STANDARD

A person's entry into services is facilitated in a competent, equitable, timely and respectful manner, when their need for services has been identified.

OBJECTIVE

- To ensure clients are referred to the appropriate service and to provide smooth transition of clients between services.
- To prioritise and process all referrals to Mental Health Services for Older People (MHSOP) within an acceptable time frame.
- To provide one point of entry that responds in a consistent manner according to standards.
- To provide relevant information and alternate options to people when they do not meet criteria for Specialist MHSOP.
- To ensure compliance with National Health And Disability Standards

SERVICE INFORMATION

MHSOP is a specialist mental health service for older people providing for the client group outlined below in the Bay of Plenty.

The aim is to provide timely access and appropriate treatment to meet the client's / family / whanau needs. The service is provided in collaboration with other geriatric / NGO services to provide holistic care.

The MHSOP service consists of two (2) departments:
1. Community Team: East and West
2. Acute In-Patient Unit: 10 bed acute inpatient unit. Access to admission via MHSOP Consultant Psychiatrist and Clinical Nurse Team Leader

The service is provided through a multi-disciplinary team approach in partnership with the person receiving the service, family / whānau and other hospital / community providers. Assessment and treatment plans take into consideration physical, psychological, social, spiritual and external factors that may all be contributing to the person's current health concerns, building on their ability to maintain autonomy and wellness.

Following a comprehensive assessment it may be determined that referral to other appropriate community services e.g. Support Net, Alzheimer's NZ, Emerge Aotearoa should be actioned to ensure the client total care needs are met.

For clients from different cultures, access and provision to interpreters / cultural resource people will be made available.

STANDARDS TO BE MET

1. Access Criteria

1.1 <u>For people with organic disorders:</u>

a) People of any age who have been diagnosed with Dementia (Alzheimer's, vascular, mixed or idiopathic front temporal dementia type) who have neuropsychiatric symptoms and / or experience behavioural and psychological symptoms of dementia.

b) Carers of clients who are experiencing significant adjustment disorder or complicated grief and may benefit from assessment and appropriate referral for treatment.
c) People being treated in general hospital wards who have been assessed by Consult Liaison as requiring MHSOP care.
d) People with unresolved or protracted delirium who would benefit from treatment in a specialist mental health in patient unit.

1.2 For People with Functional disorders:
a) People over the aged 65 or over presenting with first/recurrent episode mental health and addiction problem that requires specialist treatment
b) Clients of Adult mental health services who have been assessed by MSHOP as appropriate for transfer to MHSOP – see following exclusion guidelines
i. The person does not have a significant age-related condition of any kind, and / or;
ii. They have an existing / or recent relationship with general adult mental health service providers, and / or;
iii. They affiliate culturally and socially with adults under the age of 65 and it is their preference to receive treatment from Adult Mental Health Services who can more appropriately meet their needs.

1.3 Exclusions
a) Where the presenting problem is acute delirium without the need for specialist mental health care
b) Solely drug and alcohol, intellectual disability or brain injuries
c) Mild mental illness
d) Primarily homelessness or other social / financial difficulties

1.4 Uncomplicated dementia please refer to Bay Navigator Uncomplicated Dementia Care Pathway

2. Referral Management

2.1 MHSOP has an open referral policy but would recommend the person sees the GP for assessment first. Referrals are triaged for acceptance against the access criteria and are prioritised for urgency against the timeframe detailed in CPM.M5.34 Triage Scale.

2.2 Clients who pose an immediate significant risk to the safety of themselves or others due to mental illness should be referred directly to MHSOP Acute Intake Nurse (Monday to Friday business hours - excludes Statutory Holidays) .

2.3 If MHSOP Intake is unavailable or for after-hours referrals contact the Crisis Service on 0800-800-508 and, if necessary, the Police.

3. Referral Procedures

Step	Action	Rationale
1	• Referrals are accepted via the best practice E-referral or by email: .IntakeMHSOP@bopdhb.govt.nz Or by phone: Intake Coordinator (07) 579 8335 / Extn 8965 • Referrals are received by MHSOP reception, where they are logged into the DocMan referrals spreadsheet, date stamped and checked for correct service.	• An accurate record is kept in order to track referrals and ensure they are responded to in a timely fashion. If they have been mistakenly sent to the service, then they are promptly redirected on

Step	Action	Rationale
2	• The Intake team views all new referrals and attempts to gain additional information if necessary • GP referrals must contain recent results for appropriate screening e.g. dementia – MMSE, FBC, MSU, TFT, B12, etc. • Aged residential care referrals need to be completed on the FM.R4.42 MHSOP referral to Aged Residential Care form.	• The severity and urgency of the situation is gauged from immediately available information. Pertinent safety or other information is gathered for discussion at the MDT meeting. • To ensure treatable medical cause for presentation has been ruled out.
3	• Based on the above information the Intake Nurse will decide on the urgency of the referral and take further appropriate action. • If deemed necessary will undertake acute assessment, within office hours, and discuss with available psychiatrist or Clinical Co-ordinator. • After hours referred to Crisis Service	• The Intake team will prioritise referrals and arrange appropriate response accordingly until the referral can be discussed at the MDT meeting
4	• All referrals must have a WebPAS encounter entered with "No answer/No reply" identified for all contact attempts. A corresponding written clinical note is not required for each attempt for Non –Urgent Referrals • For people referred with functional disorders unable to be contacted after phone / H / V attempts and not contacted within 7 working days post referral, MHSOP will contact the GP by phone to request advice on the action plan. • For those people living with dementia who are not able to be contacted within one week, MHSOP will contact either the GP/ family / EPOA due to increase potential safety risks for this client group. The person contacted will be identified from the information provided in the referral.	• To ensure evidence of referral management is maintained. • To manage risks associated with an inability to provide health care to the client.
5	• Each referral will be discussed and prioritised at the next MDT meeting and checked whether it meets service criteria	• A referral will be prioritised by the wider team to firstly assess whether it meets service criteria, then if it does, an identified appropriate Case Manager / Medical Officer will be appointed and will assess further regarding ongoing follow up.
6	• If a referral is considered to not meet service criteria, the Intake team will notify the referrer with a suggested alternative service.	• To provide referrer with information on alternative services available to them, which would better meet their requirements.

Step	Action	Rationale
7	• Accepted referrals will have an identified Clinician / Case Manager assigned. The HCP on the episode of care will be amended to the correct team member by the MHSOP Administrator / Intake team.	• The Intake team will record in the notes the outcome of the referral meeting. • Intake to notify the referrer of the outcome.
8	• The Case Manager contacts client to arrange assessment. • Administration sends client a letter notifying of Clinician's appointment time.	• Referral outcome notified to client

REFERENCES

- Health & Disability Services Standards NZS 8134:2008 Standards New Zealand
- Service Specifications: Community Service Older People MHCS18

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M8.2 MHSOP Community Outreach Service (COS) Clinical Pathway
- Bay of Plenty District Health Board Clinical Practice Manual Protocol CPM.M5.34 Triage Scale
- Bay of Plenty District Health Board Clinical Practice Manual Protocol CPM.M5.25 Referral to Mental Health & Addiction Services
- Bay of Plenty District Health Board Form FM.R4.42 MHSOP referral to Aged Residential Care

Appendix 1: MHSOP Referral Management Flowchart