PURPOSE

It is the Te Whatu Ora – Health New Zealand Hauora a Toi Bay of Plenty Mental Health & Addiction Service's (MH&AS) policy intent that all tāngata whaiora / service users requiring psychiatric disability support have access to services promoting recovery and resilience that are co-ordinated to meet their individual needs and goals.

OBJECTIVE

- To ensure tāngata whaiora / service users' needs have been identified and prioritised using a comprehensive assessment approach.
- To provide regionally-funded community and residential support services in a responsive and timely manner.
- To ensure tāngata whaiora / service users, families / whānau and the clinical teams all have accurate and current information about mental health disability support services.
- To meet requirements of the Ngā paerewa Health & Disability Service and contractual obligations with the funding authority for the provision of needs assessment and service co-ordination.

EXCLUSIONS

There are no exclusions

STANDARDS TO BE MET

1. Needs Assessment

1.1 When a tāngata whaiora / service user meets the criteria for Psychiatric Disability Support Services, then it is the treating clinical team's responsibility (with the tāngata whaiora / service user's consent) to initiate the referral to NASC

1.2 The criteria for referral is

a) diagnosis of mental health and / or addictions disorder,
b) established treatment and clinical team assigned, and
c) evidence of requirement for community support for at least 3 months duration.

If these criteria are not met, consideration will be made on a case-by-case basis (such as the severity of the functional or occupational impairments, and / or the need for discharge planning from acute services).

1.3 At the time of referral, the tāngata whaiora / service user will be able to elect to be assessed by a NASC worker within Community Mental Health Services or Kaupapa / Maori Health Providers.

1.4 The appropriate NASC Referral Form will be completed by the tāngata whaiora / service user's clinician (e.g., Case Manager) and forwarded to the NASC Team Leader or Administrator.

1.5 NASC will screen the referral and will liaise with the referrer if not appropriate or if further information is required. If declined, NASC will notify the referrer, and where possible will assist the referrer / tāngata whaiora / service user to identify alternatives.

1.6 Allocation to a Needs Assessor will be made within 3 days of receiving the referral, and a comprehensive needs assessment in a timely manner. Referrals from acute inpatient services will be prioritised and undertaken as soon as practicable.

1.7 NASC will inform the tāngata whaiora / service user of the needs assessment and service co-ordination process and include full information about their rights and responsibilities.

1.8 Needs Assessment includes:

a) Utilising an appropriate Support Needs Assessment form to identify and prioritise a tāngata whaiora / service user's needs and goals, including their health, daily living, and financial, housing, employment, recreational, social and cultural needs (see Appendix).

b) Additional assessment tools that are deemed necessary to obtain a comprehensive and holistic summary of a tāngata whaiora / service user's needs.

c) A review of the tāngata whaiora / service user's clinical file, taking into consideration treatment approaches used, risk and relapse prevention strategies, and community management plans.

d) Obtaining collateral information from clinical service provider, community agencies, and family / whānau members.

e) Other forms of assessment can be used where appropriate (including OT / Functional Assessments, Psychology testing, Behavioural Support reports), and referrals for Specialist Assessments will be considered when the tāngata whaiora / service user has high and complex needs.

1.9 Relevant whānau /family, provider agency staff and significant others will be included in the process as appropriate.

1.10 Copies of completed documentation are provided to the tāngata whaiora / service user, relevant service provision agencies and filed on the tāngata whaiora / service user's clinical notes.

2. Service Co-ordination

2.1 NASC is responsible for ensuring the process of service co-ordination is conducted and documented.

2.2 Service co-ordination will be undertaken in collaboration with the tāngata whaiora / service user and where appropriate their family / whānau members, and information and access to independent advocacy services will be provided if required.

2.3 Service Co-ordination activities will include

a) Identifying the most suitable support service(s) required to meet the tāngata whaiora / service user's prioritised needs and goals. Where possible, the person will be offered a choice of support options and / or services and may need to be assisted to select their preferences.

b) Processing all referral documentation, including the Community Support Service Referral Form (see Appendix), and the completion of funding documentation and forms as required by the service provider and / or Ministry of Health.

c) Arranging referrals for further specialist assessments and treatments as recommended within Needs Assessment report (e.g., Support Net, Drug and Alcohol counselling).

d) Liaising with relevant members of the clinical team, nominated service provider(s), and the tāngata whaiora / service user and their family / whānau in the development of a Shared Support Plan (SSP).

e) Where no service can be provided, or the co-ordinated supports do not adequately meet the needs of the tāngata whaiora / service user, NASC will record this and notify the appropriate person(s) (MH&AS Business Leader, Clinical Director, and / or Planning & Funding). The use of Packages of Care (POC) or Flex-Funds arrangements will be considered in accordance with the guidelines in protocol CPM.M5.2 Packages of Care.

3. Liaison and Review

3.1 A review of the tāngata whaiora / service user's Shared Support Plan will occur at 3 monthly intervals as per protocol CPM.M5.30 Treatment Plan. NASC will attend the SSP meetings and contribute to the development of these as necessary in order to meet the needs and goals identified in the current Needs Assessment document.

3.2 NASC will liaise regularly with the clinical team / Case Manager, Service Provider, the tāngata whaiora / service user and their family / whānau (where appropriate) to ensure the support provided is appropriate to meet the individual's needs.

3.3 NASC will complete a review of the tāngata whaiora / service user's needs and support provision within 3 months after the initial placement, and thereafter as required.

3.4 A full re-evaluation of the person's needs to be completed using the comprehensive assessment at least yearly, or for those in residential support services and / or with high and complex needs 6-monthly.

3.5 If reviews or reassessment are required outside of these schedules, it is responsibility of the clinical team and / or Service Provider to notify NASC.

4. Inter–NASC Requests / Co-ordination

4.1 When required to send or receive referrals between Te Whatu Ora districts / regions, NASC will operate with other Te Whatu Ora NASC teams in accordance with the Best Practice Guidelines recommended by NASCA (see Appendix).

4.2 When referring, NASC will provide all necessary information required, including a current comprehensive Needs Assessment. Receiving NASCs will work with the tāngata whaiora / service user and their family / whānau to identify and arrange suitable support options and will then complete the service co-ordination process.

4.3 Service Co-ordination will only be finalised and processed once the corresponding transfer of care / referral is made between the appropriate clinical teams. Once the tāngata whaiora / service user is receiving the support services, ongoing liaison and review will become the responsibility of the receiving NASC.

5. Service Planning / Development

5.1 NASC will maintain an up-to-date directory of all mental health / community support services, and advise tāngata whaiora / service user's, family / whānau, and clinical teams of service options and availability.

5.2 Access to support services will be provided in a responsive and timely manner, and when barriers or delays are encountered, NASC will work to address these with Service Providers, MH&AS Management and / or Planning & Funding.

5.3 NASC will monitor the allocation and use of regionally funded supported services to ensure that resources are used appropriately, efficiently, and timely.

5.4 NASC will inform MH&AS Management and Planning & Funding if there are unmet needs or service delivery gaps. Research projects and / or service improvement initiatives will be undertaken in collaboration with all relevant stakeholders.

5.5 MH&AS will have service level agreements and Memorandums of Understanding with contracted providers, and NASC will work with Planning & Funding to monitor the provision of these.

REFERENCES

- Ngā Paerewa Health and Disability Services Standard. NZS 8134:2021
- Standards for Needs Assessment for People with Disabilities. Ministry of Health (June 1994).
- Needs Assessment & Service Coordination Service Specification, Tier Level 3. Ministry of Health (April 2009).
- Notification of Needs Assessment and Service Coordination Form (Ministry of Health)

ASSOCIATED DOCUMENTS

- NASC Referral Form
- Support Needs Assessment Form
- Community Support Service Referral Form
- Shared Support Plan
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.30 Treatment Plan
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.17 Discharge from Mental Health & Addictions Services
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.2 Packages of Care.

Appendix 1: Procedure

PSYCHIATRIC DISABILITY SUPPORT		
TASK	**ACTION**	**WHO**
Referral	Requirement for Community Support Services identified in collaboration with tāngata whaiora / service user, and family / whānau where appropriate. Referral discussed in clinical meeting, and NASC Referral Form completed with tāngata whaiora / service user consent.	**Case Manager / MDT**
	Referral screened and Needs Assessor allocated within 3 days. Declined referrals discussed with referrer.	**NASC**
Needs Assessment	Comprehensive needs assessment conducted using the appropriate Support Needs Assessment tool.	**NASC**
	Other supporting information gathered where appropriate, including clinical file, specialist assessments, and family / whānau perspective.	
Service Co-ordination	Recommendations and service provider options discussed with tāngata whaiora / service user, clinical team, and family / whānau (where appropriate). Where possible, tāngata whaiora / service user is able to select preferred support options.	**NASC**
	Referral documentation collated and forwarded to the nominated Service Provider(s). Where required relevant Ministry of Health documentation is completed and lodged.	
	Acceptance / decline of referral requested within 5 working days.	**Support Provider**
Shared Support Planning	The initial Shared Support Planning meeting arranged with key stakeholders to clarify prioritised needs, and to confirm roles and responsibilities. Initial plan developed from Needs Assessment.	**NASC**
	Within 1 month of entry to service, supports are reviewed, and recommended changes agreed. Shared Support Plan (SSP) document updated and signed by key stakeholders.	**Support Provider / Case Manager**
	SSP meeting is arranged 3 monthly, with stakeholders notified and invited to appointment.	**Support Provider**
Liaison & Review	Regular contact with Support Provider, the tāngata whaiora / service user and their family / whānau to monitor that planned support is meeting the needs as identified in the Needs Assessment.	**NASC / Case Manager**
	Support Needs are reviewed 6-monthly for those in residential support services and / or with high and complex needs, otherwise re-assessments done at least yearly.	**NASC**