoa Ltd	Respite for CAFS consumers	4 beds	Provides respite for youth in shared house staffed 24/7. House also utilised for crisis respite via CAFS direct..
	MHA24	Residential Services. Non-clinical staff.	Whatever It Takes	Kahukura	10 individual units	24/7 support for people who are unable to manage independently in the community.
				Waghorne Street	4 individual flats	24/7 support for people who are unable to manage independently in the community.
	MHA20F	Community Support Worker Service. Non-clinical staff.	Whatever It Takes	Home based peer support service	Bulk funded	Peer support workers work alongside people to develop their personalised plan, set goals, define actions and access relevant community services. Supports are defined by individualised Recovery Plans.
	MHC33F MHC34F MHC35F	Consumer Advocacy. Non-clinical staff.	Whatever It Takes	Advocacy service for consumers	Bulk funded	Provides advocacy, support and advice for consumers; Consumer Advisor provides input to DHB

	MHA21C MHA21F	Group Day Programme. Social Worker and non-clinical staff	Whatever It Takes	Manaia	25 places	Provides a range of group activities aiming to promote Recovery and Social inclusion
	MHA21C MHA21D MHA21E	Kaupapa Maori Services Group Day Programme. Occupational Therapist and non-clinical staff.	Te Taiwhenua O Heretaunga	Te Puawaitanga	25 places for Kaupapa service; 25 places for mainstream access	Provides a range of culturally based group activities aiming to promote Recovery and Social inclusion

Review Process	Review is planned within shared record (ECA) through service coordination. Maximum time for all reviews are: • Initial review = 1 month • Subsequent reviews=3 months or as required Ideally key worker and NASC complete a joint review
InterNASC Process	Moving in: same as new referrals. Clinician led. Referring NASC will contact NASC with relevant information. Director of Area Mental Health Service (DAMHS) in referring area consults Hawkes Bay DAMHS if person under the Mental Health Act 1992. Moving out: Clinician to clinician in first instance. Followed by contact to NASC in area by Hawkes Bay NASC as necessary.
Process for clients with dual or multiple needs	Negotiate with Options Hawkes Bay as to which assessment tool is most appropriate (ie InterRAI, DSS or Mental Health). One Needs Assessment completed Service provision achieved by negotiation on an individual case by case basis with relevant other NASC or NASCs. Meetings with Options Hawkes Bay around individual cases as required.

Information supplied by Bruce Green and Mary Roberts (Hawkes Bay DHB)
Updated Dec 2015, by Helene Dore, FOCUS

Hawkes Bay DHB Referral

WHAKAWATEATIA
HAWKE'S BAY
District Health Board

Fill in only if patient label is unavailable

Name: ..... DoB: .....

NHI: ..... Phone: .....

Address: .....

Mental Health and Addiction Services

Needs Assessment and Service Coordination Referral Form

PLEASE INDICATE (✓) THE TYPE OF SERVICE BEING REQUESTED:

See reverse of form for service description / location

Residential 24/7 Accommodation *		**Planned Respite**	
Support Needs Assessment *		**Home Support**	
Community Support Worker*		**Personal Cares**	
Friendly Landlord Application *			
Independent Living Skills *			
Rest Home Permanent Placement			
Rest Home Respite			

Details of Service Requested including commencement date:

All support requests require the following:

1. **RECOVERY PLAN** ☐
2. **RISK IDENTIFICATION FORM** ☐

In addition supports marked with a * must also have the following documentation:

3. **COMPREHENSIVE ASSESSMENT / OTHER MENTAL HEALTH ASSESSMENT** ☐

Assessment includes all relevant information appropriate for the service being requested e.g. Current Interventions, Medication etc.

All documentation must have been reviewed within the last 3 months and be completed in full, or a written explanation provided.

I have discussed this with the person using the service and they are in agreement with the referral.

Name: ..... Designation: .....

Signature: ..... Date: .....

Needs Assessment Service Coordination Supports Available

These supports enable a focus on promoting personal skills for support workers to work alongside people in their own recovery goals.

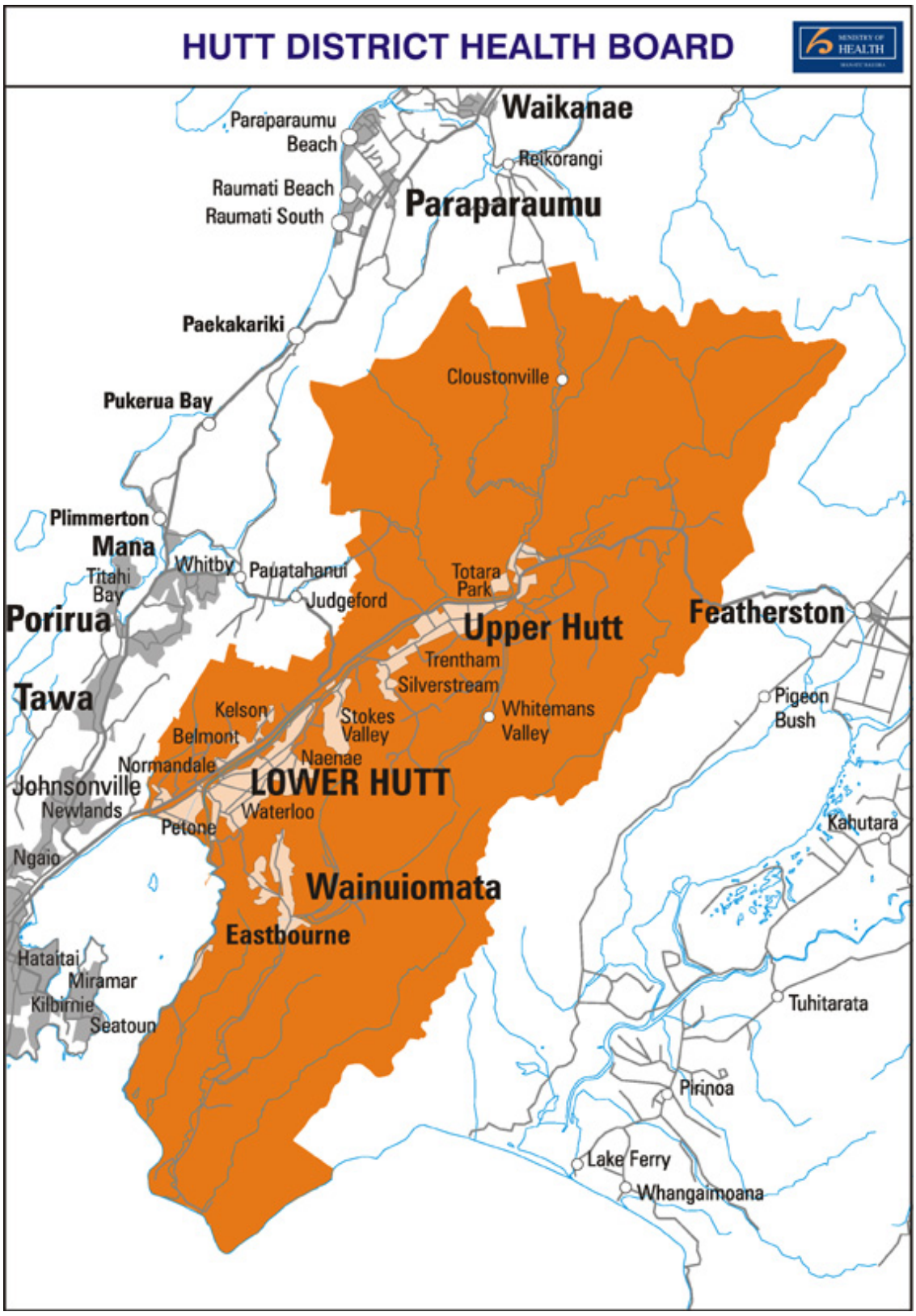
DESCRIPTORS:

Supported Accommodation	Provides a range of support options which includes 24 hours per day/ 7 days per week, or 7 day support, Friendly Landlord, 2-3 hours CSW per week.
Community Support Workers (CSW)	For people who require a CSW to work alongside them to support them in their recovery goals in their own community setting.
Community Respite Options	Provides regular planned respite for people where this supports them in their on-going recovery.

PROVIDERS:

Supported Accommodation	**Community Support Workers**
Ararau Residential 24/7 Kahukura 24/7 Centre Care Friendly Landlord Support Supported Independent Housing Option	Richmond NZ Te Taiwhenua o Heretaunga Kahungunu Executive Trust Central Health (CHB) WIT Centre Care Independent Living Skills Programme
Community Respite Options	
Richmond NZ Planned Respite Other Planned Respite Rest Home Planned Respite Rest Home Unplanned Respite	

Hutt Valley DHB Map



DHB Population Base 142,700 (https://en.wikipedia.org/wiki/District_health_board)

Hutt Valley DHB NASC Services

Contact Details	**Lower Hutt Location** Phone: 04-570 9801 Address: 40-42 Queens Dr, Lower Hutt, Wellington 5010 **Upper Hutt Location** Phone: 04 528 5595 Address: Level 6, CBD Tower, Main Street, Upper Hutt
Team Profile	Team Leader –joint role with Capital & Coast DHB Service Coordinators (2 FTE)
Access	16 years and over 1. Referral by Mental Health Clinical Team  Hutt MHS Referral Form. 17 September : Non Complex Needs Assessment used for support of up to 5 hours per week Hutt Valley DHB Mental Health referral form to Mental Health NASC for complex support needs (more than 5 hours per week required)
Approach	Providers have a Bulk funded arrangement for services that they provide. NASC functions are completed by a mix of clinical team members and NASC team depending on the complexity

Needs Assessment

Complex - Complex assessments completed by NASC.

SNA & Support Plan - Regional NASC Templ

Non Complex

Hutt Valley non complex Needs Asses

Clinical Team members complete non-complex assessments. Service coordination is completed by the NASC - the support required is up to 5 hours per week.

Service Coordination

Support plan completed within the Needs Assessment document by NASC staff.

All referrals and documentation received by service coordination are processed and sent through to the identified Provider

Services

Purchase Code	Descriptor	Provider/s	Service Name	Volume	Comments
MHA20D	Adult community support services – Non-clinical staff	Mental Health Solution / Pathways	No Name	3.9FTE	Enhanced Community Support i.e. CSW with transition accommodation option (Non Clinical)
		Richmond NZ / Emerge Aotearoa	No Name	3.9FTE	CSW from Residential Support
			Broadway	42 Service Users	Intensive transmission Accommodation with CSW
		PACT Wellington	Nil	3FTE	Mobile Community Support for adult
		Te Paepae Arahi	Nil	6.47FTE	Kaupapa Maori Mental Health & Alcohol and Other Drugs Community Support Worker Service for Rangatahi, Pakeke, Kaumatua and their whānau;
MHA20C	Adult community support	Mental Health Solution /	No Name	0.4FTE	Enhanced Community Support i.e. CSW with

		services – clinical staff	Pathways			transition accommodation option (Clinical)
	MHA24	Housing and recovery services day time/awake night support	Richmond NZ / Emerge Aotearoa	Colson Street	9 beds	
	MHA25	Housing and recovery services day time/responsive night support	Richmond NZ / Emerge Aotearoa	Colson Street	3 beds	
			PACT Wellington	Nil	7 Beds	Historically the residents are aged 60 + with long term MH & AOD and age related problems. They have continued to stay in residents for life; more recently the service has been able to place them in their own environments with CSW support
Review Process	Meeting with NGOs that are providing services monthly by NASC Form used is same as Complex Needs Assessment and Non Complex Needs Assessment Monthly reports written by each NGO to identify clients for review discussion and in-service issues Persons support package reviewed between weekly and 6 monthly by NASC 3-6 months if at Tane Mahuta (Regional Inpatient Intensive rehabilitation) and monthly clinical review by Mental Health Clinical Team					
InterNASC Process	Assessment and referral completed by NASC Risk Assessment and other clinical assessments completed by clinical mental health team					
Process for clients with dual or multiple needs	May do joint visit with Life Unlimited (DSS NASC) or Care Coordination (OPH NASC) Each NASC do their own assessment form					

Information supplied by Jayne Combes, De'arna Sculley and Matthew Hedges – Hutt Valley DHB, Simon Phillips (SIDU)
Updated Dec 2015 by Helene Dore, FOCUS

MENTAL HEALTH AND ADDICTION SERVICE – REFERRAL/ TRANSFER OF CARE

☐ Referral Transfer of Care (Tick one) to:

(please tick appropriate) ☐ CMH & A ☐ CREDS ☐ ICAFS ☐ CONSULT LIAISON ☐ OPRS ☐ NASC ☐ CATT

Referral from			Date Time Triage Cat
Surname	NHI		Religion/Spirituality
Given names	DOB / Age	Gender	Occupation / School
Other Names	NZ Resident?		Email
Address	Home Phone		Business Phone Mobile
Ethnicity 1st	Ethnicity 2nd		Ethnicity 3rd

☐ Previous Client of HVDHB MHS? ☐ Current Client of HVDH MHS? *(List care coordinator)*

Legal Status: ☐ Nil ☐ A & D Act ☐ PPPR Act ☐ CYPFA ☐ MHA ☐ CJ Act ☐ Court ordered

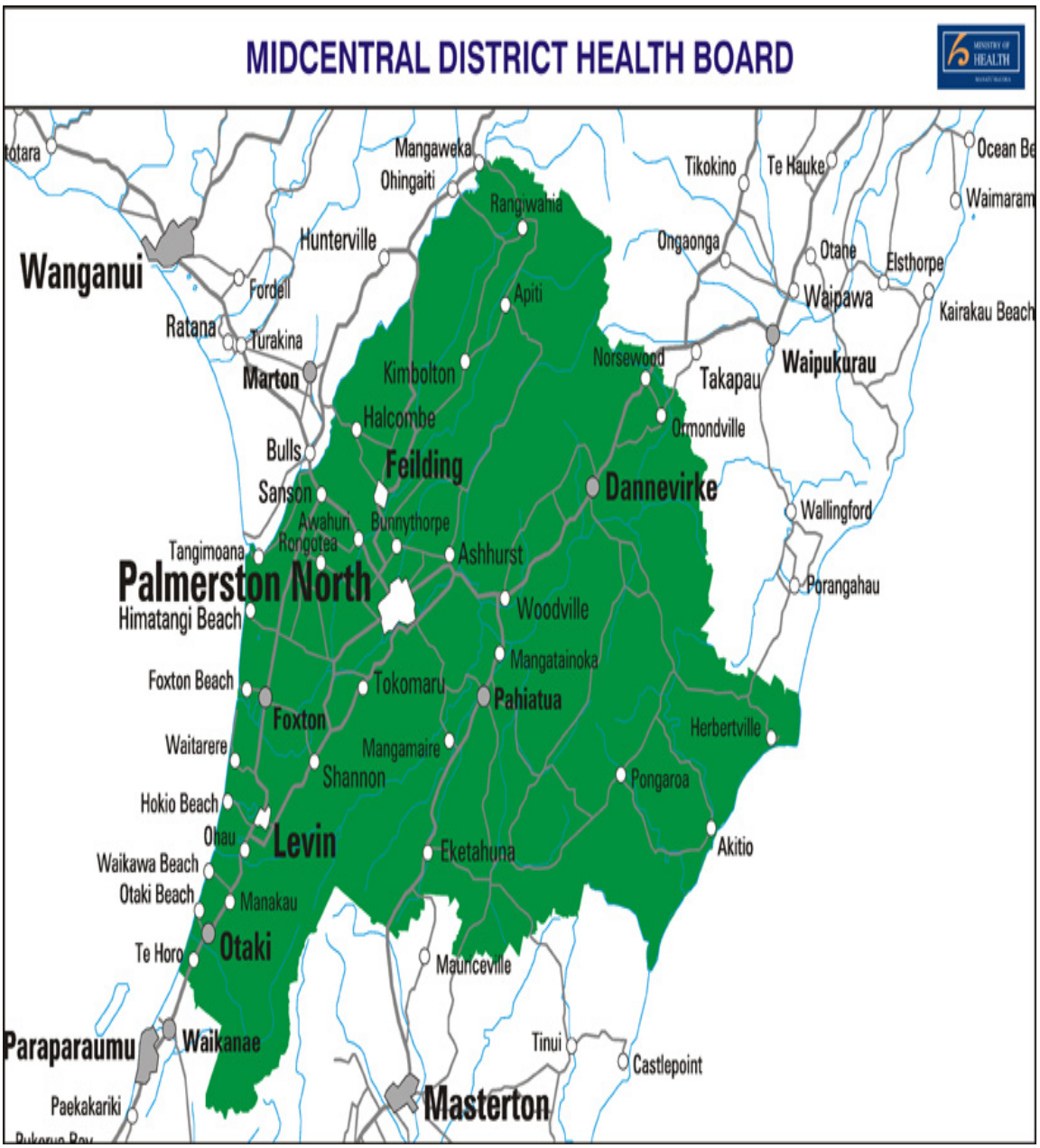
General Practitioner: (Name and Address or N/K)	Next of Kin/Guardian: Relationship:
Telephone ( ) Fax ( )	Address: Phone:

REASON FOR REFERRAL TO THE ABOVE SERVICE

DETAILS: Main mental health/A&D symptoms/problems – include behaviour, key event, time of event, circumstances, sequence of events that led to contact/referral (attach separate page or letter if necessary)

Current medications?:
Safety Issues: *(i.e: risk to self, level of aggression, forensic history, access to weapons etc.)*
Current Social/Living situation – Brief **Whānau**/family history
Significant Others (include children/gender/age) / Support people / Other agencies involved:
What would you like from the Mental Health and Addiction Service? :
Have you discussed the referral with the client (mandatory for people over 16 years of age)? ☐Yes ☐No Have you discussed the referral with the parent/guardians (mandatory for children/young people under 16 years of age)? ☐Yes ☐No
OUTCOME / ACTION PLAN: (Indicate what actions and plans are happening prior to acceptance by MH&AS)
Clinician Signature and designation:
For Office Use Only
Date referral received Referral Received By: ☐ Mail ☐ Phone ☐Fax ☐ E-Mail ☐E-Referral ☐Other
Old Notes: ☐Yes ☐No File Requested: ☐Yes ☐No
Client Information Updated IBA: ☐ Yes ☐ No Referral Entered IBA: ☐Yes ☐ No
Referral: ☐Accepted ☐Routine ☐Urgent ☐Declined ☐Letter Sent To Referrer
Initial Assessment Date: Time: Clinician:
E-Referral Priortised: ☐
Appointment Booked: ☐IBA Updated:☐ Responsible HCP ☐ MDT Review Date
Cover Sheet/Patient Labels Printed: ☐ New Client File Made & Record Set-Up On IBA: ☐
E-Referral Processed: ☐ Appointment Letter Sent To Client: ☐

MidCentral DHB Map



DHB Population Base 166,000 (https://en.wikipedia.org/wiki/District_health_board)

MidCentral Mental Health NASC Services

Contact Details	Sue Fitzpatrick (Service Coordinator) Telephone: 06 3508 035 Mobile: 027 444 8943 Internet Address link: www.suzanne.fitzpatrick@midcentralhealthdhb.govt.nz
Team Profile	1.0 FTE – Clinical Needs Assessment Service Coordinator – incumbent is a registered nurse.
Access	Child and Adult Service 1. Via secondary services: Community Mental Health or Acute Services including Alcohol and Drug (email). 2. Via Primary Health Organisation (PHO) for clients supported by PHO mental health services referring for support (by letter). PHO and CAFS can only access support in community.
Approach	PHO has a Bulk Funded arrangement for the allocation of a support worker for 1 hour per week or as required. The emphasis is on personal care and community integration (no household management). Hands on support or oversight as required. Crisis respite available, if needed. Secondary Services – The Support Needs Assessment is completed by the referrer (if assessment trained) with attached risk assessment and then sent to Service Coordinator, otherwise assessment is completed by Service Coordinator Maternal Mental Health -Up to 5 days for urgent situations (without a needs assessment) – provided by Mash with a flexible package. Completion of a support needs assessment occurs after initial support is established.
Needs Assessment	Referrals are triaged by the Service Co-ordinator who then allocates to one of the following to complete the Needs Assessment: • Service Coordinator or Case Managers for clients in the community • Social worker for clients in hospital. Needs Assessment Document MCDHB_SUPPORT NEEDS ASSESSMENT.

Service Coordination	Completed by service coordinator or after hours emergency team for access to crisis respite. The Support Plan is part of the Needs Assessment documentation. Support hours (recovery based) are agreed jointly by key worker, service coordinator and provider, but allocation is done by the service coordinator. Support plan is completed by the key worker with the client and approved by the service coordinator.

Services

Purchase Code	Descriptor	Provider /s	Service Name	Volume	Comments
MHA20D	Adult community support services – Non-clinical staff	PHO	Support in the Community - PHO	86 clients at one hour per week	Both Primary and secondary clients can access this service – those in primary must have used secondary at some time. Service reviewed 3/12 by NASC
		MASH Flatting	Manawatu	22 beds	*(Former Level 2)* Flats. Phone available 24/7 Daily visit by support worker. Length of Stay 6-12 months
			Papeoa		
			Totara		
			Anderson		
			Ringitira		
MHA20DH	Adult community support services- Non-Clinical Staff- UoM hour	MASH	Recovery Packages	800hours per month	Bulk funded Service coordinator authorises. SC reviews 6 weekly. Can included medication support?
		MASH	Medication support	30 clients	6 week reducing package – goal is for person to be independent with taking medications.
MHA23D	Housing coordination service- non clinical staff				

	MHA24	Housing and recovery services day time/awake night support	St Dominics	Residential	41 beds	*(Former level 3)* Co-located on the same site as the former level 4. Sleep over staff available.
			St Dominics	Residential	10 beds	24 Hours support with Registered nursing input. Day program Reviewed annually. Length of Stay up to 2 years.
	MHA25	Housing and recovery services day time/responsive night support	MASH	Erin	Total 42 beds across 6 houses	
				Terrace End		
				Hokowhitu		
				Limbrick		
				Russell		
			St Dominic's	Enhanced Package of Care Beds	4 beds	Provide transition from ward to home. Up to 6 week length of Stay. Beds are funded via PPS
	MHW68D	Family whānau support education, information and advocacy service – Non-clinical staff	SF (Supporting Families)	Family support services		Direct access no involvement of NASC. People do not need to be using MH services.
	MHA07	Sub-acute extended care - Inpatient beds	St Dominic's	Psycho-geriatric semi secure	8 beds	Clients over 65 with complex MH needs that cannot be supported in other H&R services. 24 hour care with RN input. Annual Review
	Provider Arm	Inpatient Rehabilitation Service	Te Korowai Whariki -	Regional Rehab in Porirua	2 beds	Access via NASC – with selection panel. Standard stay is 6 months.

	MHA17	Planned respite service. Non-clinical staff	MASH Russell	Respite for MHS consumers – not for those in crisis	2 beds	Service is provided in shared flat. Staff not on site 24/7.
			MASH Te Motu	Respite for child and youth	6 beds	
	MHA19	Maternal Mental Health.	MASH	Home based wrap around service and support for Mother and Baby	Up to 5 days flexible package	Support and advice in the community regarding for new mothers.. If service longer than 5 days SNA is competed.

Review Process	All allocated support and services reviewed by Service Coordinator at least annually • Recovery and Medication Management reviewed every 6 weeks • Supported Accommodation reviewed annually or earlier if required • Crisis and planned respite reviewed each month with relevant provider • Monthly meetings with all other Providers delivering services allocated via Midcentral mental health NASC
InterNASC Process	For clients moving out of Mid Central area the transfer of information and coordination is completed by the Service Coordinator For clients moving into the Mid Central area access for coordination of support is via the Service Coordinator.
Process for clients with dual or multiple needs	**Older Persons Health**: 1. Supportlinks NASC complete an assessment (InterRAI); 2. Mental Health completes a Needs Assessment 3. Supportlinks assessor and Mental Health Service Coordinator met and agree support plan together **DSS Client Group**: 1. Enable NASC complete a Needs Assessment 2. Mental Health completes a Needs Assessment 3. Enable assessor and Mental Health Service Coordinator met and agree support plan together Monthly meeting with Supportlinks NASC to discuss cases Monthly meeting with Enable NASC to discuss cases

Information supplied by Sue Fitzpatrick Midcentral DHB
Updated Dec 2015 by Helene Dore, FOCUS

Whanganui DHB Map

DHB Population Base 63,200 (https://en.wikipedia.org/wiki/District_health_board)

Whanganui DHB Mental Health NASC Services

Contact Details	Mihi Backhouse - Service Co-Ordinator Mental Health & Addiction Services Whanganui District Health Board Private Bag 3003, Whanganui Telephone: 06 348 3469 Mobile: 027 274 1349 Fax: 06 348 1255 Email: mihi.backhouse@wdhb.org.nz
Team Profile	Enrolled Nurse (1 FTE)
Access	20 years and over with some flexibility for those aged 18 -20 years. Referral criteria : 1. must be current service user/tangata whaiora of Whanganui District Health Board Mental Health & Addiction Services 2. must identify reason for referral based on mental health and addiction needs
Approach	NGOs Pathways, Whanganui Community Living Trust and Te Oranganui who provide services to Whanganui DHB Mental Health and Addiction have bulk funding arrangement. This includes residential and community. Packages of Care (POC)– through service coordination 1. This provides services not covered by the bulk funding eg. Short term of 4 weeks support, support to rural locations and “out of the box” solutions 2. Pre-approved by Manager Mental Health and approved and reviewed by service coordination. 3. Referrals to service coordination from Community Mental Health and Addiction Services (CMH&AS) team.  REFERRAL FOR PACKAGES OF CARE Long Term POC through Funder or NASC – Access ability

Needs Assessment

Key workers / Case manager / Service Coordination from the Community Mental Health and Addiction Service) complete the Whanganui version of the Regional Mental Health & Addiction Service Collaborative Support Plan.

Triage process considering age and complexity determines which assessment tool is used for clients over 65 years

1. Over 65yrs with a combination of needs with an identified diagnosis impacting on the persons physical health and day to day ability InterRAI – this requires referral to Community Assessment Rehabilitation Team(CART)

2. Support Needs Assessment as national standard DSS form if person has no diagnosis impacting on physical abilities (predominately mental health support needs) Completed by members of the over 65 team or service coordination

Service Coordinati

Support plan part of the Needs Assessment. Completed by person that undertakes Needs Assessment.

All referrals and documentation received by service coordination processed and sent through to the identified Provider

Services

Purchase Code	Descriptor	Provider/s	Service Name	Volume	Comments
MHA19C	Package of Care Clinical staff – Marton and Wanganui	Whanganui Community Living Trust	Mobile	1.1 FTE	Marton is rural
MHA19D	Package of Care – Non clinical staff	Whanganui Community Living Trust	Mobile	2 FTE	Available in Marton and Whanganui. Marton is rural
		Pathways		2.25 FTE	Individual 24/7 in clients flat
MHA20D	Adult community support services – Non-clinical staff	Pathways	Mobile	12.1 FTE	Work alongside people to develop their personalised plan, set goals, define actions and access relevant community services. Support hours are defined by actions in plan. This service is Mon - Fri
		Whanganui Community Living Trust		3.5 FTE	
MHA20C	Adult community support services – Nurses & allied health staff	Pathways	Enhanced Mobile Service	4.2 FTE Includes 2 registered health professionals	Work alongside people to develop their personalised plan, set goals, define actions and access relevant community services. Support hours are defined

			Whanganui Community Living Trust	365 Service	7 FTE Includes 1.5 registered health professionals	by actions in plan. These services are 7 days per week Includes medication oversight
	MHA21D	Day Activity & Living Skills	Te Oranganui Trust Inc.	Day Programme	1.6 FTE	Can include transport
	MHA22D	Vocational support service - Non-clinical staff	Workwise	Occupation Services	1 FTE	Employment/Occupation consultants. Support people into occupation or assist people to retain occupation.
	MHA23C	Housing coordination service- non clinical staff	Keys Living Choices	Housing Facilitation Service	2 FTE	Support people to find and maintain tenancies. Develop networks with housing providers to enhance accessibility.
	MHA24D	Housing and recovery services day time/awake night support – non clinical staff	Pathways	Residential	8 beds	4 twin share units = 8 beds Focus on recovery and reaching independent living
	MHA26	Supportive Landlord Service	Whanganui Community Living Trust	Residential	12 FTE	Monday to Friday service doesn't include medication oversight
	MHA03D		Pathways	Respite	3 beds	3 beds managed through Mental Health, Assessment & Home Treatment Team
	MHA07	Residential long term service	BUPA Care Services NZ Ltd	Mental Health Unit	9 Beds	gazetted secure mental health unit – part of rest home care village. Criteria – must be on Mental Health Act. Not age related

	MHA17C	Planned Adult Respite – Nursing and /or allied health staff	Pathways	Respite	1 FTE	1 bed managed by service coordination mental health & addiction service Priority carer respite
	MHD73D	Alcohol and other drug – community support service – non clinical staff	Pathways	AOD support worker	1 FTE	Sits under Pathways Mobile Service has capacity for 15
	MHAD14D	Co-Existing Disorders Mental Health & Addiction	Te Oranganui Trust	AOD support Worker	1 FTE	
	MHD78	Managed Withdrawal home/community Programme & Residential accommodation	Te Oranganui Trust	AOD 6 weekly Programme	1 FTE	
	MHK59C	Kaupapa Maori Community Based Clinical & Support Service	Te Oranganui Trust		2.6 FTE	
	MHK59D	Kaupapa Maori Community Based Clinical & Support Service Mental Health	Te Oranganui Trust		2.4 FTE 0.6 FTE rural 4.7 FTE AOD	
	MHI42D	Child, adolescent and youth crisis respite – non clinical staff	Pathways	Jnr Respite	1 FTE	2 bed house staffed on demand
	MHO100	Mental Health Older People – Sub-Acute Extended Care Service (permanent assessment bed)	BUPA Care Services NZ Ltd	Assessment Bed	1 Bed	Situated in the mental health unit. Criteria for those with challenging needing further assessment and not able to remain where they are. Must be under the Mental Health Act.

		Inpatient Rehabilitation Service	Te Korowai Whariki:	The service provides both longer-term care (Tawhirimatea Unit) and intensive rehabilitation (Tane Mahuta) within both secure and open settings.	65 Beds (1 Whanganui DHB funded bed)	The service's focus is on recovery and rehabilitation through providing people with the opportunity to learn new skills, as well as gain independence and empowerment for community living. Both units provide clients with individualised recovery, treatment plans in both a safe care or open setting. Rehabilitation length of stay is individual but anticipated to not be longer than 2 years.
Review Process	6 weekly meetings with major NGO Providers include Service coordinator, Manager CMH&AS and Manager of acute unit Short term support packages reviewed monthly by Service Coordination Enhanced Mobile Service reviewed 3 monthly at outpatients Dr appointment. Support worker, key worker, family and client invited. Accessibility review packages of support that they have allocated Long term packages of care reviewed at least annually by support team Those clients discharged back to GP.- may remain with the NGO provider who then review processes					
InterNASC Process	Moving out: Assessment and Risk Assessment completed by clinical mental health team then passed to service coordination. Service Coordination liaison with area/service person is transferring to Moving in: Referrals are considered through Community Mental Health & Addiction Services Triage.					
Process for clients with dual or multiple	Once relevant parties are identified a professionals meeting is called to identify needs and the best option and plan the process moving forward for best outcomes for the client					

Information supplied by Mihi Backhouse WDHB May 2015
Updated Dec 2015 by Helene Dore, FOCUS

Whanganui DHB Referral

REFERRAL FOR PACKAGES OF CARE

Person Details	**Surname:**	**Given Name:**
	NHI:	**DOB:**

Referrer		
Team Details	**Team:**	
	Referring clinician:	
	Psychiatrist:	
	Other(s) involved:	

Legal Status		
	Section: **Review Date:**	**Responsible Clinician:**

Presentation and Plan	
Presentation:	
Risk issues:	
Specific goals of application :	
Proposed exit plan:	
Potential barriers to discharge:	

Details			
Diagnosis:			
Identified Unmet Needs Requiring Packages of Care:			
Proposed services to be purchased:			
Expected outcomes from purchased services:			
Discussed and agreed with client?	Yes/No	**Input from family?**	Yes/No
Start Date:		**Review Date:**	
Estimated Discharge Date:			

Forms Attached		
Current Risk Management Plan ☐	**Referral** ☐	**Needs Assessment & Support Plan** ☐

	REFERRAL FOR PACKAGES OF CARE	
Person Details	**Surname:**	**Given Name:**
	NHI:	**DOB:**

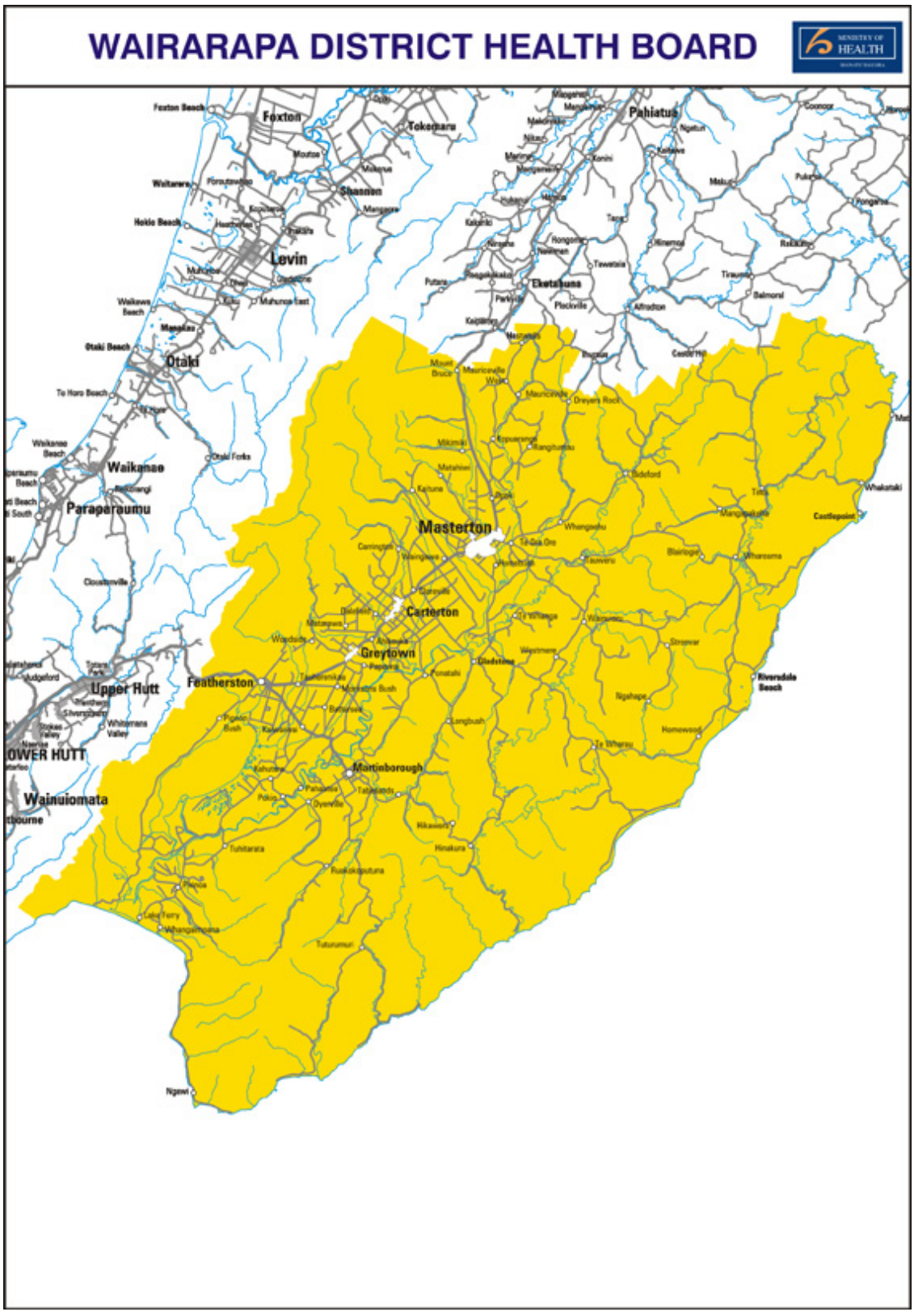
Service Coordination Use Only:
Costings (– include where invoices will be coming from)

Service Provider:	

Comments:

Approval			
Name:	Designation:	Signature:	Date:
Katheryn Butters	Clinical Manager		
Mihi Backhouse	Service Coordinator		

Wairarapa DHB Map



DHB Population Base 39,900 (https://en.wikipedia.org/wiki/District_health_board)

Wairarapa DHB NASC Services

Contact Details:	Adult Community Mental Health Services (Masterton) • Business hours phone: 06 946-9805 • Fax: 06 946 9835 • Address: Hospital Campus Te Ore Ore Road Masterton
Team Profile	Clinical Nurse Manager (1 FTE) Medical Officer (2.6 FTE) Registered Nurse (6 FTE) Allied Health (4 FTE) Community Support Worker (8FTE) Administration (3 FTE)
Access	19 years and over 1. Referral by Adult Mental Health Clinical Team to FOCUS 2. Referral to Adult Mental Health Services  Community Nursing and Support Services  003 MHS Referral.docx
Approach	Wairarapa offers a mix of bulk funding arrangements, case management and NASC services Standard approach – The Bulk funded provider is Pathways Joint assessment with FOCUS for: 1) InterNASC transfers 2) psychiatric service provision (not provided by Pathways eg. hands on support) 3) assessment for person with dual or multiple disability needs

Needs Assessment

There is no separate Needs Assessment for the bulk funded arrangement with Pathways.

When a joint assessment is completed with FOCUS, the following Needs Assessment form is used.

Full Support Needs Assessment - manual

Service Coordination

Completed by FOCUS NASC staff with input from relevant Mental Health Clinical Team members. For Service Co-ordination Plan.

Service Coordination Plan.doc

Services

PROVIDER: FOCUS (fee for service allocated support arranged by FOCUS provided by a Home Support Agency)

Personal Care

- Assistance (including hands on if necessary) with ADL, IADL support
- Services via FOCUS for clients accepted as needing to access psychiatric funding

Household Management

- Assistance with indoor tasks to maintain the home environment
- Services via FOCUS for clients accepted as needing to access psychiatric funding

Purchase Code	Descriptor	Provider/s	Service Name	Volume	Comments
MHA20D	Adult community support services – Non-clinical staff	Mental Health Solution / Pathways	Nil	3FTE	Provide clinical oversight and support to the CSW non clinical staff
MHA20C	Adult community support services – clinical staff	Mental Health Solution / Pathways	Nil	18FTE	Provide CSW and Transition type accommodation and Employment Support (1FTE inclusive)

	MHK59E	Kaupapa Maori Community Clinical Support Service - Cultural	Te Hauora Runanga o Wairarapa	No Name	2FTE	Provide specific cultural support to Tangata Whaiora / Service Users, Families / Whānau and the Kaimahi / Staff
	MHK59C	Kaupapa Maori Community Clinical Support Service – Nursing Allied	Te Hauora Runanga o Wairarapa	No Name	4FTE	Provide specific clinical support to Tangata Whaiora / Service Users, Families / Whānau with Mental Health & Addiction Problems
Review Process	Persons package and clinical review completed 3 monthly by Adult Mental Health Services Clinical Team Medication Support reviewed monthly as required Community Services allocated via FOCUS reviewed annually					
InterNASC Process	Assessment completed by NASC Risk Assessment completed by clinical mental health team					
Process for clients with dual or multiple needs	FOCUS completes standard form for all clients that are under 65 years.					

Information supplied by Andrew Curtis-Cody and Kate Lawrence Mental Health Services Wairarapa, Simon Phillips (SIDU)
Updated Nov 2015 by Helene Dore, FOCUS

Wairarapa DHB Referral

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

REFERRAL
MENTAL HEALTH SERVICES

Referral To: _____ Date: _____

Referral From: _____

Surname: _____ NHI No: _____ DOB:
Given Names: _____ Gender: ❑Male ❑ Female Age:
Other Names:_____ Occupation/School:_____ Medical Alerts:
Address: _____ Home Phone:
_____ Business Home:
Ethnicity:_____ Iwi: _____ ____ Years in NZ:
Hapu:

❑Active MHS Client ❑ Previous Client ❑ Unknown
If Known:- MH Team: Primary Clinician: Psychiatrist/RC:

Legal Status: ❑ Nil ❑ MHA (specify section) ❑ PPPR Act ❑ CYPFA ❑ CJ Act

General Practitioner:_____ Phone: _____ Fax:
Address:_____

Next of Kin/Guardian: (for CAMHS referrals include Father full name/Mother full name & Phone contacts). (Include Emergency Contact)
Name: _____

Address: _____

Phone: _____

REASON FOR REFERRAL TO THE ABOVE SERVICE

Details: Main mental health/A & D symptom/problems - include behaviour, key event, time of event, circumstances, sequence of events that led to contact/referral

Current Medications: _____

Continuation Sheet Used ☐

Other Agencies currently involved (please list): _____

1. Referral discussed with client: ☐ Yes ☐ No * Whanau/Family/Guardian ☐ Yes ☐ No
2. In agreement with referral client: ☐ Yes ☐ No * Whanau/Family/Guardian ☐ Yes ☐ No

*Discussed with Whanau/Family/Guardian with Client consent where necessary

COMPLETE SECTIONS OVER PAGE AND SIGN OFF

MHS REFERRAL Continued.

Client Surname: DOB NHI
Given Names:

Summary Current Social / Living Situation – Whanau/ Family History and Relationships

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Continuation Sheet Used ☐

Significant Others/Support People: (For CAMHS include siblings/ gender/ age)
Names _____Telephone: ( ) _____Fax: ( ) _____

_____
_____
_____
_____

Possible Disorder/Diagnosis		Identified Stressors	
☐Mood Disorder	☐Psychosis	☐Primary Support group/ family/whanau	☐Occupation/School
☐Anxiety /Phobia	☐Post Traumatic Stress	☐Social Environment	☐Abuse
☐Depression	☐Attention Deficit/Hyperactivity	☐Ante/Post Natal	☐Housing
☐Mania	☐Alcohol Abuse	☐Loss	☐Legal
☐Delirium/Dementia	☐Substance Abuse	☐Custody	☐Financial
☐Schizophrenia	☐Other	☐Physical Illness	☐Other

Action Plan

Indicate actions taken and plans for management prior to acceptance by MHS

_____
_____
_____
_____

Describe Outcome desired for this Referral

_____
_____
_____
_____

Identify any support client requires for assessment eg cultural/interpreter/family:

Completed by: (ensure legibility – Name & Designation) Date: Time:
Contact Phone:

WDHB MHS Use Only
Assessing Clinician: ☐ Appt Date: Notified client by [ ] Letter [ ] Phone Date:
Admin Notified Referrer of assessment : [ ] Letter/Fax/Email [ ] Phone Date:

FOCUS REFERRAL

Information for referrers on reverse	FAX (06) 946 9898 *or* POST to FOCUS PO Box 96, Masterton, 5840	Date received:

Community Nursing and Support Services - Referral Form

ACC DETAILS (must be entered if ACC)	**↓ Affix patient label here if available ↓**
Number: Date of Injury:	NHI: DOB:
PRIORITY (RISK) LEVEL ☐ **ROUTINE** ☐ **URGENT**	Surname: ☐ Male ☐ Female
(Focus Office Use Only) **Current FOCUS client?** ☐ Yes ☐ No HM hrs/wk: PC hrs/wk: Provider: Other FOCUS funded support:	First Name(s) Address: Phone(s): ☐ Lives alone ☐ Lives with others
Other refs through SPoE within last month: Other info:	GP: Consultant: Ethnicity / Iwi: Community Services Card No. Expiry Date:
CONSENT (**If consent not given please identify why**) Has the person agreed to this referral ☐ Yes ☐ No Referral to NGO discussed with person ☐ Yes ☐ No	Next of Kin/Caregiver/Contact person: Address: Relationship: Phone:

Diagnosis/Disability/brief medical history (for intellectual disability please attach copy of psychometric testing)

What do you want us to do/What does the person need help with? (Nursing referrals: attach appropriate information e.g. Nursing transfer, Medication, Wound management)

Help with housework only? Yes ☐

☐ Referral to Palliative Care Pathway (Kahukura)
Has the person consented? Yes ☐ No ☐
Has this been discussed with the G.P? Yes ☐ No ☐ ***(referrer must have had a discussion with the GP)***

Referral following acceptance on to palliative pathway to:

☐ Hospice Wairarapa Community Trust (Te Kowhai)
Has the person consented? Yes ☐ No ☐
Has this been discussed with the G.P? Yes ☐ No ☐ ***(referrer must have had a discussion with the GP)***

Date Admitted Date Discharged Follow-up appointments

WAIRARAPA DHB FOCUS Nga Kaupapa Hauā

Referrer Name (please print) _____
Organisation/Ward/Depart _____
Designation _____ Phone/Fax _____
Signed _____ Date _____

Information for Referrers: Services

Community Nursing	Support Services	Allied Health (& Others)
Post Discharge Follow-Up • Asthma • Enteral Feeding • Intravenous Therapy (IV) at Home • Oxygen Therapy • Palliative Care • Shower Assessment • Suture or Clip Removal • Wound Care Clinical Nurse Specialists: • Cardiac • Diabetes • Health of Older persons and Rehabilitation • Oncology • Respiratory • Stoma/Continence • Wound Specialty Clinical Nurse • Psychogeriatrics	Assessment for: • 24 hour care • Day activity 65+ (day respite) • Housework & other • Housework Only • Level of care change • Palliative care • Personal care (showering, dressing etc) • Planned Breaks for carers • Short or long term residential care Support by: • ASD Coordinator	If the referral is for Allied Health Services ONLY, please use the Allied Health Services REFERRAL FORM (AH01) • Child (<18) Oral Health • Dietician • Meals on Wheels • Occupational Therapy • Physiotherapy • Social Work • Speech Language Therapy • VNT (Neurodevelopment) Referrals that are for Orthotics or Podiatry can go on the Allied or SPoE referral form

Ethnicity	**Urgent/Routine**	**Palliative Care Pathway**
• African • Asian Not Further Defined • Chinese • Cook Island Maori • European Not Further Defined • Fijian • Indian • Latin American/Hispanic • Middle Eastern • New Zealand European • Niuean • Not Stated • New Zealand Maori • Other Asian • Other European • Other Pacific Island Group • Other • Pacific Island Not Further Defined • Southeast Asian • Samoan • Tongan • Tokelauan	Urgent Consider if the person needs services to keep them safe immediately. If they are not safe consider short term services. Routine Consider if the person is safe until services can be put in place. Semi-urgent is not an option. If you select urgent you may be contacted for more information. *If uncertain about whether to tick urgent or routine please call triage at FOCUS 06 946 9813*	Kahukura (DHB Community Palliative Care) • Community Nursing • Dietician • Occupational Therapy • Physiotherapy • Social Work • Speech Language Therapy • Support Services (as above) * Hospice Wairarapa Community Trust (Te Kowhai) • Patient and family/caregiver support • Biographics/Life story • Te Kowhai Day Programme • Bereavement support • Counselling • Podiatrist • Gentle touch massage • Books, DVD's, information and advice • Baking • Transport • Companionship/home visits • Precious memories photographic session • Veterinary support • Music CD library

All District Health Boards

MENTAL HEALTH AND ADDICTION SERVICES TIER LEVEL ONE SERVICE SPECIFICATION

STATUS: **MANDATORY ☑**

It is compulsory to use this nationwide service specification when purchasing this service.

Review history	Date
First Published on NSF Library	**June 2009**
Amended: Section 9.1 National collections workforce reporting and 9.1.2 Additional Reporting Items for NGO Providers only: Organisational Governance.	**April 2011**
Amended: Section 9. Added purchase unit codes MHFF, MHSD, MHQU and MHWF that do not have nationwide service specifications but are covered under this Tier One specification.	**July 2012**
Amended: Background content to reflect current policy requirements	**October 2013**
Amended: Updated link to Health and Disability Services Standards	**June 2014**
Amended: Addition of new purchase unit code MHFF0001	**August 2015**
Consideration for next Service Specification Review	**Within five years**

Note: Contact the Service Specification Programme Manager, National Health Board Business Unit, Ministry of Health to discuss the process and guidance available in developing new or updating and revising existing service specifications. See the Nationwide Service Framework (NSF) Library website for further information: http://www.nsfl.health.govt.nz/

GLOSSARY FOR MENTAL HEALTH AND ADDICTION SERVICES SERVICE SPECIFICATIONS

The definitions in this glossary are consistent with the definitions used in other national documents.

Addiction
Addiction in the context of the mental health and addiction services relates only to alcohol and other drug use and/or problem gambling. It refers to a maladaptive pattern of substance abuse, or problem gambling leading to significant impairment or distress.

Advocacy
Actively advancing or protecting the rights and interests of people with mental illness and/or addiction.

AOD
Alcohol and other drugs.

Assessment
A service provider's systematic and on-going collection of information about a consumer to form an understanding of consumer needs.

Clinical Assessment
Forms the basis for developing a diagnosis and an individualized treatment and support plan with the Service User, their family, whanau and significant others.

Community Service
A service based within the community that maybe delivered in hospital outpatient and/or community settings.

Consultation
Obtaining opinions and views of people affected by potential or proposed changes or developments, in order to consider those views in the decision making process.

Culture
The beliefs, customs, practices, and social behaviour of a particular nation or people, a group of people whose shared beliefs and practices identify the particular place, class, or time to which they belong.

Family Inclusiveness
Families and whānau have a fundamental role in supporting recovery and wellness and their participation in service planning and delivery will be critical.

Harm Reduction
Harm reduction focuses on reducing harms associated with addiction, including health, social economic and other harms experienced by individuals, families, communities and society.

Lived Experience
The term refers to having experience of mental illness or addiction.

Natural Supports
Natural supports include family whānau, partners, friends, neighbours, colleagues or those from an identified group who help the Service User in his/her recovery.

PRIMHD
Programme for the Integration of Mental Health Data; a common code set for the health sector.

Protective Factors
Supports, strengths and activities that help build resilience.

Recovery
Recovery is defined as the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential. Recovery in the addiction sector includes a view of both abstinence and harm minimization perspectives that have evolved over time to represent the individual's view. There is a long and generally held view that in the addiction field recovery involves an expectation/ hope that people can and will recover from their addiction / unwellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the word's widest sense) providing help. Health and Social Services will need to expect recovery and work in a way that will support it and will build future resilience.

Relapse Prevention Plan
Relapse prevention plans identify early relapse warning signs of clients. The plan identifies what the client can do for themselves and what the service will do to support the client.

Ideally, each plan will be developed with involvement of clinicians, clients and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the individual. Each client will know of (and ideally have a copy of) their plan.

Residential
The term residential has been replaced by the terms "housing" or "accommodation" dependant on the type of service.

Resilience
Personal and community strengths or skills that enable people to rebound from adversity, trauma, tragedy, loss or other factors, and go on with life with a sense of control, competence, and hope.

Service User
A person who uses specialist mental health or addiction services regardless of level of need. This term is often used interchangeably with consumer and/or tāngata whaiora

Strength based
A treatment approach, that focuses on and helps develop the Service User's strengths. This approach combines both provision of direct services and treatment, along with helping people define or priorities their needs, navigate the system and link into community resources.

Talking Therapies
Talking therapies involve people taking about their problems or issues with trained therapists. They encompass a wide range of psychological and behavioural therapies, including behavioural therapy, cognitive therapy and other types of counselling.

Whanāu
Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term in this document is not limited to traditional definitions, but recognises the wide diversity of families represented within Māori communities.

Whanāu Ora
Māori families achieving their maximum health and wellbeing, and provides an overarching principle for recovery and maintaining wellness.

MENTAL HEALTH AND ADDICTION SERVICES
TIER LEVEL ONE
SERVICE SPECIFICATION

Background

This tier one service specification provides the overarching specification for all specialist mental health and addiction services (the Service). Tier two and tier three service specifications are supplementary to this service specification and provide additional service-specific detail. Please refer to the accompanying glossary for definitions of terms used within the tier one, two and three service specifications.

Eligible people will have timely access to high- quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. The specialist mental health and addiction services included in this range of specifications are publicly funded for those who are most severely affected by mental illness or addiction. However, it is recognised that a focus on early intervention strategies will mean specialist services may be delivered to people who are more at risk of developing a severe mental illness or addiction.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017 sets the direction for service delivery across the health sector over the next five years.

The primary focus of Rising to the Challenge is to assist health services to collectively take action to achieve four overarching goals-

The ABCD overarching goals and desired results

Overarching goal	Results we wish to see
A Actively using our current resources more effectively	Increased value for money
B Building infrastructure for integration between primary and specialist services	Enhanced integration
C Cementing and building on gains in resilience and recovery for: i. people with low-prevalence conditions and/or high needs (psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions) ii. a) Māori b) Pacific peoples, refugees, people with disabilities and other groups	Improved mental health and wellbeing, physical health and social inclusion Disparities in health outcomes addressed
D Delivering increased access for: i. infants, children and youth ii. adults with high-prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms) iii. our growing older population	Expanded access and decreased waiting times in order to: • avert future adverse outcomes • improve outcomes • support their positive contribution in the home and community of their choice

Rising to the Challenge seeks to improve outcomes for all people with mental health and addiction issues. It also seeks to improve the integration of and quality of services to reduce disparities. A key step in achieving these goals is through developing a culture of responsiveness where Service Users, families, whānau and significant others are actively supported and involved in treatment and recovery.

Social and economic inequalities are associated with poor health outcomes. Section four of the Mental Health and Addiction Service Development Plan has a focus on building on gains in resilience and

recovery for Māori and Pacific peoples, refuges, people with disabilities and other groups. The expected result is consistent mental health and addiction outcomes for all.

It is unlikely that any single provider will deliver the full range of services, therefore all services in the mental health and addiction sector must work collaboratively and co-operatively to provide a well-integrated and seamless continuum of care. Effective, robust planning and partnerships within and across health service providers, other government-funded services and private sector service providers are critical in enabling better recovery outcomes for Service Users, their family, whānau and communities.

1.0 SERVICE DEFINITION

Specialist mental health and addiction services are delivered to those eligible people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. However it is recognised that a focus on early intervention strategies will mean services may be delivered to people who are at greater risk of developing more severe mental illness or addiction. To the extent that funding for specialist mental health and addiction services does not support coverage for all target populations, it is expected that DHBs will have criteria in place for prioritising the provision of services, to people with the highest level of need.

2.0 SERVICE OBJECTIVES

These following objectives have been developed in collaboration with, and should apply to all specialist mental health and addiction services:

2.1 General

Services will be responsive

Responsive services adapt to meet the unique needs of specific population groups and individuals. This is achieved through being flexible around service delivery settings in both urban and rural areas and adaptable to the Service Users' individual circumstances and needs, including cultural and spiritual needs. Services should be age and gender appropriate.

Responsive services focus on recovery, reflect relevant cultural models of health and take into account the clinical and cultural needs of people affected by mental illness and addiction. Services working together will also ensure adequate referrals between mainstream services and those developed to meet the unique needs of specific population groups.

Service delivery should be flexible and responsive to the local situation, national direction and future innovation and evidence.

Where services have smoke-free policies, Service Users should be routinely offered advice on how to quit smoking and should have access to appropriate cessation supports, including nicotine replacement therapy (NRT) products.

2.2 Māori Health

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to, matters such as referrals and discharge planning, ensuring that the services are culturally competent and that services are provided that meet the health needs of Māori. Actively involve tangata whenua in planning for mental health and addiction services.

2.2.1 Responsive to Māori

The overall aim of *Te Puāwaiwhero*, is whānau ora, which is defined as; Māori families achieving their maximum health and wellbeing. Kaupapa Māori services working together with Whānau Ora providers will support positive outcomes for those using infant and child services.

2.3 Responsive to Family and Whānau

Family and whānau are critical to successful recovery. Services will acknowledge the particular role the Service User plays in their family and whānau. This may include their role as parents or carers. For most Service Users, family and whānau plays a key role in the road to recovery. There are significant clinical, social and economic advantages to providing mental health and addiction services in a family inclusive way. Services need to listen to family and whānau and respond to their specific needs, including providing education on recovery and referral of family and whānau to appropriate support services.

2.4 Recovery Focused

Recovery is defined as the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential. Recovery is different for everyone; therefore there should be a range of service models and flexibility of services. For those with addiction problems, recovery is a process whereby Service Users are assisted to minimise harms and to maximise wellbeing. Recovery may or may not involve abstinence.

2.5 Foster Resilience

Resilience can be encouraged through a continuous process where individual and family whānau capacities are recognised along with protective factors in the community. Building upon and fostering these factors can help people counter life challenges such as mental illness and/or an addiction. Strength-based approaches help to promote engagement and build resilience.

2.6 Encourage Natural Supports

Supports may include family whānau, partners, friends, neighbours, colleagues or those from an identified group. Mental health and addiction workers will foster relationships with natural supports, as defined and chosen by the Service User, as supports play an important role in building resilience and recovery.

2.7 Promote Independence

Services should support individuals to live as independently as possible within the context of their treatment and support needs, and in an environment that is consistent with these goals.

2.8 Support Service Users to Make Informed Choices

All providers need to ensure information about services is available and easily accessible to Service Users and their family and whānau. Service Users should be informed of their choices and options for care.

2.9 Reduce Inequalities

A desired result of Rising to the Challenge is to see disparities in health outcomes addressed. Social and economic factors, such as income, poverty, employment, education and housing, have been cited as contributing significantly to mental health and addiction status. It is acknowledged that socioeconomically disadvantaged groups bear a disproportionate burden of risk for mental ill health. This highlights the importance of mental health and addiction services, to co-ordinate and co-operate with other government agencies, such as, housing, employment and education. Responsiveness to infants, children, adolescents and youth is critical to interrupt cycles of mental illness and addiction within families, whānau and communities.

2.10 Promote Seamless and Integrated Services

An overarching goal for Rising to the Challenge is building infrastructure for integration between primary and specialist services. Service Users may be receiving care/treatment for both addiction and mental health issues. Both types of services need to be provided in a seamless way. It is vital that ‘any door is the right door’ and the mental health and addiction sector must build capacity and capability to respond to co-existing disorders.

Mental health and addiction Service Users may also access other services. Services should work together to determine shared care arrangements that best meet the Service User’s needs. It is important that those with a mental illness and/or addiction also have their physical health needs met.

Increasing recognition by the Justice system of the need for health interventions for offenders requires mental health and addiction services to interface well with the Justice system. This population is particularly high risk, with a high incidence of co-existing disorders.

2.11 Develop Organisational Governance

Organisational governance structures contribute to the stability and viability of organisations. A strong and active engaged board that is structured to provide fiscal oversight, has the skills and experience to work alongside other mental health and addiction organisations to deliver seamless, well-integrated services and meet the organisation’s governance needs is promoted.

2.12 Develop Workforce

Workforce development needs to be part of the focus for every service. This development involves building the capacity and capability of the Service providers to work in partnership with the Service Users. Investment in the development of the mental health and addiction workforce is key to ensuring the delivery of effective services. Integrated care and treatment can be achieved through the establishment of a competent workforce appropriately trained to recognise and respond to mental health and addiction issues.

Let's get real: Real Skills for people working in Mental Health and Addiction (Ministry of Health 2008) is a framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services.

Rising to the Challenge will deliver a national workforce development plan which considers:

- new ways of working
- new roles to complement existing staff groups
- future services, changing demography and future demand for services.

2.13 Value Lived Experience

People with a lived experience of mental illness and addiction offer a unique contribution to services. The important perspective of those with a lived experience should be utilised in the planning and implementation of services. Services should foster a culture that promotes Service Users participation and recovery. Real life examples of recovery can offer hope to Service Users. Service Users should be encouraged into a range of roles, both within consumer-led services and across the continuum of services.

The valuable perspective and experience of family and whānau supporting a loved one with a mental illness and / or addiction should also be seen as an asset within the mental health and addiction workforce.

3. SERVICE USERS

A person or people deemed to receive or be receiving mental health and / or addiction healthcare, health information, or support services resulting from direct contact with a healthcare provider where the healthcare results in use of resources associated with observation, assessment, diagnosis, consultation, rehabilitation or treatment. This includes on-going support, education, training, or ensuring or monitoring compliance with relevant legislation. Service Users include all eligible people.

Not all patients who are referred or present to the Service are eligible for publicly funded services. Refer to http://www.moh.govt.nz/eligibility for more eligibility information

4.0 ACCESS

4.1 Entry and Exit Criteria

Referrals to the Service may be made from any source, including self-referral. Some speciality services have specific requirements before accepting a referral. In these circumstances, services need to have clear documented access criteria and protocols, and ensure these are communicated with family, whānau and others making contact with the Service.

On referral (including self-referral), the criteria for assessment is based on the person having a suspected, developing or identifiable mental illness, and/or an addiction problem.

Services may prioritise referrals based on:

- clinical assessment about need and the severity of the mental illness and/or addiction
- the likely impact the mental illness and / or addiction will have on the person's ability to participate in activities of daily living, work, education and community life, and their role as a family and whānau member
- relevant legal requirements including the Mental Health Compulsory Assessment and Treatment (CAT) Act 1992 and Alcoholism and Drug Addiction Act 1966
- the safety of the individual and/or of others such as family members
- patients may exit the Service by transfer, discharge from the Service or death
- the Child Health Strategy (1998), defines a child as being aged from before birth to 14 years, and further identifies that young people up to the age of 18 years should be given care within the most developmentally appropriate services, as young people have specific developmental needs which require that they are cared for in youth appropriate settings. It is also necessary to recognise that the transition to adult services must occur at the appropriate time
- on entry to the Service, the most appropriate course of action will be discussed in consultation with the Service User and their family and whanau. This will be based on needs, strengths, mental health and /or status and supports. Service Users must be informed of their choices and options for care in line with consent protocols.

4.2 Distance

Services will be delivered locally where possible. DHBs are also expected to have in place arrangements that ensure the people of their DHB area have access to regionally and nationally provided mental health and addiction services.

4.3 Time

When assistance is required under the Mental Health (CAT) Act 1992, 90% of people presenting should be assessed within four hours. DHBs with isolated rural communities will ensure that effective arrangements are in place.

If a person is assessed as needing hospital care under the Mental Health (CAT) Act 1992, 90% should be admitted to a hospital within six hours of being assessed by a doctor or health professional.

The DHB will ensure that crisis services to deal with a critical or urgent mental health and/ or addiction needs will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act) as follows:

- telephone or other remote assistance will be available at all times with minimal delay
- where telephone assistance is insufficient to meet the person's needs, direct contact with a clinician will be provided within four hours; DHBs with isolated rural communities will ensure that effective arrangements are in place
- other services will be arranged when required, including acute inpatient admission and crisis respite.

People are seen and assessed as needing services will receive those services as soon as possible. For some services, there may be a wait before treatment can begin (eg, opioid substitution programmes.)

- Note: until a person is assessed, it will not be known whether they fall under the Mental Health (CAT) Act 1992.

5.0 Service Components

5.1 Processes

Processes occur as part of a Service User pathway. Processes that include: health education, health promotion, engagement, assessment, diagnosis, treatment, rehabilitation, onward referral, family support, case management, liaison and consultation and on-going support.

At all stages of this pathway, skilful engagement, consultation and, where appropriate joint care planning between services will be used to ensure the needs of the Service User are identified and responded to. Service Users and their family and whānau should be encouraged to participate in evaluation/review at each step. Appropriate risk management procedures should also be put in place for the safety of the Service Users, staff and others.

5.1.1 Assessment

Assessment will be appropriate and sufficiently comprehensive for the purpose of the particular service. It forms the basis of the recommended treatment, intervention or support and must be completed by staff with the required competency, knowledge and skills.

The assessment process will vary and take into account individual circumstances and, as well as the Service User, will include agreed family, whānau and support people where practicable. The assessment will take into consideration cultural needs. A full explanation of the process must be provided and reiterated to the Service User and those accompanying them.

The assessment will help develop an initial recovery plan, which will include treatment, intervention or support options, appropriate risk assessment/management and the plan for discharge. Recovery plans will be developed in a collaborative process with Service Users, their family and whānau and support networks and will address their broader physical, spiritual, social and psychological needs and aspirations. The recovery plan will be discussed with the Service User, and informed consent must be sought. There will be a process in place for reassessment. The assessment process should take into account identification of parental roles and responsibilities. Because the Service Users may be linked into several different services, all will contribute to the overall recovery plan.

5.1.2 Treatment, Intervention and Support

Treatment, intervention and/or support are the key focuses for the Service delivery. The models for treatment, intervention and/or support will vary, and are described in further detail in tier two and three specifications.

After the initial assessment, treatment, intervention and/or support options will be recommended specific to the Service Users' individual needs and circumstances. The recovery plan will be developed

collaboratively with the Service User and, if appropriate, their family and whānau that will identify goals towards discharge and outline supports to assist the person to achieve those goals. It will include early warning signs, wellness maintenance, relapse prevention information and may include advance directives. Recovery plans will address the Service User's broader physical, spiritual, social and psychological needs and aspirations. Recovery plans will be kept current by regular review. Evidence-based, best practice education and information will be proactively provided to Service Users and their family and whānau. The Service User will give written informed consent for treatment, intervention and/or support and will receive a copy of their recovery plan.

More positive outcomes occur when people are able to easily access services, and when services show flexibility and encourage Service User participation within clearly communicated and coherent treatment programmes. Information should also be provided about the role of family and whānau and the supports available to them, and other social networks.

5.1.3 Review Process

This is the process of formally reviewing recovery plans, goals and outcomes both with the Service User and in a multi-disciplinary setting. Reviews must occur at a minimum of every six months but the frequency will be determined by the Service User's individual circumstances, for example, their specific goals and the specific role of the service involved. In the addiction sector it is recommended that a review of progress is more frequent, occurring at a minimum of once every four months.

The review will include the Service User and with their consent, their family and whānau. Reviewed outcomes and new treatment goals will be reflected in ongoing recovery plans.

5.1.4 Discharge

Discharge is a planned process that is part of the recovery plan. It should begin from when the service is accessed.[1] Discharge planning must involve Service Users and, with their consent, be communicated to all relevant support people. It will include reassessment of risk, the relapse prevention plan and follow-up arrangements. Discharge planning may also include advance directives and will identify medication on discharge and education about this. The Service Users, family, whānau and other services and agencies involved should be informed of how to re-engage with the service if required.

A discharge summary will be given to the Service User and, where relevant, the general practitioner/primary care provider and support people.

5.2 Settings

The Service will be provided in the appropriate setting to provide the desired health outcomes. A consideration in determining the settings for the service should include (but not be limited to) issues such as cultural appropriateness, accessibility, gender, age and developmental stage, and the most effective and efficient use of resources. Services may be provided using hospital settings such as inpatient and day hospital, and outpatient settings such as those community based and mobile services. Some services may be electronic, such as e-therapies.

5.3 Support Services

The following support services, if required, are to be provided as an integral part of the Service and are included in the agreed Purchase Unit price.

- clinical support services such as:
  - laboratory
  - pharmaceutical
  - pathology
- allied health support services such as:
  - dietetic
  - physiotherapy
  - social work and counselling service
  - infection control
- ancillary services such as:
  - sterile supplies department
  - hotel services (laundry and cleaning)
  - maintenance
  - occupational health
  - infection control

- interpreting services (including sign language)
- chaplaincy services
- corporate services such as:
  - human resource department
  - legal
  - finance
  - stores
  - accounts

Additional support services are listed in the appropriate tier two and three service specifications.

5.4 Key Inputs

The key input for mental health and addiction services is the workforce and national electronically delivered programmes such as the National Depression Initiative and Like Minds Like Mine.

5.5 Pacific Health

Pacific peoples share similar risk factors to Māori in terms of health and social inequalities. Te Rau Hinengaro. The New Zealand Mental Health Survey (Ministry of Health 2006) confirms that Pacific peoples experience mental illness at higher levels than the general population. Pacific people are also less likely to access treatment than the total New Zealand population. The service must take account of key strategic frameworks, principles and be relevant to Pacific health needs and identified concerns.

For regions that have significant Pacific populations, the service must link service delivery to the improvement of Pacific health outcomes. Health service providers should also ensure that their service provides a holistic approach to health and wellbeing, assessment and treatment for Pacific peoples. This approach should include focusing on family, relationships, spiritual, physical, language, cultural, emotional and mental dimensions.

5.6 Health for other Ethnic Groups

Mental health and addiction services will be relevant and responsive to the diversity of cultures within local communities. Services will recognise resources, relationships and other protective factors in the community that will empower and promote wellbeing. Services will deliver culturally appropriate care, considering the individual ethnic, spiritual and cultural beliefs of those served.

Service planning, development and delivery will ensure that people are not discriminated against or disadvantaged. Mental health and addiction services will acknowledge that different cultures come with varying perspectives. Mental health and addiction services shall demonstrate effort to recruit staff from different cultures to reflect and match the cultural needs of people from Asian, migrant and refugee backgrounds in the community. Services will take steps to ensure that the mental health and addiction workforce is culturally competent and that qualified interpreters are available to provide maximum access for ethnic/cultural communities.

6.0 Service Linkages

Service linkages are requirements regarding linkages to other related services and provide a description of such links. The costs of such services are not included in the price of the Service, however, the costs of liaison and linkages with these services are included within the Service Purchase Unit price.

Service Provider	Nature of Linkage	Accountability
Other primary, secondary and tertiary services that the service refers Service Users to	Refer and access to skills, expertise and resources within other disciplines ie medical services, surgical services	Referral processes and protocols are in place include mechanisms for shared working where appropriate. Services assist the Service User to access the other services that are required
Supporting services not purchased within this service specification	Provide continuity of care and facilitate access to services that best meet the needs of the Service User	Knowledge of other services within a district maintained Relationship with other providers through stakeholder networks
Publicly funded disability or long term support services for the Service Users with co-existing disabilities/ conditions who meet other funding streams eligibility criteria		

such as: Needs assessment and service co-ordination (eg, NASC) Specific support services such as: home and community support; carer support and respite; residential services; supported independent living; habilitation/rehabilitation; other specialist support services, as appropriate Environmental support services (eg, long-term equipment, including specialist assessment services, home modifications) to assist with essential daily activities Information and advisory services (eg, on available services and how to access these)	• Referral and liaison • Consultation • Referral and liaison • Liaison	• Effective local and regional linkages are in place to facilitate appropriate referrals • Service Users needing long-term support services have timely access to individual needs assessment and service coordination services • Service Users needing long-term support receive appropriate services across the continuum of care and support to meet their individual needs, within available resources • Service Users needing environmental support services receive appropriate equipment and environmental modifications • Service Users have timely access to appropriately presented information and relevant advice
Local Māori health providers, Māori agencies and community groups	To improve mental health and addiction outcomes and reduce health inequalities for Māori	Local Kaupapa Māori services are strengthened by relationships, networks and cross agency working.
Local Pacific health providers, Pacific agencies and community groups	To improve mental health and addiction outcomes and reduce health inequalities for Pacific people.	Local Pacific services are strengthened by relationships, networks and cross agency working.
Other Government funded social services such as Education, Justice, Police, Social Development eg Work and Income and Child Youth and Family	Alignment of delivery of health services and delivery of other government funded social services to better meet the goals of government strategies and policies from health and related sectors (eg Social Development , Education, Justice, etc) Where children/young people are receiving services from other agencies, the service provider will participate in inter-sectoral collaboration and co-ordination initiatives such as 'Strengthening Families'.	Agreements and protocols regarding obligations of lead providers and collaborative working.
Consumer support groups	Share information with other providers about how to better meet the needs of Service Users.	Maintain communication with consumer groups. Support the consumer voice at planning and delivery of services.
Between DHB providers, non-governmental organisations and Primary Health Organisations	Share innovative ideas, solve problems and improve access to services Provide co-ordinated support to people affected by mental illness and/or addiction.	Document agreements in memorandum of understanding (MOU) and protocols.

There will be clear arrangements/protocols/statements describing the accountabilities for access, entry, treatment, care management, exit processes, follow up and information sharing between linked providers.

There will be definitive statements on the boundaries between services and whether these are a matter of clinical judgement or prescribed by regulation / other mechanism.

There will be clear arrangements/protocols/statements describing how the provider will ensure treatment is delegated to the most appropriate person or agency, and which provider is primarily responsible for the care on each occasion.

There will be the requirement for providers to establish dispute resolution processes (depending on the linkage / relationship).

7.0 Exclusions

Mental illness or addictions often co-exist with other health or social service needs that impact on intervention outcomes. The presence of such needs shall not reduce a Service User's access to mental health and addiction services to which they would otherwise be eligible, but should be a signal that collaboration with another agency or health provider and joint intervention planning/provision is likely to be required.

District Health Boards (DHBs) do not fund services for mental health and addiction when the service or support needs are solely orientated to:

- sexual abuse
- violence and anger
- intellectual disability (including post-head injury), with or without behavioural problems
- learning difficulties
- criminal activities (anti-social behaviours)
- conduct disorder
- parenting difficulties
- relationship issues
- nicotine addiction.

Where people are eligible for services funded under the Injury Prevention, Rehabilitation, and Compensation Act 2001, they are excluded from receiving these services through public funding under Vote: Health.

The following services are not funded mental health and addiction treatment services where they are the sole focus of the intervention. They may be funded through other health funding or, in some cases, by other agencies:

- relationship services
- sexual abuse counselling services
- any counselling interventions not related to mental health and addiction
- psychological testing for educational requirements
- preparation of court reports ordered by the Ministry of Justice, except for those under the Criminal Procedure (Mentally Impaired Persons) **Act** 2003
- preparation of court-ordered reports or parole board reports
- assessments under section 65 of the Land Transport Act 1998
- assessments and reports under section 333 of the Children, Young Persons, and Their Families Act 1989.

8.0 Quality Requirements

The generic Provider Quality Specification, including the Health and Disability Sector Standards (HDSS) applies to this Service.

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework (OPF) [2] or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

Please refer to the OPF for a comprehensive and updated list of standards and legislation that require provider compliance.

8.1 General

It is important that at each stage of the pathway Service Users and their family and whānau are able to give feedback on the Service. Regular contract monitoring and auditing will occur and contribute to a continuous quality improvement cycle for all services.

When assessing the quality of the Service to the extent to which the Service has met the following priorities will be considered:

The process of service delivery should ensure:

- the Service User's needs are central
- Service User and wherever possible family / whānau participation
- recognition that many Service Users will have parental roles and this will impact on their needs and those of their children
- high-quality mental health and/or addiction care is supported
- compliance with the Health and Disability Services Standards[3]
- Mental Health and Addiction key performance indicators and PRIMHD data are reported
- evidence-based best practice is followed.

When selecting the appropriate service specifications required for a Mental Health and/or Addiction service to be purchased, the following steps are taken:

- select tier one Mental Health and Addiction service specification
- consider the most appropriate service type and select one or more tier two service specifications
- consider the Service User needs to be met and the preferred service delivery mode
- select the tier three service specification that best meets these requirements.

(A minimum of three service specifications are required for each contract- a tier one, at least one tier two and a tier three service specification).

9.0 Purchase Units and Reporting Requirements

The Mental Health Purchase Unit Codes are found in the joint DHB Ministry Nationwide Service Framework Purchase Unit Data Dictionary on **www.nsfl.health.govt.nz**. They are reviewed, agreed and updated annually.

The following four Purchase Units do not have specific mental health and addiction services nationwide service specifications but are covered under this Tier One service specification.

PU Code	Name	Description	PU Unit of Measure
MHFF	Mental Health - flexifund	Service to cover the costs for flexible funding for mental health services in addition to specific services with a unit of measure client, available bed day, occupied bed day or FTE.	Programme
MHFF0001	Individual Treatment bed (Mental Health & AOD)	Bed for a client of mental health and/or alcohol and other drugs (AOD) services, of any age, who requires individualised care	Occupied bed day
MHQU	Mental Health -	Service to cover the costs for quality and	Programme

[2] The Operational Policy Framework is updated annually by the Ministry of Health and published on the website link: http://www.nsfl.health.govt.nz/apps/nsfl.nsf/menumh/Accountability+Documents

[3] Health and Disability Services Standards: http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards

	quality and audit	auditing of mental health services	
MHWF	Mental Health - workforce	Service to cover the costs for mental health workforce development.	Programme
MHSD	Mental Health - service development	Costs to cover service development projects.	Project

Purchase Units for mental health and addiction services are included at tier three service specification level and reflect the tier one and tier two level components.

9.1 Additional Reporting Requirements

9.1.1 National Collections

Mental Health and Addiction providers will provide data electronically to the Ministry of Health Information Service Directorate via the Programme for the Integration of Mental Health Data (PRIMHD).

A transitional process for all providers to report via PRIMHD is in place.

There will be participation in KPI Benchmarking project as this work is implemented in the sector.

All providers will report on the following:

Workforce

Frequency	**Data**
Quarterly	Actual FTE's by designated 6 FTE groupings
Quarterly	Staff turnover ratio

To calculate staff turnover ratio:

Numerator	Number of employed staff who have left within the reference period
Denominator	Total number of employed staff within the reference period

9.1.2 Additional Reporting Items for NGO Providers only:

Organisational Governance

Frequency	**Data**
Six monthly	Number of Board member changes
Six monthly	Number of governance meetings held

9.2.1 Data Definitions and Descriptions

Definition	Description
Admissions	The number of people admitted to the residential/inpatient service during the reporting period. The number of unique clients who have had an inpatient admission within the reporting period. Admission = first activity start date within the referral.
Available Beds	The total number of resourced beds usually available in the facility. NB: This is usually the number of beds funded/resourced and does not mean that the bed is unoccupied.
Available Bed Days	Total number of inpatient beds that are available to be occupied during the period multiplied by the number of days they are available during that period. This would normally be the number of available beds from above multiplied by the number of days in the period. Example: Number of resourced beds x Number of days in the period.

Definition	Description
Available Budget	The total budget available during the reporting period for the service.
Average Length of Stay	Inpatient/Accommodation/Housing- The average number of days between first admission and final discharge for all people "discharged" from the service during the period. If there have been no discharges in the period please enter "N/A". You will only be able to measure this when you have had a client exit your service during this period. Community Services - The average number of days between first contact and final contact for all people "discharged" from the service during the period. Where this cannot be measured, record "not measured". This is calculated as the sum of the total number of calendar days for each client between first contact/admission and final contact/discharge during the reporting period, divided by the total number of clients who have been "discharged" during the reporting period. Each day should be counted even if the service was unavailable eg, public holidays and weekends. The first and last day should be counted. Example: Two clients are discharged, one after 22 days and one after 87 days. Add the days together and then divide by the number of clients discharged – this gives you the average length of stay. 22 + 87 = 109 (days in service) ÷ 2 (clients discharged) = 54.5 days The average length of stay (ALOS) for clients who have had an inpatient or community discharge within the reporting period. Discharge = last activity end date of the referral. Admission = first activity start date within the referral whether it is in the reporting period or not.
Average Length of Time on Waiting List	The Average number of days that people currently on waiting lists for Methadone Treatment Programmes have spent on the waiting list. Count on the last day of the reporting period. The sum of the total number of days between referral and to waiting list and the last day of the reporting period divided by the total number of clients on the waiting list.
Bed Days	Total number of beds that are available and occupied each day in a community residential facility during the reporting period.
Clinical FTE	This is a full time equivalent (see definition of "FTE") staff member with a health professional qualification (including senior medical staff) who directly delivers clinical/therapeutic services to Mental Health consumers. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Completed Support Needs Assessments	The total number of completed support needs assessments during the period. The assessment process is to meet the "Standards for Needs Assessment for People with Disabilities". All visits and contacts required as part of the Support Needs Assessment are included and are not counted elsewhere. Count of all clients with an activity type code of T10 within the reporting period.
Consultation/Liaison Contacts	A planned discussion (over the phone or face-to-face) with a health professional from outside the service or a professional from another agency, for the purpose of providing specialist advice in relation to a particular person (who is not a current client of the service) with a mental

Definition	Description
	health problem. Count of all clients with an activity type code of T08 within the reporting period.
Consultation/Liaison Training Sessions	Number of education or training sessions provided for people working outside of the service (eg, GPs, Iwi Organisations, School Guidance Counsellors, Police).
Current Client	Any person who is currently receiving assessment, treatment/therapy or support from a service, where the person has been seen by the service within the past three months. Exclude people who have been seen by the service within the past three months but have since been discharged from the service. For inpatient services, this will be the number of people currently in an inpatient in the service, or on trial leave for less than ten days where a bed has been kept available. Unique count of clients without a referral end date during the reporting period, who have had an activity in the last three months (excluding Activity Type = T35).
Day	A day is a 24 hour period beginning immediately after midnight and ending at midnight
Day Attendances	Total number of attendances by non-inpatient consumers at a day programme for assessment, treatment or therapy related to a mental health diagnosis. Count each consumer attendance at the service only once in a day. Attendance of couple, family, or group, only one of whom is a mental health consumer is one attendance. Count of all clients with an activity type code of T23 within the reporting period. Each client to be counted only once per day.
"Day Places" Available	For each day programme offered, multiply the number of places available by the number of days they were available in the period.
Day Programme	A treatment /therapy /skills development programme provided for greater than 3 hours and less than 24 hours. Count of all clients with an activity type code of T22 within the reporting period. Each client to be counted no more than once per programme.
Expenditure (Promotion/Prevention)	The total sum of money spent on this service during the reporting period.
Expenditure with a breakdown of service utilisation **(Community Acute/ Respite Services)**	The total sum of money spent on this service during the reporting period. Each service will be required to report details of the types and volumes of services utilised during the reporting period. The content of these reports is to be negotiated between the funder and each service provider.
Face-to-face Contacts (Groups)	Face-to-face contact between an individual/family and one or more mental health professionals in a group session (Refer to Definition of Terms). Count one contact for each client attending the group session (ie, group session with four clients would be counted as four contacts). Clients counted once only, regardless of numbers of clinicians involved in the activity. Attendance of clients' carer/significant other/whanau not

Definition	Description
	included in the count. Count of all clients with an activity type code of T07 within the reporting period. Each client to be counted no more than once per session.
First Face-to-face Contacts (Individual /Family)	Initial face-to-face contact between an individual/family and a mental health professional regarding an episode of mental illness, a mental health problem or set of problems. The contact is the first assessment contact for this episode or problem, with an individual who is not a current client (refer to definition) of the service in question at the time the referral was received. (T Codes: T32,T36,T42)
Follow-up Face-to-face Contacts (Individual /Family)	All face-to-face contacts between an individual/family and mental health professional which occur after the initial face-to-face contact for this episode, problem or related problems. (T Codes: T32, T36, T42)
FTE	This is a full time equivalent employee (40 hours per week), and is calculated as the total number of hours employed per week (to a maximum of 40 hours per week), divided by 40. For example, where one staff member works 40 hours per week and another works 10 hours per week, the calculation would be: 40/40 + 10/40 = 50/40 = 1.25 FTEs Please note that where an employee (eg, a consultant psychiatrist) has been job-sized as being employed for more than 1.0 FTE (eg, employed as 1.2 FTE for undertaking additional management duties), only 1.0 FTE is to be recorded.
General Hospital Beds	The total number of General Hospital beds in the region on the last day of the period. Count occupied and unoccupied beds.
Group Session	A group session is a psychotherapy/skill development/education programme designed for more than two individuals which lasts between one and three hours.
Group Session Delivered	The total number of group sessions provided during the period.
Hui Held	The total number of Hui held during the period.
Hui Narrative Report	Number of trainees supported/individual training packages developed.
Hui Participants	The total number of attendees participating in Hui held during the period.
Hui Narrative Report (Details of each Hui)	A summarised report of each Hui held during the period, the report should include: • Details of attendees origin eg, HHS, NGO, family/whanau • Location of Hui • Topics of discussion
Inpatient Admissions	The number of people admitted to the inpatient service during the period.

Definition	Description
Involuntary Discharges Commenced	The number of clients who have ended involvement with the service during the period, where the decision to end involvement was not made by either the service or the client, eg, justice or prison involvement.
Kaumatua & Taua (Kuia) FTE Staff	Report the total number of FTE Kaumatua and Taua employed by the service. Kaumatua and Taua FTEs are defined as full-time equivalent (see definition of FTE) staff, who are specifically employed to provide guidance and support to the mental health service. Only include those people employed in a specified Kaumatua and Taua position. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Longest Time on Waiting List	The most days that any one person on the waiting list has spent on that waiting list. Count on the last day of the reporting period.
Maori Advisory FTE staff	Report the total number of FTE (see definition of FTE) Maori Advisory staff (who may or may not hold a professional qualification). Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Maori Training Posts FTE staff	Report the total number of FTE (see definition of FTE) staff specifically employed in Maori Training Posts. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Methadone Places Available	The number of places available on Methadone Treatment Programmes at one point in time in the period, if the number of people so treated were constant during the period. (Include both GP and Specialist Alcohol and Drug Services.)
Monthly Expenditure for Flexi-Fund with a breakdown of information re: utilisation	A report which provides summary level information regarding utilisation of the Regional Co-ordination Service flexi-fund. This report will provide the following information regarding each individual support package purchased: the type of support purchased, the number of days the support was provided and the cost per day.
Number of FTE staff (Senior Medical)	Report the total number of FTE Senior Medical (SMO) staff employed in the service. Senior Medical FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a medical or therapeutic role with clients and who are Registered Medical Practitioners and hold a current practising certificate. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Junior Medical)	Report the total number of FTE Junior Medical staff employed in the service. Junior Medical FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a medical or therapeutic role with clients and who are Registered Medical Practitioners and hold a current practising certificate. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Nursing	Report the total number of FTE Nursing and allied staff employed in the service. Nursing and allied staff FTEs are defined as a full-time

Definition	Description
and Allied)	equivalent (see definition of FTE) staff who have face-to-face contact in a medical or therapeutic role with clients and who are Registered Practitioners and hold a current practising certificate or affiliation with a professional body. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Cultural)	Report the total number of FTE staff employed in cultural specific roles in the service. Cultural staff FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a therapeutic or support role with clients and who maybe Registered Practitioners and hold a current practising certificate or registered or regulated by a health or social service professional body and or have demonstrated cultural competencies. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Maori Mental Health Worker)	Report the total number of FTE Maori Mental Health Workers employed for the service. A Maori Mental Health FTE is defined as full-time equivalent (see definition of FTE) staff member employed specifically to deliver Maori Mental Health services to consumers, whanau or iwi. Only include those people employed in a specific Maori Mental Health position and not Maori staff employed in other clinical positions. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Medical)	Report the total number of FTE Medical staff employed in the service. Medical FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a medical or therapeutic role with clients and who are Registered Medical Practitioners and hold a current practising certificate. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Nursing)	Report the total number of FTE Nursing staff employed in the service. Nursing FTEs are defined as full-time equivalent (see definition of FTE) staff who have face-to-face contact in a nursing or therapeutic role with clients and who hold a current practising certificates, Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Occupational Therapy)	Report the total number of FTE Occupational Therapy staff employed in the service. Occupational Therapy FTEs are defined as full-time equivalent (see definition of FTE) staff who have face-to-face contact in a occupational therapy or therapeutic/supportive role with clients and are currently registered as Occupational Therapist. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Other)	Report the total number of FTEs (see definition of FTE) for the service for 'other staff'. 'Other Staff' include any staff member involved in direct delivery of services to consumers other than medical nursing, psychology, occupational therapy, social work or Maori mental health worker. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).

Definition	Description
	For recording purposes exclude vacant positions.
Number of FTE staff (Peer support)	Report the total number of FTE staff employed in specific peer support roles in the service. Peer support staff FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a therapeutic or support role with clients and who maybe Registered Practitioners and hold a current practising certificate or registered with and regulated by a health or social service professional body or received a recognised qualification and or training in Peer Support. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Psychology)	Report the total number of FTE Psychology staff employed in the service. Psychology FTEs are defined as full-time (see definition of FTE) staff who have face-to-face contact in a psychology or therapeutic role with clients and are currently registered as psychologists. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Social Work)	Report the total number of FTE Social Work staff employed in the service. Social Work FTEs are defined as full-time equivalent (see definition of FTE) who have face-to-face contact in a social work or therapeutic/supportive role with clients and hold a social work qualification. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Non-Clinical FTE	This is a full time equivalent (see definition of FTE) staff member without a health professional qualification who directly delivers clinical/therapeutic services to Mental Health consumers. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Occupied Bed Days	Sum of number of beds that are occupied each day during the period. For reporting purposes, count beds occupied as at 12 midnight each day. Do not count beds reserved for people on formal leave. Formal leave is defined in practice as any planned leave where a person is not physically in the inpatient or residential facility. That is, a bed would not be counted as occupied if the person was on pre-discharge leave, away visiting friends or relations for a period of time, on respite care or transferred to another service temporarily. Example: You have 7 beds but only 6 are occupied, therefore it would be 6 (beds) x No of days in period = Occupied Bed Days.
People Currently on Waiting List	The total number of people who have been assessed as eligible for receiving methadone treatment services and are waiting to begin the programme. Report the number on the waiting list on the last day of the reporting period.
People Receiving Methadone (GP prescribing on Specialist	The total number of people receiving methadone prescribed by GPs under specialist service authority while receiving case management from specialist Alcohol and Drug services on the last day of the working period. (T Code: T19)

Definition	Description
Service Authority)	
People Receiving Methadone (GP Case Management)	The total number of people receiving methadone under GP case management on the last day of the working period.
People Receiving Methadone (Specialist Service Case Management)	The total number of people receiving methadone treatment under specialist Alcohol and Drug service case management on the last day of the reporting period. (Exclude GP prescribing and GP methadone case management.) (T Code: T18)
People Referred Back from GP	Number of people referred to a specialist methadone service by a GP in circumstances where the GP has previously been responsible for providing methadone treatment services to that person. ie, Where the GP has been the "case manager" and requests a specialist methadone service take over this role.
People Supported by this Service at the End of the Period/Month (by NZ Maori, Pacific Island, Other)	The number of current clients (individuals or families) currently receiving services. For definition of 'current client', see above. Although a client may identify as more than one ethnicity, for reporting purposes count them only once. You should prioritise by the Ministry of Health standards ie, NZ Maori, Pacific Island and Other. Example: A client identifies as NZ Maori and Pacific Island. You should count this person only once. They should be reported as NZ Maori. If a client does not identify as any ethnicity then you should enter in Other.
People Supported by this Service during the Period/Month (by NZ Maori, Pacific Island, Other)	Where provider can count Service Users individually, this figure should be the total number of people who have been current clients during the period. Count only once those people who have been discharged and re-entered the service during the period or who have used multiple services. **Where the provider cannot count Service Users once only for recurrent service use or for use of multiple services, record "not measured".** Although a client may identify as more than one ethnicity, for reporting purposes count them only once. You should prioritise by the Ministry of Health standards ie, NZ Maori, Pacific Island and Other. Example: A client identifies as NZ Maori and Pacific Island. You should count this person only once. They should be reported as NZ Maori. If a client does not identify as any ethnicity then you should enter in Other.
Planned Discharges	The number of clients who have finished their involvement with the service during the period where the decision to finish involvement with the service was reached by mutual agreement between the client and the service.
Programmes Delivered	The total number of mental health promotion programmes delivered during the period.
Re-admissions	The total number of consumers re-admitted to an inpatient mental health service within twenty eight days of previous discharge, where:

Definition	Description
	• the readmission was not planned at the time of discharge; and • the readmission is to the same service. Count those consumers who are on trial leave for 10 days or more who returned prior to their planned re-admission date.
Senior Medical FTE	This is a full time equivalent (see definition of FTE) senior medical staff member (including DAMHS, but excluding Registrars and House Surgeons) involved in the direct delivery of services to Mental Health consumers. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Suicides of Current Clients	The number of suicides of current clients during reporting period. Count only once for users of multiple services.
Transfers to an Inpatient Unit/Off Site Respite	The total number of people transferred from an accommodation service to a mental health inpatient unit or crisis respite service during the reporting period.
Unplanned Discharges - Self Initiated	The number of clients who have ended involvement with the service during the period, where the decision to end involvement was made by the client before the planned therapy/treatment was completed.
Unplanned Discharges - Service Initiated	The number of clients who have ended involvement with the service during the period, where the decision to end involvement was made by the service before the planned therapy/treatment was completed.

MINISTRY OF HEALTH
MANATŪ HAUORA

All District Health Boards

ADULT MENTAL HEALTH SERVICES -NEEDS ASSESSMENT AND SERVICE CO-ORDINATION MENTAL HEALTH AND ADDICTION SERVICES -TIER LEVEL THREESERVICE SPECIFICATION

STATUS:	**MANDATORY ☑**
It is compulsory to use this nationwide service specification when purchasing this service.	

Review History	Date
First Published on NSFL	June 2009
Working Party Review	April 2009
Amendments: Removal of unapproved Purchase Unit MHAK18A. Minor editing changes for consistency.	February 2011
Amendments: clarified reporting requirements	February 2013
Consideration for next Service Specification Review	Within five years

Note: Contact the Service Specification Programme Manager, National Health Board Business Unit, Ministry of Health to discuss proposed amendments to the service specifications and guidance in developing new or updating and revising existing service specifications.

Nationwide Service Framework Library web site http://www.nsfl.health.govt.nz

ADULT MENTAL HEALTH SERVICES -
NEEDS ASSESSMENT AND SERVICE CO-ORDINATION
MENTAL HEALTH AND ADDICTION SERVICES -
TIER LEVEL THREE
SERVICE SPECIFICATION
MHA18A, MHA18B, MHA18C, MHA18D, MHA18E

This tier three service specification for Adult Mental Health Services - Needs Assessment and Service Co-ordination (the Service) is linked to tier one Mental Health and Addiction Services and tier two Adult Mental Health service specifications.

1. Service Definition

The Service will work with the Service User, their family and whānau and significant others, to assess their needs and plan and co-ordinate appropriate services.

Needs assessments will be undertaken to identify individual strengths and supports / activities required that are likely to lead to resilience and recovery outcomes for the service user and their family and whānau.

2. Service Objectives

2.1 General

The Service facilitates the access of adults, to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support, needs assessment and prioritisation of access according to identified needs.

2.2 Māori Health

Refer to the tier one Mental Health and Addiction Services service specification.

3. Service Users

The Service Users are eligible adults as detailed in the tier two Adult Mental Health Services service specification.

4. Access

4.1 Entry Criteria

Referral to the Service is from community mental health services or inpatient mental health and addiction services.

5. Service Components.

5.1 Processes

The Service includes needs assessment, service planning, and co-ordination.

Needs Assessment:

The assessment process meets the requirement of the Standards for Needs Assessment and Service Co-ordination (Ministry of Health 1994) and utilises a recognised best practice assessment tool. The assessment process includes:

- identification and prioritisation of the service user's needs, both support and developmental needs, within the context of their
- attention to any immediate needs that may interfere with the family and whānau
- independent advocacy, where required person's ability to participate in a support needs assessment
- attention to cultural needs
- attention to the Service User's educational requirements and or employment concerns within the family and whānau context
- attention to the Service User's housing, social, recreational and financial concerns within the family and whānau context
- further specialist assessments as determined by the Service User.

Needs assessments are then repeated and updated at not greater than six monthly intervals.

Family and whānau are engaged (if appropriate) in the assessment process. Where a Service User is Māori, assessment will include a cultural needs assessment with their whānau present (in accordance with principles of informed consent) in the assessment process. Providers will ensure that the holistic view of health, as defined by Māori, is included in service provision for Māori.

Service Planning:

This includes:

- access to an up-to-date directory on mental health / community services
- identification of current services involved in meeting aspects of the needs and remaining unmet needs
- identification and documentation of actions that are necessary to address those unmet needs and to achieve agreed goals
- when needs cannot be met from publicly funded services, referrals will be made to a range of community-based services as appropriate in accordance with the assessment.

Co-ordination:

This includes:

- facilitation of access to community mental health and disability support services that will enable people with mental illnesses to lead their lives as independently and productively as possible
- development of practical service and support options to address identified needs utilising public, private and voluntary services
- prioritisation of the needs of the Service User and management of the demand for available services by determining relative priority between those accessing services
- development of a service or 'lifestyle' plan
- the match of available resource with needs, ensuring resources are used efficiently
- management of an allocation for carer relief or home support
- access management to support services, including residential services.

Needs assessment / service co-ordination services may provide the above services to people with addictions, in addition to those people with severe mental health problems, according to local requirements / agreements between funders and service providers.

5.2 Settings

The Service is community based.

5.3 Key Inputs

The Service is provided by a multi-disciplinary team, including people with qualifications in assessing, planning and co-ordination, Service Users, people with experience of disability, cultural workers and health professionals.

6. Service Linkages

Linkages are not limited to those described in tier one Mental Health and Addiction Services and tier two Adult Mental Health Services service specifications and include the table below.

Service Provider	Nature of Linkage	Accountabilities
Providers of other needs assessment and service coordination services	Referral Liaison	Work with the relevant professionals and agencies in the care and support of the Service user

7. Exclusions

Refer to tier one Mental Health and Addiction Services service specification.

8. Quality Requirements

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

9. Purchase Units and Reporting Requirements

9.1 Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service.

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definitions	Payment Systems
MHA18A	Needs assessment and service coordination – Senior medical staff	A service by senior medical staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	Full-time equivalent staff member (clinical or non-clinical) involved in direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions e.g. half-time coordination of a community team.	Sector Services
MHA18B	Needs assessment and service coordination – Junior medical staff	A service by junior medical staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	As above	Sector Services
MHA18C	Needs assessment and service coordination – Nursing and/or allied health staff	A service by nurses and/or allied staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	As above	Sector Services

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definitions	Payment Systems
MHA18D	Needs assessment and service coordination – Non-clinical staff	A service by non-clinical support staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	As above	Sector Services
MHA18E	Needs assessment and service coordination – Cultural staff	A service by cultural support staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	As above	Sector Services

9.2 Reporting

Details of any additional information to be collected and the frequency of reporting to Sector Services Contract Management System are as specified and documented by the Funder in the Provider Specific Schedule of the contract.

The Service must comply with the requirements of national data collections PRIMHD.

Prior to the Services satisfactorily reporting to PRIMHD, the following information will be reported to:

The Performance Reporting Team, Sector Services
Ministry of Health
Private Bag 1942 Dunedin 9054.

Email performance_reporting@moh.govt.nz.

Prior to PRIMHD Reporting to Sector Services, Ministry of Health:

Frequency	Data
Monthly	First face to face contact individual/family
Monthly	Follow up face to face contact individual/family
Monthly	Number completed support needs assessments
Monthly	Number of people supported by services at end of period (by NZ Maori, Pacific Island, Other)
Monthly	Number of people supported by services during month (by NZ Maori, Pacific Island, Other)
Monthly	Monthly expenditure for flexi fund with a breakdown of information re utilisation.
Quarterly	Senior Medical FTEs
Quarterly	Junior medical FTEs
Quarterly	Nursing and allied FTEs
Quarterly	Non clinical FTEs
Quarterly	Cultural FTEs

Quarterly	Peer support FTEs
Quarterly	Staff turnover ratio
Quarterly	Average Length of Stay
Six monthly	Number of NGO Board member changes (NGOs only)
Six monthly	Number of NGO Governance meetings held (NGOs only)
Annually	Number of FTEs in each of these groups: • Medical • Nursing • Psychology • Occupational Therapy • Social Work • Maori Mental Health • Other

When the Service is satisfactorily reporting to PRIMHD, and agreement is reached with the DHB, only the following information needs to be reported to:

The Performance Reporting Team, Sector Services
Ministry of Health
Private Bag 1942 Dunedin 9054.

Email performance_reporting@moh.govt.nz.

After PRIMHD Reporting to Sector Services, Ministry of Health:

Frequency	Data
Monthly	Monthly expenditure for flexi fund with a breakdown of information re utilisation.
Quarterly	Senior Medical FTEs
Quarterly	Junior medical FTEs
Quarterly	Nursing and allied FTEs
Quarterly	Non clinical FTEs
Quarterly	Cultural FTEs
Quarterly	Peer Support FTEs
Quarterly	Staff turnover ratio
Six monthly	Number of NGO Board member changes (NGOs only)
Six monthly	Number of NGO Governance meetings held (NGOs only)
Annually	Number of FTEs in each of these groups: • Medical • Nursing • Psychology • Occupational Therapy • Social Work • Maori Mental Health • Other

MINISTRY OF HEALTH
MANATŪ HAUORA

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ADULT MENTAL HEALTH SERVICES -NEEDS ASSESSMENT AND SERVICE CO-ORDINATION MENTAL HEALTH AND ADDICTION SERVICES -TIER LEVEL THREESERVICE SPECIFICATION

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MENTAL HEALTH AND ADDICTION SERVICES -
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2. Service Objectives

2.1 General

The Service facilitates the access of adults, to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support, needs assessment and prioritisation of access according to identified needs.

2.2 Māori Health

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3. Service Users

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4. Access

4.1 Entry Criteria

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5. Service Components.

5.1 Processes

The Service includes needs assessment, service planning, and co-ordination.

Needs Assessment:

The assessment process meets the requirement of the Standards for Needs Assessment and Service Co-ordination (Ministry of Health 1994) and utilises a recognised best practice assessment tool. The assessment process includes:

- identification and prioritisation of the service user's needs, both support and developmental needs, within the context of their
- attention to any immediate needs that may interfere with the family and whānau
- independent advocacy, where required person's ability to participate in a support needs assessment
- attention to cultural needs
- attention to the Service User's educational requirements and or employment concerns within the family and whānau context
- attention to the Service User's housing, social, recreational and financial concerns within the family and whānau context
- further specialist assessments as determined by the Service User.

Needs assessments are then repeated and updated at not greater than six monthly intervals.

Family and whānau are engaged (if appropriate) in the assessment process. Where a Service User is Māori, assessment will include a cultural needs assessment with their whānau present (in accordance with principles of informed consent) in the assessment process. Providers will ensure that the holistic view of health, as defined by Māori, is included in service provision for Māori.

Service Planning:

This includes:

- access to an up-to-date directory on mental health / community services
- identification of current services involved in meeting aspects of the needs and remaining unmet needs
- identification and documentation of actions that are necessary to address those unmet needs and to achieve agreed goals
- when needs cannot be met from publicly funded services, referrals will be made to a range of community-based services as appropriate in accordance with the assessment.

Co-ordination:

This includes:

- facilitation of access to community mental health and disability support services that will enable people with mental illnesses to lead their lives as independently and productively as possible
- development of practical service and support options to address identified needs utilising public, private and voluntary services
- prioritisation of the needs of the Service User and management of the demand for available services by determining relative priority between those accessing services
- development of a service or 'lifestyle' plan
- the match of available resource with needs, ensuring resources are used efficiently
- management of an allocation for carer relief or home support
- access management to support services, including residential services.

Needs assessment / service co-ordination services may provide the above services to people with addictions, in addition to those people with severe mental health problems, according to local requirements / agreements between funders and service providers.

5.2 Settings

The Service is community based.

5.3 Key Inputs

The Service is provided by a multi-disciplinary team, including people with qualifications in assessing, planning and co-ordination, Service Users, people with experience of disability, cultural workers and health professionals.

6. Service Linkages

Linkages are not limited to those described in tier one Mental Health and Addiction Services and tier two Adult Mental Health Services service specifications and include the table below.

Service Provider	Nature of Linkage	Accountabilities
Providers of other needs assessment and service coordination services	Referral Liaison	Work with the relevant professionals and agencies in the care and support of the Service user

7. Exclusions

Refer to tier one Mental Health and Addiction Services service specification.

8. Quality Requirements

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

9. Purchase Units and Reporting Requirements

9.1 Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service.

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definitions	Payment Systems
MHA18A	Needs assessment and service coordination – Senior medical staff	A service by senior medical staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	Full-time equivalent staff member (clinical or non-clinical) involved in direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions e.g. half-time coordination of a community team.	Sector Services

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definitions	Payment Systems
MHA18B	Needs assessment and service coordination – Junior medical staff	A service by junior medical staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	As above	Sector Services
MHA18C	Needs assessment and service coordination – Nursing and/or allied health staff	A service by nurses and/or allied staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	As above	Sector Services
MHA18D	Needs assessment and service coordination – Non-clinical staff	A service by non-clinical support staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	As above	Sector Services
MHA18E	Needs assessment and service coordination – Cultural staff	A service by cultural support staff to facilitate the access of adults to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support needs assessment and prioritisation of access according to identified needs.	FTE	As above	Sector Services

9.2 Reporting

Details of any additional information to be collected and the frequency of reporting to Sector Services Contract Management System are as specified and documented by the Funder in the Provider Specific Schedule of the contract.

The Service must comply with the requirements of national data collections PRIMHD.

Prior to the Services satisfactorily reporting to PRIMHD, the following information will be reported to:

The Performance Reporting Team, Sector Services
Ministry of Health
Private Bag 1942 Dunedin 9054.

Email performance_reporting@moh.govt.nz.

Prior to PRIMHD Reporting to Sector Services, Ministry of Health:

Frequency	Data
Monthly	First face to face contact individual/family
Monthly	Follow up face to face contact individual/family
Monthly	Number completed support needs assessments
Monthly	Number of people supported by services at end of period (by NZ Maori, Pacific Island, Other)
Monthly	Number of people supported by services during month (by NZ Maori, Pacific Island, Other)
Monthly	Monthly expenditure for flexi fund with a breakdown of information re utilisation.
Quarterly	Senior Medical FTEs
Quarterly	Junior medical FTEs
Quarterly	Nursing and allied FTEs
Quarterly	Non clinical FTEs
Quarterly	Cultural FTEs
Quarterly	Peer support FTEs
Quarterly	Staff turnover ratio
Quarterly	Average Length of Stay
Six monthly	Number of NGO Board member changes (NGOs only)
Six monthly	Number of NGO Governance meetings held (NGOs only)
Annually	Number of FTEs in each of these groups: • Medical • Nursing • Psychology • Occupational Therapy • Social Work • Maori Mental Health • Other

When the Service is satisfactorily reporting to PRIMHD, and agreement is reached with the DHB, only the following information needs to be reported to:

The Performance Reporting Team, Sector Services
Ministry of Health
Private Bag 1942 Dunedin 9054.

Email performance_reporting@moh.govt.nz.

After PRIMHD Reporting to Sector Services, Ministry of Health:

Frequency	Data
Monthly	Monthly expenditure for flexi fund with a breakdown of information re utilisation.
Quarterly	Senior Medical FTEs
Quarterly	Junior medical FTEs
Quarterly	Nursing and allied FTEs
Quarterly	Non clinical FTEs
Quarterly	Cultural FTEs
Quarterly	Peer Support FTEs
Quarterly	Staff turnover ratio
Six monthly	Number of NGO Board member changes (NGOs only)
Six monthly	Number of NGO Governance meetings held (NGOs only)
Annually	Number of FTEs in each of these groups: • Medical • Nursing • Psychology • Occupational Therapy • Social Work • Maori Mental Health • Other

ADULT MENTAL HEALTH SERVICES – ADULT COMMUNITY SUPPORT SERVICES MENTAL HEALTH AND ADDICTION SERVICES –
TIER LEVEL THREE
SERVICE SPECIFICATION
MHA20C, MHA20D, MHA20E, MHA20F, MHA20DH

Service Definition

The Service will include:

- facilitating a recovery plan with the Service User and include any other persons that the Service User deems appropriate for the development of this recovery plan
- where possible, provision of culturally preferred support options for the Service User
- assisting the Service User to access a range of services, including community-based activities, social networks, health intervention, education, employment options, vocational and social services
- when appropriate, collaboration with clinical mental health services
- facilitating, where appropriate, linkages to natural supports and strengths within the family and whānau
- facilitating linkages to natural supports and strengths with the wider community to improve independence
- when required, assisting the Service User to manage household tasks and activities of daily living, including personal care
- the Service will ensure that an appropriate support worker is assigned to the Service User, that is, age, gender and culturally compatible
- support hours may be available seven days a week

- visits normally pre-arranged by mutual agreement between the Service User and support worker, but there should be flexibility to allow for unexpected needs
- documented support hours and service expectations that are clearly communicated to the Service User.

The Service will be:

- person centred and responsive to individual consumer needs
- recovery focused and enable the Service User to lead their own recovery
- able to provide choice, promote independence and value diversity
- aligned to community development
- aimed to have a family systems / whānau ora philosophy to facilitate ongoing sustainable recovery / whānau ora.

MHA20C	Adult community support services – Nurses & allied health staff	A person centred service for people living with mental illness who live independently but not necessarily alone in their community. The service provides support in relation to family-whanau, community living, education, employment and self-management of their wellbeing. The service is provided by nurses and/or allied health with appropriate training and qualifications to meet the support needs of people with mental illness.
MHA20D	Adult community support services – Non-clinical staff	A person centred service for people living with mental illness who live independently but not necessarily alone in their community. The service provides support in relation to family-whanau, community living, education, employment and self-management of their wellbeing. The service is provided by non-clinical support staff with appropriate training and qualifications to meet the support needs of people with mental illness.
MHA20E	Adult community support services - Cultural staff	A person centred service for people living with mental illness who live independently but not necessarily alone in their community. The service provides support in relation to family-whanau, community living, education, employment and self-management of their wellbeing. The service is provided by cultural support staff with appropriate training and qualifications to meet the support needs of people with mental illness.
MHA20F	Adult community support services - Peer support staff	A person centred service for people living with mental illness who live independently but not necessarily alone in their community. The service provides support in relation to family-whanau, community living, education, employment and self-management of their wellbeing. The service is provided by peer support groups with appropriate training and qualifications to meet the support needs of people with mental illness.

MHA20DH	Adult community support services- Non-Clinical Staff-UoM hour	A person centred service for people living with mental illness who live independently but not necessarily alone in their community. The service provides support in relation to family-whanau, community living, education, employment and self-management of their wellbeing. The service is provided by non-clinical support staff with appropriate training and qualifications to meet the support needs of people with mental illness.

ADULT MENTAL HEALTH SERVICES - DAY ACTIVITY AND LIVING SKILLS SERVICEMENTAL HEALTH AND ADDICTION SERVICES
TIER THREE
SERVICE SPECIFICATION
MHA21C, MHA21D, MHA21E, MHA21F

The Service includes day activity services that:

- are provided in a community-based setting
- may be long term
- promotes recovery and community involvement by including socially inclusive activities in community mainstream settings
- offers Service Users key roles in determining the content of the programmes and the ways in which activity services are managed
- provides a flexible and varied programme of activities determined largely by the Service User's needs and aligned with their individual goals
- provides a safe environment for mutual support, information exchange and socialisation.

The style of Service provided is such that:

- there is an emphasis on supporting and developing the strengths of the Service Users and their families / whānau and significant others. Mental Health workers will work together with the Service User to reach desirable outcomes for all
- the particular needs of Māori and Pacific peoples Service Users is met by the provision of culturally derived skills programmes. Wherever possible, the ethnicity of staff will reflect the ethnicity of the local population / client group.

It is expected that the services contribute to the following outcomes for Service Users:

- improved participation in community life
- development and maintenance of work skills and routines
- greater stability of lifestyle
- increased social 'connectedness' and sense of belonging
- fulfilment of self-expression in arts and creative / recreational pursuits.

MHA21C	Activity based recovery support services - Nursing and/or allied health staff	A recovery-oriented service by nurses and/or allied health staff to assist people with mental illness to develop their life and living skills and enjoy their relationships with others.
MHA21D	Activity based recovery support service - Non-clinical staff	A recovery-oriented service by non-clinical support staff to assist people with mental illness to develop their life and living skills and enjoy their relationships with others.
MHA21E	Activity based recovery support service – Cultural Staff	A recovery-oriented service by cultural support staff to assist people with mental illness to develop their life and living skills and enjoy their relationships with others.
MHA21F	Activity based recovery support service – Peer Support	A recovery-oriented service by peer support staff to assist people with mental illness to develop their life and living skills and enjoy their relationships with others.

ADULT MENTAL HEALTH – VOCATIONAL SUPPORT SERVICE
MENTAL HEALTH AND ADDICTION SERVICES
TIER LEVEL THREE
SERVICE SPECIFICATION
MHA22C, MHA22D, MHA22E, MHA22F

The Service includes employment and education support that is community-based and provides Service Users with the support, training and assistance necessary for them to gain employment.

The Service will also provide flexible ongoing support to help Service Users maintain their vocational goals. Service Users will be given as much responsibility as they are able to take for determining the content of the programme and the day-to-day running of the service.

The Service will provide a flexible and varied programme of activities that are determined largely by the individual needs of each Service User, and will provide a safe environment for the development of educational, employment and social skills.

The style of the Service will be such that:

- there is an emphasis on supporting the strengths of the Service Users and their families and whānau and significant others
- mental health workers will work together with the Service User to reach desirable outcomes for all
- the particular needs of Māori and Pacific peoples Service Users are met by the provision of culturally derived skills programmes
- wherever possible, relevant staff will be of Māori or Pacific Peoples descent.

MHA22C	Vocational support service - Nursing and/or allied staff	A recovery-oriented vocational support service, provided by nurses and/or allied health staff to assist service users attain their vocational goals.
MHA22D	Vocational support service - Non-clinical staff	A recovery-oriented vocational support service, provided by non-clinical support staff to assist service users attain their vocational goals.
MHA22E	Vocational support service - Cultural staff	A recovery-oriented vocational support service, provided by cultural support staff to assist service users attain their vocational goals.
MHA22F	Vocational support service - Peer support staff	A recovery-oriented vocational support service, provided by cultural support staff to assist service users attain their vocational goals.

ADULT MENTAL HEALTH – HOUSING CO-ORDINATION SERVICE
MENTAL HEALTH AND ADDICTION SERVICES-
TIER THREE
SERVICE SPECIFICATION
MHA23C MHA23D

The Service will include any or all of the following for any person:

- consultation and liaison with mental health service providers in respect of availability of housing suitable for the person that best meets their identified needs
- co-ordination and/or management of access to, or exit from, support services with housing, supportive landlord arrangements, models of supported independent living (as agreed with the DHB and local service co-ordination services)
- liaison with other agencies and providers of housing, to maintain knowledge of available housing stock within the district.

The mental health service of the applicable DHB will have agreed to provide clinical treatment. People for whom this service is provided will generally not solely require sustained crisis/acute intervention and will not generally be an immediate risk of harm.

MHA23C	Housing coordination service- nursing and / or allied health staff	A service to ensure that people receiving interventions and support from mental health services are able to also access a range of housing options that assist them on their recovery path.
MHA23D	Housing coordination service- non clinical staff	A service provided by non clinical staff to ensure that people receiving interventions and support from mental health services are able to also access a range of housing options that assist them on their recovery path.

The Service will include:

- comfortable accommodation that is well-maintained to a high standard and meets relevant national and local building standards/requirements
- planned and time-limited support services / responses, based upon regular support needs assessment that informs a recovery / support plan that:
  - is designed to meet a person's individual needs
  - reduces their need to utilise more intensive mental health services
  - is inclusive of the person's cultural needs
  - might contribute to meaningful, positive change in that person's life
- access to awake support staff 24-hours per day, seven days per week
- a separate bedroom for each person that enables their enjoyment of privacy or the choice of sharing a bedroom should this be preferred
- allocation of an appropriately trained and supervised support worker from the service, who is acceptable to them
- access to clinical support and assistance.

One support staff member will be awake and directly available for the hours 10.00pm to 6.00am to respond to the needs of the Service User. There will be on-call access at all times to a health professional with experience in mental health and addiction, who is able to provide clinical support and assistance as required.

As described in tier one service specifications, a mutually agreed individual recovery /support plan will be developed with each person and their worker in conjunction with the DHB community mental health team. The plan will set out specific plans and goals that will be reviewed three monthly with a formal reviewing at least six monthly. In accordance with their plan, people using the service will aim to progress towards more independent living, or, as mutually agreed, will maintain their level of independence by developing skills and supports.

The Service will further assist a person's recovery through the provision of services that may:

- provide assistance and coaching in meeting responsibilities (cleaning, meal preparation, purchasing household provisions, laundry) in such a way as to enable each person to participate as fully as they are able without unreasonable expectations and with health and safety requirements met
- support people to take responsibility for decisions about household management and activities
- provide support and access to community resources (for example, income support, social networks, sports, employment and / or training opportunities) where this is indicated as a support need by the person.

Each person using the Services will be encouraged to take a lead role in the preparation, implementation and evaluation of their individually planned recovery-focused support services.

Recovery / support plans will identify the relative roles of the support staff and visiting DHB community mental health team's clinical staff, including matters (but not limited to) relating to personal, clinical, cultural, spiritual and social domains.

Clinical support will also be provided for each person by an assigned clinician from the local DHB community mental health service and/or local primary health service if a shared care arrangement is in place, working in partnership with the service provider.

MHA24	Housing and recovery services day time/awake night support	Community-based housing and recovery-focused support services for people who experience mental health disorders, with higher levels of acuity with 24-hour support, provided by appropriately trained and qualified support workers and access to clinical staff are required to meet individual needs
MHA24C	Housing and recovery services day time/awake night support - Nursing and/or allied staff	Community-based housing and recovery-focused support services provided by nurses and/or allied health support staff for people who experience mental health disorders, with higher levels of acuity with 24-hour support, provided by appropriately trained and qualified support workers and access to clinical staff are required to meet individual needs
MHA24D	Housing and recovery services day time/awake night support - Non-clinical staff	Community-based housing and recovery-focused support services provided by non-clinical staff for people who experience mental health disorders, with higher levels of acuity with 24-hour support, provided by appropriately trained and qualified support workers and access to clinical support staff are required to meet individual needs

This Service will include:

- comfortable accommodation that is well-maintained to a high standard and meets relevant national and local building standards / requirements
- planned and time-limited support services / responses, based upon regular support needs assessment that informs a recovery / support plan that:
  - is designed to meet a person's individual needs
  - reduces their need to utilise more intensive mental health services
  - is inclusive of the person's cultural needs
  - might contribute to meaningful, positive change in that person's life
- a separate bedroom for each person that enables their enjoyment of privacy or the choice of sharing a bedroom should this be preferred
- will be recovery and family and whānau oriented and responsive to individual consumer needs as outlined in the tier one service specification.

Each person using the Service will be allocated an appropriately trained and supervised support worker from the Service, who is acceptable to them.

A mutually agreed individual recovery / support plan will be developed with each person and their support worker in conjunction with the DHB community mental health team. The agreed recovery / support plan will set out specific goals that will be reviewed three monthly with a formal reviewing at least six monthly.

In accordance with their recovery / support plan, people using the Service will aim to progress towards more independent living, or, as mutually agreed, will maintain their level of independence by developing skills and supports.

The Service will further assist a person's recovery through the provision of services that may:

- provide assistance and coaching in meeting responsibilities (cleaning, meal preparation, purchasing household provisions, laundry) in such a way as to enable each person to participate as fully as they are able without unreasonable expectations and with health and safety requirements met
- support people to take responsibility for decisions about household management and activities
- provide support and access to community resources (for example, income support, social networks, sports, employment and/or training opportunities) where this is indicated as a support need by the person.

There will be access to support staff 24-hours per day, seven days per week. Face-to-face support will be available between 7.30am and 11.00pm seven days per week. There will be at least one staff member on duty at all times who is readily available to people who use the Service. Where the need for additional support is indicated (in collaboration with the person and DHB staff), sleep-over or awake support may be provided over-night. Each person using the Services will be encouraged to take a lead in the preparation, implementation and evaluation of their individually planned recovery-focused support services.

Recovery / support plans will identify the relative roles of the support staff and the visiting DHB community mental health team's clinical staff, including matters relating to (but not limited to): personal, clinical, cultural / spiritual and social recovery.

Clinical support will also be provided for each person by an assigned clinician from the local DHB community mental health service and / or local primary health service if a shared care arrangement is in place.

MHA25	Housing and recovery services day time/responsive night support	A service to provide community-based housing and recovery-focused support services for people who experience mental health disorders, and who would respond positively to a housing and recovery environment and actively agree to access this type of service.
MHA25C	Housing and recovery services day time/responsive night support - Nursing and/or allied health staff	A service delivered by nurses and/or allied health staff to provide community-based housing and recovery-focused support services for people who experience mental health disorders, and who would respond positively to a housing and recovery environment and actively agree to access this type of service.
MHA25D	Housing and recovery services day time/responsive night support - Non-clinical staff	A service delivered by non-clinical support staff to provide community-based housing and recovery-focused support services for people who experience mental health disorders, and who would respond positively to a housing and recovery environment and actively agree to access this type of service.

ADULT MENTAL HEALTH- SUPPORTIVE LANDLORD SERVICE-
MENTAL HEALTH AND ADDICTION SERVICES
TIER THREE
SERVICE SPECIFICATION
MHA26

The Service will include recovery-oriented, regular practical contact and social support to persons with mental illness in their own rented accommodation.

Standard accommodation within the community is provided, for example:

- clean, furnished or semi-furnished self-contained individual accommodation (except for couples who choose to share). Some may also wish to share with a flatmate or flatmates of their choosing in larger accommodation
- regular, unobtrusive inspections and maintenance to take place by the landlord
- external maintenance, such as gardening and lawn mowing done by the landlord
- payment of rates and insurance on the property paid by the landlord
- landlord will assist Service Users to maintain ongoing contact with appropriately trained and supervised community support workers, who are acceptable to the Service User
- all tenants receive regular education to ensure they are familiar with appropriate action to be taken in the event of fire or emergency. Note: this responsibility can be taken on by the 'lead tenant' where appropriate.

The Service will assist the development of a mutually agreed care/support plan developed jointly by the tenant, and allocated support people from a contracted provider who are acceptable to the Service User.

Where boarding-type settings are preferred by the Service User, the accommodation must not be restricted nor solely provided to people with mental health or addiction issues.

The rental is to be no more than current market rates as can be determined under the Residential Tenancy Act 1986 and amendments.

MHA26	Supportive landlord service	A service to provide flexible community-based, affordable, furnished or unfurnished flats with regular social support for people with mental health disabilities. Tenants will have security of tenure and social supports will be minimally intrusive.

ADULT MENTAL HEALTH- ADULT PACKAGE OF CARE
MENTAL HEALTH AND ADDICTION SERVICES
TIER THREE
SERVICE SPECIFICATION
MHA19, MHA19C, MHA19D, MHA19E

The Service will include packages of care that are:

- well integrated with other adult mental health services
- focused to ensure active treatment, crisis intervention and prevention of the escalation of development of the Service User's illness, prevention of disability, and the prevention of the development of dependency
- conscious of the safety needs of the Service User and the community, including staff, reflecting that some Service Users may present a risk of suicide, self-harm or danger to others
- delivered in accordance with a comprehensive system of risk management within which least restrictive intervention strategies will be determined.

Individualised treatment plans and relapse prevention plans are developed for each person using the service. These plans are comprehensive, based on assessed needs, and include identified goals for the period of treatment/care. Plans are developed in conjunction with the Service User and their family/whānau, and carers, and with relevant community service involvement.

The provider will be responsible for:

- the development and funding of individualised packages of treatment/care aimed at meeting the specific needs of each Service User and their family/whānau
- reviewing and monitoring the safety and appropriateness of each care package, modifying according to need, and the assessment of ongoing requirements
- ensuring an emphasis is placed on the provision of treatment and support in an environment and context that is safe and familiar for Service User
- ensuring that care packages are culturally appropriate and safe for each individual and their family/whānau
- ensuring that criteria and guidelines are in place to manage entry to and exit from the service, including criteria for prioritisation of referrals
- ensuring that care funding is not used to duplicate existing services but it is used to provide supports in addition to those provided by existing health, welfare and support agencies and to those services provided by other specialist mental health services
- management of the package of care funding (including flexi-fund budgets) within the annual budget and ensuring that the available funding is used efficiently and effectively.

The provider may enter into subcontracting arrangements with other organisations for the delivery of components of the package but will be accountable for the total package deliverables.

MHA19	Package of care	A service to provide individually tailored packages of care/treatment for adults who are experiencing severe and enduring mental illness/mental health problem
MHA19C	Package of care - Nursing and/or allied staff	A service by nurses and/or allied health staff to provide individually tailored packages of care/treatment for adults who are experiencing severe and enduring mental illness/mental health problem
MHA19D	Package of care - Non-clinical staff	A service by non-clinical support staff to provide individually tailored packages of care/treatment for adults who are experiencing severe and enduring mental illness/mental health problem

MHA19E	Package of care - Cultural Staff	A service by cultural support staff to provide individually tailored packages of care/treatment for adults who are experiencing severe and enduring mental illness/mental health problem

FAMILY AND WHANAU SERVICES –
SUPPORT, EDUCATION, INFORMATION AND ADVOCACY SERVICE
MENTAL HEALTH AND ADDICTION SERVICES
TIER LEVEL THREE
SERVICE SPECIFICATION
MHW68C, MHW68D, MHIW68C, MHIW68D

The Service is provided to family and whānau at the place they prefer and will be flexible in its hours to allow contact with family and whānau who work during the day. It is not a 24 hour service.

The Service will enhance the ability of family and whānau to support a person who has, or may be developing, a major mental illness or addiction.

The Service may include:

- provision of accurate information and education, about mental illness and/or addiction, mental health and/or addiction services, community agencies and supports, available to both Service Users and family and whānau
- the understanding and affirming of the personal, social and work-related impacts of mental illness and/or addiction, on family and whānau
- assistance with the development of strategies for the family and whānau to support the Service User, and themselves, before as well as during the recovery process.

These strategies may include, but are not limited to:

- communication, problem-solving and self-advocacy skills
- crisis planning, risk and safety
- liaison with other services eg, with mental health service
- family and whānau maintaining their own wellness
- referral of family and whānau to other community agencies or services
- advocacy and liaison with other service providers or agencies
- assessment of the families strengths, roles, responsibilities and support needs
- peer support networks (family to family) or support groups may be offered
- work in partnership with the relevant teams of District Health Board mental health and addiction services . For infant, child, adolescent and youth services, this would involve working closely with CAMHS

The family and whānau will be offered a range of time limited support options. The level of support and engagement will vary according to the particular needs and requirements of family and whānau. Service provision will include the development of a support plan, reflecting the issues and goals of the family and whānau, and transition planning for service exit. This will also include the role of the family and whānau in their family members relapse prevention plan.

MHW68C	Family whānau support education, information and advocacy service – Nurses & allied health	Community based service to provide support, education, information and advocacy to the family and whānau of mental health Service Users at the place they prefer. The service will be flexible in its hours to allow contact with family and whānau who work during the day. The service is provided to families by nursing and allied health staff.
MHW68D	Family whānau support education, information and advocacy service – Non-clinical staff	Community based service to provide support, education, information and advocacy to the family and whānau of mental health Service Users at the place they prefer. The service will be flexible in its hours to allow contact with family and whānau who work during the day. The service is provided to families by non-clinical staff.

MHIW68C	Family whānau support education, info and advocacy service ICAY – Nurses & allied health	Community based service to provide support, education, information and advocacy to the family and whānau of mental health users at the place they prefer. The service will be flexible in its hours to allow contact with family and whānau who work during the day. The service is provided to infants, children and adolescents (ICAY) by nursing and allied health staff by nursing and allied health staff.
MHIW68D	Family whānau support education, info & advocacy service ICAY – Non-clinical staff	Community based service to provide support, education, information and advocacy to the family and whānau of mental health users at the place they prefer. The service will be flexible in its hours to allow contact with family and whānau who work during the day. The service is provided to infants, children and adolescents (ICAY) by non-clinical staff.

ADULT MENTAL HEALTH-
SUB-ACUTE/ EXTENDED CARE INPATIENT BEDS
MENTAL HEALTH AND ADDICTION SPECIALIST SERVICES
TIER THREE
SERVICE SPECIFICATION
MHA07

The Service includes a goal-oriented, recovery-focused, skill development inpatient programme that increases the Service User's ability to:

- manage their own illness
- achieve life goals
- develop positive relationships
- develop problem-solving skills.

Plans will be developed in accordance with formally assessed needs. Progress against plans and identified goals will be reviewed at specified intervals with modification of plans accordingly. Plans will aim to:

- meet individual needs
- manage clinical risk
- assist reintegration into the community
- maintain cultural links
- regain and maintain family/whānau links
- educate the Service User and their carers about illness, symptoms and the management of symptoms.

The emphasis will be on the implementation of the treatment plan and reintegration into the community. A comprehensive range of community- and hospital-based treatment and therapy options will be available including:

- pharmacotherapy and bio-medical investigations and interventions
- psychological treatments
- social treatments
- occupational therapy
- recreational activities
- social skills training
- budgeting
- domestic skills training
- assertiveness and self-esteem building
- development of cultural links.

MHA07	Sub-acute extended care - Inpatient beds	An inpatient recovery-oriented service that enhances the skills and functional independence of service users. The service is for people who are assessed as requiring care in a more structured environment because of diagnostic and treatment complexity, or insufficient response to treatment, and have a continuing need for a high level of ongoing supervision and support