Mental Health & Addictions Services, Integrated Care Pathway

Policy Responsibilities and Authorisation

Department Responsible for Policy	Waikato DHB, Mental Health & Addictions service
Document Facilitator Name	Rachael Aitchison
Document Facilitator Title	Director: Acute, Forensic & Specialty Service
Document Owner Name	Rees Tapsell
Document Owner Title	Clinical Services Director
Target Audience	Staff
Committee Approved	Mental Health Clinical Governance Forum
Date Approved	20 May 2019
Committee Endorsed	Board of Clinical Governance
Date Endorsed	14 June 2019

Disclaimer: This document has been developed by Waikato District Health Board specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and Waikato District Health Board assumes no responsibility whatsoever.

Policy Review History

Version	Updated by	Date Updated	Summary of Changes
02	Rachael Aitchison	March 2019	Change from circle of care to multidisciplinary team and other minor wording changes

Contents

1 Introduction 4
1.1 Purpose 4
1.2 Background 4
1.3 Scope 4
2 Definitions and Acronyms 4
2.1 Acronyms 9
3 Integrated Care Pathway Policy Statements 10
4 Integrated Care Pathway Policy Processes 11
4.1 Responsibilities 11
5 Integrated Care Pathway Process 14
6 Integrated Care Pathway Tools 20
7 Audit Indicators 29
8 Legislative requirements 30
9 Associated Waikato DHB Documents 30
Appendix A, Metabolic monitoring standard 32

1 Introduction

1.1 Purpose

The purpose of this policy is to outline the set of standard expectations for the care of all people referred to the Mental Health and Addictions service. In this policy the term "integrated care pathway" is used to refer to a key strategy for ensuring care is managed and organised in a standardised manner (see Appendix B, definitions and acronyms).

The Mental Health and Addictions service will deliver coordinated care by means of an integrated care pathway. This policy provides the outlines of the essential set of standardised care inputs which affect progressive service user flow through services. The Mental Health and Addictions service recognises that health care is unique to the service user and variations to the pathway may occur. Ongoing monitoring of variations in care delivery will be part of the learning and continuous improvement process with the service. When they do, variations in care will be monitored as a response of learning and continuous quality improvement.

1.2 Background

Waikato DHB Mental Health and Addictions services recognises its responsibility for providing safe, effective and efficient mental health care for service users1 and their whānau, and other carers.

1.3 Scope

This policy is to be used for all service users referred to Mental Health and Addiction services. It applies to all clinical employees, students and contractors working within the Mental Health and Addictions service and describes the responsibilities of both managers and other individuals in relation to service delivery. It highlights the key accountabilities for the governance forums, and other individuals in relation to quality of care.

2 Definitions and Acronyms

The following definitions are used through the document.

- ***Addiction***
  Addiction in this document relates only to alcohol and other drug use and/or problem gambling.

- ***Alcohol or any other Drug Clinician***
  Offer recovery focused services for individuals with addictions (as outlined above)

- ***Assessment***
  A service provider's systematic and ongoing collection of information about the needs of a person. A clinical assessment forms the basis for development a diagnosis and an individualised treatment and support plan with the service user and their carer.

- ***Clinical practice guidelines***
  Clinical practice guidelines describe best evidenced clinical choices to treat a specific disorder. they can be found here https://www.ranzcp.org/publications/guidelines-and-resources-for-practice

- ***Bio-psycho-social***
  The bio-psycho-social model is a general model or approach stating that biological, psychological (which entails thoughts, emotions, and behaviours), and social (socio- economical, socio-environmental, inclusive of cultural and spiritual factors, their complex interactions all play a significant role in understanding health, illness, and health care delivery.

- ***Clinical record***
  Information about the physical or mental health of a service user, which has been made by, or on behalf of the multidisciplinary team (which is recorded either electronically or in a paper file).

- ***Clinical psychologist***
  Clinical psychologists apply psychological knowledge and theory derived from research to the area of mental health and development, to assist children, young persons, adults and their families with emotional, mental, development or behavioural problems by using psychological assessment, formulation and diagnosis based on biological, social and psychological factors, and applying therapeutic interventions using a scientist -practitioner approach. Such practice is undertaken within an individual's area and level of expertise and with due regards to ethical, legal, and the New Zealand Psychologists Board-prescribed standards.

- ***Consultant psychiatrist (SMO – senior medical officer)***
  A qualified doctor who has completed special advanced training in diagnosing and treating mental health illness or disorders.

- ***Crisis***
  Crisis is viewed as a turning point towards health or illness, a self-limited period of a few days to six weeks in which environmental stress leads to a state of psychological disequilibrium. Crisis is defined on the basis of the severity, not the type of problem facing the individual, and whether any acknowledged trigger factors for a crisis are present.

- ***Diagnosis***
  Identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and possible causes for the symptoms. DSM IV or ICD 10 classification systems for are used for diagnosis.

- ***Evidence-based practice***
  An approach to decision-making in which the health practitioner/s uses the best evidence available, in consultation with the service user, to decide on a course of action that suits the person best.

- ***Family Whānau***
  The service user's whānau, extended family, partner, siblings, friends or other people that the service user has nominated as a carer (see other carer).

- ***History***
  When a healthcare professional obtains an account from a person, and usually a carer/relative, of how an illness or disorder has developed, together with details of the person's social and personal background. A diagnosis is usually made on the basis of the history that has been obtained, a mental state assessment, a physical examination and other necessary investigations.

- ***HoNOS***
  Health of the National Outcome Scale.

- ***Integrated care pathway***
  An integrated care pathway (or ICP) is an outline of anticipated care, placed in an appropriate timeframe to help a service user move progressively through a clinical experience to improved outcomes

- ***Intervention***
  Healthcare action intended to benefit the service user.

- ***Kaitakawaenga***
  Cultural facilitators that work specifically with tāngata whaiora Māori, conduct cultural processes, assessments and interventions

- ***Key worker***
  Is a registered health professional / health practitioner or social worker eligible for registration. He/she coordinates (but does not necessarily provide) all care for the service user, including external agency input. He/she is responsible for coordinating the treatment care / recovery / relapse prevention planning process, including transfer of care planning, and all documentation. He/she is the service user and whānau primary point of contact within the service.

- ***Mental health***
  A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community.

- ***Mental health (registered) nurse (definition extracted from NZNC Scope of Practice)***
  Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. They practice independently and in collaboration with other health professionals, perform general nursing functions, and delegate to and direct enrolled nurses, health care assistants and others. They provide comprehensive assessments to develop, implement and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. This occurs in a range of settings and partnership with individuals, families, whanau and communities

- ***Mental illness***
  A general term for a wide range of disorders where mental functioning such as perception, memory, emotion or thought is affected.

- ***Multi-disciplinary team***
  A group of registered health professionals / health practitioners who work together to determine goals, evaluate outcomes, and make recommendations and deliver bio-psycho- social and cultural interventions and treatment to assist

in the service user recovery at a particular point in time. An MDT collaborates across the system to ensure the needs of the individual and their whanau are met.

- ***Occupational therapist***
  Occupational therapy is a person-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable service users to participate in the activities of everyday life. Occupational therapists achieve this by working with service users, whānau and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.

- ***Outcome***
  The end result of care and treatment and/or rehabilitation. In other words, a measurable change in health, functional ability, symptoms or situation of a person, which is attributed to interventions and/or rehabilitation or services.

- ***Other carers***
  Other carers, who may be whānau or close friends, have a major role in supporting people with mental health difficulties to recover or cope as best they can with the condition.

- ***Prescription***
  A set of written instructions from a doctor to a pharmacist regarding the preparation and dispensing of a medication, etc for a particular patient.

- ***Primary care***
  The conventional first point of contact between a service user and MH&AS. This is the component of care delivered to service users outside hospitals and is typically provided through their general practitioner (or GP).

- ***Psychiatry***
  A branch of medicine concerned with the diagnosis, care and prevention of mental illness.

- ***Psychosocial***
  Relating social conditions to mental health.

- ***Recovery***
  Recovery is defined as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience). The term is also used to describe recovery from an addiction

- ***Recovery Approach***
  People living well in the presence or absence of mental illness. The alcohol and other drug sector have a similar yet different view of recovery, one that includes both abstinence and harm minimisation perspectives that have evolved over time, allowing service users a choice to adopt the approach that best represents their world view.

- ***Recovery plan***
  A written protocol of care which is developed with the user, and which specifies the roles and responsibility of all individuals involved in the person's care and

when their care arrangements are to be reviewed, (may also be referred to as a treatment plan)

- ***Resident Medical Office (RMO) / Resident Doctor***
  A term that covers house officers and registrars. RMOs or resident doctors may also be known as junior doctors in some countries.

- ***Registered health professional / health practitioner***
  A health professional means a person whose profession is appointed by or under the Health Practitioners Competence Assurance Act 2003 or Social Work Registration Act 2003.

  A health practitioner means a person who or is deemed to be, registered with an authority as a practitioner of a particular health profession, or a social worker eligible for registration.

- ***Referral***
  The process by which a service user is transferred from one professional to another, usually for specialist advice and/or treatment.

- ***Relapse***
  The worsening of symptoms which a person is experiencing, or the return of symptoms associated with an illness.

- ***Risk management***
  A systematic approach to the management of risk, staff and service user safety. Risk management involves identifying, assessing, controlling, monitoring, reviewing and auditing risk.

- ***Service user***
  A person who uses mental health services. Some people do not identify with the term 'user' and may instead prefer 'patient', 'client', 'consumer' and/or 'tāngata whaiora' (or whatever people choose to name their experience).

- ***Service user journey***
  The pathway through the mental health services taken by the person who is receiving care and treatment, and as viewed by that person.

- ***Social Work***
  Social work is a practice-based profession that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.

- ***Standard***
  Agreed level of performance.
- ***Tāngata whaiora***
  People seeking wellness, mental health service users.

- ***Transfer of care***
  A transfer of care marks the end of an episode of care. Types of transfers of

care include inpatient, day-case, care from specific professionals and transfer from the care of MH&AS service.

- ***Treatment***
  To organise and manage healthcare and related service for a person (this may include cultural approaches)

2.1 Acronyms

The following acronyms are used through the document.

ADOM	Alcohol and Drug Outcome Measure
AOD	Alcohol and other drugs
DHB	District Health Board
HoNOS	Health of the Nation Outcome Scale
ICP	Integrated care pathway
KPI	Key performance indicator
MDT	Multi-disciplinary team
MHA	Mental Health (Compulsory Assessment & Treatment) Act 1992
MH&AS	Mental Health and Addictions service

3 Integrated Care Pathway Policy Statements

Mental Health and Addictions service is committed to ensuring a culture of improved mental health status for people with severe mental health illness. This culture will be achieved, in part, through the systematic management and organisation of care focused on progressive and supported transition through services:

1. **Informing and educating service users and whānau of the recovery approach, the integrated care pathway ethos and the values (person-centred, culturally responsive, recovery focused, bio-psycho-social, whānau inclusive) approach to recovery oriented service delivery.**
2. **Assessing each service user's individual risk and vulnerability using the Mental Health and Addiction service Risk Assessment Tool on an ongoing and dynamic basis working together to minimise any risk concern/s identified.**
3. **Ensuring all service users and whānau know who their keyworker is.**
4. **The service user's complexity of need may determine when care is delivered. Ensuring all service users and whānau, and relevant primary care providers have been involved in the transfer of care process through their contributions from the onset and throughout the pathway of care delivery.**
5. **Ensuring that continuous quality improvements are designed, implemented and evaluated to minimise risk and improve service delivery.**

4 Integrated Care Pathway Policy Processes

4.1 Responsibilities

	The service user integrated care pathway journey is everyone's responsibility within Mental Health and Addictions service and therefore requires a whole of service approach with clear points of responsibility and accountability for the management and coordination of care inputs. The following outlines the key responsibilities for all health professionals working at all levels in Mental Health and Addictions service. **Note:** Not every type of staff type has been listed.
All MH&AS employees	**All Mental Health and Addictions employees are responsible for:** • ensuring a commitment to the service goal including: o fostering a person-centred and whānau inclusiveness environment for service users, and an understanding of the Code of Health and Disability Services Consumer Rights 1994 o fostering an environment where the philosophy of recovery principles are encouraged o fostering an environment where bio-psycho-social intervention responsiveness and cultural responsibility is encouraged
Ward / team / line managers	**Ward / team / line managers are responsible for:** • ensuring participation in the implementation of person-centred, culturally responsive, recovery focused, bio-psycho-social, whānau inclusive to interventions and the integrated care pathway as required • assisting in the performance focus of teams through monitoring and providing feedback on indicators • ensuring appropriate resources are available to support multi- disciplinary or multi agency team functioning • ensuring safe and progressive service user flow and appropriate transfer and transition of care by facilitating partnerships across services

Operations managers	**Operations managers are responsible for:** • managing resource to appropriately meet service demand and capacity to support service user and staff safety • reviewing and overseeing the care input which affect demand on services • fostering an environment where service delivery risk escalation and management is encouraged • facilitating the implementation of change and ensuring overall quality of service delivery • assisting in the management of resources for continuous improvement learning and develop of staff competency and capability
Consumer roles	**Consumer roles are responsible for:** • ensuring service users are involved at all levels of the organisation • fostering an environment of partnership which reflect recovery principles • facilitating education and staff development training to support person-centred, culturally responsive, recovery focused, bio-psycho-social, whānau inclusive interventions including the bio-psycho-social and cultural
Clinical specialists / educators	**Clinical specialists / educators are responsible for:** • facilitating professional education and staff development training to support continuous quality improvement and standards of practice • ensuring an effective framework is in place for auditing and disseminating feedback on variances
Heads of disciplines/Professional Leads	**Heads of disciplines/Professional leads are responsible for:** • ensuring appropriate bio-psycho-social and cultural interventions are being delivered • ensuring that clinical interventions are being carried by staff with the appropriate scopes of practice and/or skills • ensuring that each profession maintain their own professional skills
Governance groups / Directors and clinical Directors	**Governance groups and Directors and Clinical Directors are responsible for:** • ensuring an effective focus on key performance indicators and the quality framework are in place • facilitating and ensuring compliance with external and internal key performance reporting and quality requirements • monitoring compliance with the integrated care pathway in accordance with this policy

Key worker	**Key worker functional responsibility includes:** • facilitating the service user through the integrated care pathway and acting as the first point of contact for the service user, whānau and other carers (Mental Health and Addictions key worker policy 0899) • acting as a communication resource and coordinator for other members of the multi-disciplinary team, services or agencies involved in the delivery of care • fostering an environment of continuity of care and managing transitions of care through the pathway within planned timeframes • ensuring appropriate knowledge and links with Mental Health and Addictions service, primary care services and other agencies to guide and inform service users
Multi-disciplinary Team (MDT)	**Multi-disciplinary team members functional responsibility includes:** • ensuring effective participation with the wider care team, multi- disciplinary or multi-agency team involved in the delivery of care through contributing to assessment and interpretation of information or outcomes • ensuring an ability to work in partnership with service users and whanau • ensuring the appropriate collection and use of HoNOS and ADOM data • fostering an environment of respect and an ability to work in a collaborative way through clarity about role and purpose of the team and individual members.

5 Integrated Care Pathway Process

e service user journey is a continuous process that has many components. It is not simply about tasks. The integrated care pathway management process involves a number of steps.

1. Contact / referral

People seeking assistance or referred to our Mental Health and Addictions service will have their information recorded. There are a number of options available to make a referral including:

- self-referral (e.g. walk-in to Mental Health and Addictions service)
- carer (e.g. whānau member, member of the public, police, or other individual who has a role in providing support)
- primary care practitioner
- secondary care practitioner (e.g., emergency department)
- or other agency (e.g., probation services)

The service user's ethnicity (self-identified) and whānau or support carer (who the service user agrees should be involved in their recovery care) are identified at the initial point of service contact.

Mental Health and Addictions will ensure a standardised approach for managing all referrals to enable prompt and accurate identification of service user needs, urgency and preliminary assessment of risk.

2. Initial screening referral

Mental Health and Addictions will have standardised referral systems in place to manage referrals into mental health services. A set of criteria will be used to allow service user to be signposted to the most appropriate service and reduce wait times based on level of urgency and complexity of need. This may include referral to a more appropriate service provider or agency.

3. Triage assessment

Triage is a clinical process to assess and identify the needs of the person and the appropriate response required. The team managing the entry to services will have the functional responsibility for coordinating the service user care until transfer of care to the appropriate agency or team for follow up has occurred.

A triage or intake assessment will be undertaken using the appropriate assessment form. Ethnicity is a vital demographic and collection of ethnicity data must comply with policy (Waikato DHB Ethnicity data collection policy 0100). Typically the mental health triage is conducted by telephone contact, and can be conducted in person (face-to-face). Additional information may be required from the referrer.
Further information may be sought by whānau or other carer. Triage may also include triage for addictions.

4. Entry	The referral, triage assessment and any other relevant information may be discussed within other clinicians, including a Psychiatrist. Entry recovery care planning formulation discussion will identify: a) long term care - a scheduled identified appointment to the most appropriate member of the Mental Health and Addiction service will occur so that a comprehensive assessment can be carried out prior to the presentation of the referral to a multi-disciplinary team OR b) short term care - assisted referral facilitation of access to advice and information on other services where Mental Health and Addictions service intervention is not required. Other services such as: o general practitioner o health service or agency (not Waikato DHB Mental Health and Addictions) o non-government organisation o specialist mental health service o information for possible future referral
5. Comprehensive assessment	Persons entering a community long term care pathway who have complex need requiring multi-disciplinary or multi-agency input must receive a comprehensive (holistic) assessment and/or cultural assessment. The comprehensive assessment covers the bio-psycho- social and cultural environment elements specific to the service user.it may also include current and past alcohol or other drug history. The assessment is done with the service user by an appropriately skilled and qualified health professional to deal with the type and level of assessment. The holistic assessment will guide decisions regarding multidisciplinary care members. The assessment will be shared with the service user, and with their consent with their whānau. [Note: the comprehensive assessment and evaluation may be updated and the recovery plan amended as the service user progresses through their journey of care]. For people who identify as Māori in inpatient and or have a specific cultural issue in a community, it is important to consider unique aspects relevant to their specific journey. This may necessitate access to input from Te Puna Oranga Kaitakawaenga. For people from minority communities this may require input from a trained interpreter and/or independent advocates (Waikato DHB Interpreters policy 0137).

6. Admission to service	The referral, comprehensive/cultural assessment and any other relevant information will be presented in full and actioned at the multi-disciplinary meeting. Recovery care plan formulation discussion will be identified based on the assessment including: o trigger areas for further assessment, including referral for cultural assessment o agree eligibility for appropriate Mental Health and Addictions service o allocation of key worker and other disciplines' intervention as identified in the assessment. On admission to the long term care pathway inpatient, specialty and community teams have responsibility for ensuring clinical documentation includes: o the rationale for admission to the service o any alternative options considered o the aims of admission to the service o the expected and actual length stay o the plan for transfer of care
7. Recovery planning	A full recovery plan is identified based on the comprehensive and/or cultural assessment and multi-disciplinary discussion. The team will focus on the service user placing varying degrees of emphasis on the distinct elements of bio-psycho-social and cultural interventions to debate recovery approaches and planning including: o diagnosis o set recovery goals and objectives o identify bio-psycho-social and cultural interventions and treatments o identify members of the team (and external agency/s) who need to provide action/input o develop a recovery plan that includes practical coping strategies the service user can use when early warning signs are identified o set transfer of care goals The recovery plan will be developed in consultation with the service user and/or whānau (as appropriate). Any advanced directives identified must be taken into account in plan development. The advanced directive is to be developed with the service user and a copy of the advanced directive is to be provided to the service user (Mental Health and Addictions Advanced Directives Procedure 2181).

8. Intervention phase	The intervention and care management phase will be delivered through a person-centred, culturally responsive, recovery focused, bio-psycho- social- whānau inclusive approach to recovery. The recovery care plan will detail the type and timing of interventions. During the intervention phase the key worker will facilitate: o timing of planned interventions o assess the person's needs and level of risk o monitor the recovery plan o arrange for appropriate care to be provided o monitor the quality of care and psycho-education provided o maintain contact with the person o follow-up on all 'did not attend' (or DNA) on pre-arranged appointments (Mental health and Addictions Appointment planning and the management of DNA's with service users / tāngata whaiora 0900) o liaise with whānau and carers The service user's record shows that a treatment pathway based on the recovery care plan, is followed.
9. Recovery review	The recovery review will be an inclusive process with the service user and/or whānau (as appropriate). The recovery care plan must be formally reviewed as necessary or when there is a change in the service user circumstances that warrant a review (i.e., reviewed at least every 91 days in the community setting and weekly in the inpatient setting or earlier dependent on recovery plan objectives).. The keyworker (who is also actively involved clinically with the person) liaises with and reviews the progress with other team members involved. The outcome of the recovery review will be documented and discussed with the wider multi-disciplinary team as indicated by the level of risk and complexity.

10. Transfer of care	Careful consideration should be given to alternative services capable of meeting the service user's needs. Effective transition or transfer of care from one setting to another should begin as early as possible from the time of admission and should involve the multi- disciplinary team (including multi-agencies, the service user and whānau). For people who identify as Māori in inpatient, it is important to consider a Māori cultural process of poroporoaki/ farewell or transfer of care to the whānau/ community, conducted by Kaitakawaenga. The transfer of care process should include: o updated formulation o impending transfer o areas of potential concerns and strategies to overcome these o likely course of recovery / rehabilitation o follow-up arrangements – including preferred ongoing health provider and identifying other people likely to be involved o crisis plan/early warning signs and plan o re-entry to Mental Health and Addictions process o any other relevant details as identified by the person who receives the service and their whānau o evidence of multi-disciplinary team discussions rationalising transfer of care The transfer of care process should be a seamless process, ensuring that appropriate services are in place to support the service user. The transfer of care needs to be well coordinated, based on the service user's assessed needs, reviewed regularly, and include ongoing risk assessment and management (which includes information for possible future referral).

11. Supported assisted referral

To ensure safe and effective supported and assisted transition of care from Mental Health and Addictions the agreed involvement of primary and community health care is important from the onset and through the pathway of care. To support this process the collection of social indicator (i.e., general practitioner, employment and housing status) information will occur at the point of initial contact to inform the recovery plan. The change in social status at the point of initial contact and at the point of transition from Mental Health and Addictions service will be collected and monitored.

For a referrer, there are likely to be a number of options available locally to make regarding seeking and providing advice or assisted referral prior to transfer of care (includes but not limited to):

- general practitioner
- health service or agency (not Waikato DHB Mental Health and Addictions)
- non-government organisation
- specialist mental health service
- information for possible future referral

There will be systems in place for staff to ensure their awareness about local primary and community stakeholders and services

6 Integrated Care Pathway Tools

Care Assessment Tools

The below list identifies tools that can be used to structure the often complex assessment of need and risk management process. Any assessment needs to balance care needs against risk needs and emphasises:

- positive risk management
- importance of understanding and responding to vulnerability
- collaboration with the service users and whānau
- importance of recognising and building on the service user's strengths
- role in risk management

Triage assessment

An initial triage assessment is undertaken with the person.

- a triage assessment is carried out with the person that obtains sufficient information to:
  - determine whether the person requires a mental health intervention
  - identify possible symptoms of acute mental health illness
  - identify possible suicidal behaviour or thoughts
  - determine the level of risk of harm to self or others
  - determine the level of risk of harm from others
  - determine level of risk of harm to children (includes unborn child)
  - determine compounding addictions issues
  - when Mental Health and Addictions bio-psycho-social intervention is not required, identify the service most likely to meet the needs of the person
  - give the person clear and concise information about the services available and options for further assessment or treatment
- refer the person to the service likely to meet the identified need for further comprehensive or cultural assessment or short term intervention
- triage can be completed for all people existing or unknown to the service

Comprehensive assessment

A holistic comprehensive assessment is undertaken with the service user.

- a comprehensive assessment is carried out with the service user that identifies:
  - current and past mental health history (including the carer's perspective)
  - current and past interventions (including outcomes, adverse reactions and side-effects)
  - personal, whānau and social circumstances
  - mental state examination

  - strengths and aspirations
  - functioning
  - service user needs assessment (and, where appropriate, carer needs assessment)
  - capacity to consent to care and treatment
    - legal status
    - enduring power of attorney (or EPOA)
  - risk (including falls)
  - substance (smoking, drug and alcohol) use, abuse and misuse
  - social indicators
  - provisional formulation and recovery pathway
- a target time for completion of the comprehensive assessment is recorded
- For people who identify as Māori in inpatient and or have a specific Māori cultural issue in the community, it is important to consider unique cultural aspects relevant to their specific journey. This may necessitate access to input from Te Puna Oranga Kaitakawaenga and a cultural assessment as per Waikato DHB Tikanga recommended best practice guidelines.

Assessment and management of risk	A risk assessment, formulation and management process is carried out (Mental Health and Addictions Risk: the assessment and management of service users at risk of harm to self or others procedure 5241). • there is a record of the service user's vulnerabilities and risks, including: o self-harm o suicide o harm to or from others o occupation o vulnerability (e.g., social, sexual, cultural) o abuse (e.g., violence, physical, psychological and emotional, financial / material, sexual) o neglect (includes, active, passive or self-neglect) o carer risk assessment, where relevant • the risk assessment leads to the generation of a risk formulation and management plan that is: o developed with the service user and whānau o communicated to all those involved and identifies roles and responsibilities o reviewed at regular intervals (i.e., reviewed at least every 91 days in the community setting and daily in the inpatient setting or as a new risk is identified) o amended as necessary • serious incidents or near misses are reported in accordance with policy (Waikato DHB Incident management policy 0104) • consider advice from a Duly Authorised Officer (DAO) regarding the Mental Health Act 1992
Physical health assessment and management (see Appendix A, flowchart for metabolic monitoring)	A general physical health assessment and management of the findings are recorded. The clinical record shows that physical health needs are assessed at least every 6 months in the community setting and daily (as clinically indicated) in the inpatient setting (or earlier dependent on results) using the following features

	• the completion of a physical health assessment o vital signs o physical examination o risk factors at assessment o lifestyle risk factors o family history risk factors o assessment summary and management plan • the provision of health promotion advice • service users receiving medication should have side-effects and physical health assessed and managed according to the appropriate clinical guideline for that medication (e.g., clozapine) The clinical record shows information on the management of physical health needs, including; o information on who is responsible for the physical health assessment o evidence that results have been shared o evidence that results have been acted on o evidence that information and/or advice on promoting a healthy lifestyle has been provided
Diagnosis	There is a record of a diagnosis or diagnoses. The clinical record shows: o the diagnosis or diagnoses o information on how the diagnoses were reached following evidence based guidelines or established diagnostic criteria, where available o confirmation that the diagnoses have been explained to the service user and whānau o post-diagnosis support is offered
Suitability for bio-psycho-social and cultural interventions	The need for structured bio-psycho-social and cultural interventions for the service user is assessed. • the assessed need for bio-psycho-social and cultural interventions are recorded • where needs have been identified, there is a record that the service user has been offered a range of bio-psycho-social and cultural interventions • bio-psycho-social and cultural interventions are delivered by appropriately trained and accredited staff who have regular practice supervision as per procedures • there are systems for the provision of interventions including: o delivery within three months of referral o review of individual service user progress o recording outcome

Recording medication decisions	There is a clinical record of individual psychopharmacology medication decisions. • the clinical record shows the decision making process, including when to initiate change, maintain or discontinue psychopharmacology medication

Care Planning Tools

	The service user and whānau are at the centre of recovery care planning, along with the multidisciplinary team and others (including community support and primary care, circle of care and other mental health community networks). The wider care team should have a flexible / permeable structure in the sense that members of the wider networks may be part of the team according to the needs of a specific service user. The keyworker has responsibility for advocating and co- coordinating the close liaison with the members as necessary.
Person-centred and whānau inclusive care	There is a record that the service user and whānau have actively participated in the planning of care and treatment (Mental Health and Addictions Consumer participation policy 1855), and the participation reflects personal values and beliefs, cultural choices and partnership and the following recovery principles: o hope o personal responsibility o personal meaning o self-advocacy / choice o support o education • the clinical record shows that care is planned and agreed with the service user and/or whānau (Mental Health and Addictions Family / Whānau inclusive practice procedure 5795) in a format that is accessible, at critical points of care e.g. discharge there is evidence of partnership with family whanau. • the clinical record shows that advice has been provided to the service user, their family whānau and/or carer on sources of further information and support, (e.g. voluntary organisations and advocacy services) Whānau should have the opportunity to be involved in decisions about care and treatment (Mental Health and Addictions Family / Whānau inclusive practice procedure 5795).
Recovery plan	The recovery action plan that operates across all service care providers. o the recovery plan records a named key worker o is based on the assessment of needs, strengths and past experience o identifies goals and aspirations o specific tasks treatment and interventions (including social indicators and risk management) o records roles and responsibilities of all individuals and agencies involved o includes a record of service user perspective (including wellness statement if appropriate) o identifies early warning signs / triggers o current medication/s and objectives

- records that service users are invited to hold a copy of the recovery plan
- records unmet needs since the last assessment

The single recovery plan is reviewed regularly (i.e., reviewed at least every 91 days in the community setting and daily in the inpatient setting or earlier dependent on recovery plan objectives):

- service user perspective
- strengths
- whānau perspective
- risk behaviours, events and patterns
- psycho-education
- cultural intervention
- medical / co-existing disorders
- psychology therapies and/or interventions
- vocational rehabilitation
- current medications and changes
- recovery transition progress

Multi-disciplinary team approach	Systems are in place to ensure a multi-disciplinary service delivery that ensures that all bio-psycho-social and cultural components of intervention and care are delivered. • there are systems to ensure that service users are assessed and managed by a multidisciplinary team • the team will enable the following functions to be available to service users: o continued proactive care of those with mental health problems o access to information, and intervention / treatment before and during crisis • there are systems allowing service users to access appropriate services (e.g., when a referral is made, a record of all relevant assessments must be included with the referral documentation) • systems are in place to involve multi-agencies (including, general practitioner, advocacy services and voluntary organisations) in the care of service users Multi-disciplinary team working enables the provision of a wide range of specialty inputs and resources for service users and to provide a seamless service to service users' which enhances continuity of care. o within teams o across inpatient and community o across services o and, external agencies While verbal communication is central to all aspects of multi-disciplinary team functioning, discussion must be recorded. Team conflict will be resolved through communication.

Bio-psycho-social and Cultural Interventions

	At the heart of Mental Health and Addictions service delivery and care is a varied selection of bio-psycho-social interventions and treatment preferences. These interventions or treatments define the capabilities and competences required by health practitioners and professionals. These are the skills that will be evidence in their practice and work with an individual service user. Health practitioners' expertise may vary according to their experience, their qualifications and the work involved in obtaining their qualifications.
Bio-psycho-social and cultural interventions	Care is delivered within the person-centred, culturally responsive, recovery focused, bio-psychosocial-whānau inclusive approach to interventions: • there are systems in place to deliver bio-psycho-social and culturally appropriate care through the integrated care pathway • appropriate processes to support prospective planning of the bio- psycho-social and cultural care inputs
Workforce development	Workforce development needs are identified and acted upon. • there are systems to ensure that the training and supervision needs of staff are acted upon • training and supervision needs are incorporated into the organisation's workforce development plans • each profession maintain their own professional skills and will bring to their work the skills associated with their discipline or professional group

7 Audit Indicators

	Mental Health and Addictions service support recovery driven care, and seek to monitor and measure changes in service user's health, wellbeing and circumstances overtime. Measuring outcomes for service users using services supports the best possible service delivery and understanding of effective service delivery. Using outcome and audit information appropriately ensures a recovery focus and supports continuous quality improvement and innovation.
Timeliness	There are systems in place to measure compliance with the care interaction tasks timeframe which affect progressive service user integrated care pathway flow through service: • service wide systems are in place to monitor and plan service delivery demand and capacity • systems in place for the multi-disciplinary team to prospectively plan and schedule individual service user care along the pathway interaction tasks
Measure of needs and outcome	A professionally rated validated tool is used to measure service user need and outcome: • the clinical record includes a needs assessment scale which is rated by service users and whānau (e.g., HoNOS, ADOM) • the clinical record includes a professionally rated assessment tool (e.g., HoNOS, ADOM) which is validated for the relevant service user group to monitor outcome
Service improvement	The information gathered through regular review of integrated care pathways and from analysis of variance leads to continuous improvement of practice and service change:
Success indicators	Mental Health and Addictions meets the reporting requirements and complies with national, regional and service determined key performance indicators: • there is an agreed decision-making quality framework to support the identification of key performance, flow and variation indicators of recovery care • there are systems in place to monitor, report and action the quality of care on a regular basis (i.e., quality framework)

8 Legislative requirements

Waikato DHB Mental Health and Addictions service is required to meet and comply with the following legislation (this list is not exclusive):

- Alcoholism and Drug Addiction Act 1966
- Code of Health and Disability Services Consumers' Rights Act 1994
- Crimes Act 1961
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Health and Disability Sector Standards NZS8134:2008
- Health and Disability Consumer Rights Act 1994
- Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003
- Land Transport Act 1998
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1998
- Misuse of Drugs 1975 – section 24
- Protection of Personal and Property Rights Act 1988
- Victims' Rights Act 2002
- Health and Safety in Employment Act 1992
- Privacy Act 1993
- Employment Relations Act 2000
- Treaty of Waitangi Act 1992

9 Associated Waikato DHB Documents

This policy should be read in conjunction with the following:

- Waikato DHB incident management policy (0104)
- Waikato DHB managing behavior and performance (5250)
- Waikato DHB Violence Intervention Programme – Intimate Partner Violence (2202)
- Waikato DHB Violence Intervention Programme – Child Protection (1809)
- Waikato DHB Violence Intervention Programme – Vulnerable and Older Adult Protection (3025)
- Waikato DHB employee information policy (1775)
- Waikato DHB interpreters and translation policy (0137)
- Waikato DHB informed consent policy (1969)
- Waikato DBH suicidal or deliberate self-harm thoughts or behaviour, management of patients policy (1811)
- Waikato DHB tikanga best practice guidelines
- Waikato DHB Information Privacy Policy (1976)
- Mental Health and Addictions advance directives procedure (2181)

- Mental Health and Addictions appointment planning and the management of DNA's with service users / tāngata whaiora (0900)
- Mental Health and Addictions Risk: the assessment and management of service users at risk of harm to self or others procedure (5241)
- Mental Health key worker procedure (1558)
- Mental Health consumer participation policy (1855)
- Mental Health and Addictions Family / Whānau inclusive Practice (5795)
- Waikato DHB Ethnicity Data Collection Policy (0100)

Appendix A, Metabolic monitoring standard