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OIA REQUEST

Received: 09 December 2021
Due: 27 January 2022
Response Date: 21 January 2022
Subject: Treatment Protocols

In response to your request under the Official Information Act, please find our response below:

Request

1. **Guidelines/procedure differentiating subtypes of primary (idiopathic) constipation.**
   There are no organisational guidelines or procedures for differentiating subtypes of primary (idiopathic) constipation. Specialist assessment and support is available via referral to the Regional continence (bowel and bladder management) team

2. **Guidelines/procedure in the treatment of patients after a suicide attempt and/or suicidal ideation.** See attached.
   CPM.M5.37 – Assessment and Management of people at risk of suicide
   CPM.M5.34 – Triage Scale
   CPM.M5.26 – Risk Assessment Mental Health and Addiction Services
   CPM.M5.10 – Mental Health and Addiction Services Assessment
   CPM.M5.17 – Transition from Mental Health and Addiction Services (MH&AS)
   CPM.M5.5 - Crisis Alert;
   CPM.M7.3 - Intake and Access to Adult CMHAS

3. **Guidelines/procedure for the management/prevention of persistent Postsurgical Pain.**
   BOPDHB provides a comprehensive Acute and Chronic Pain service. Post operative patients are referred to the Acute Pain team by an Anaesthetist. Treatment available includes, but is not limited to:
   - Patient Controlled Analgesia
   - Spinal and other regional blocks
   - Opioid management
   - Acute on chronic pain management
   - Acute pain patients with substance use disorders

   Individual acute pain management plans can be tailored for individual patients in conjunction with the primary care team and pain management anaesthetist.
   Patients at risk or who have required large amounts of medication will be booked into a pain service outpatient clinic to manage opioid reduction.

4. **Guidelines/Procedures for the management of postoperative Urinary Retention (POUR)**

   There are no specific guidelines or procedures for the management of post-operative urinary retention. POUR could cover a broad spectrum of patients and each one is managed individually depending on their circumstances.

Bay of Plenty DHB supports the open disclosure of information to assist the public understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website. Please note this response may be published on our website. Official Information Act | Bay of Plenty District Health Board | Hauora a Toi | BOPDHB

You have the right to request the Ombudsman investigate and review our response. www.ombudsman.parliament.nz or 0800 802 602.

Yours sincerely

DEBBIE BROWN
Senior Advisor Governance and Quality

PURPOSE

It is the Bay of Plenty District Health Board (BOPDHB) Mental Health &Addiction Service's (MH&AS) policy intent that people who present to acute psychiatric services are provided with appropriate assessment and evidence based interventions. These need to be continued for long enough to reduce suicide risk and improve mental health in the long-term.

OBJECTIVE

The purpose of these guidelines is to support best practice in responding to people who present following a self-harm or suicide attempt.

SCOPE

Mental Health &Addiction Service's Referral, Triage, Assessment, Risk Assessment Treatment Planning, Service Provision, Discharge, Family/ Whanau involvement and Information Sharing mechanisms for all persons who report/are referred or notified to the service with self-harm or suicidal intent and meet the threshold of Triage Categories A, B & C as per the Mental Health & Addiction Services Triage Scale See MHAS.A1.53 Triage Scale

STANDARDS TO BE MET

1. TRIAGE and RESPONSE

1.1 All people who report self-harm or suicidal ideation or who present following a suicide attempt should be presumed to be at high risk of further self-harm/suicide until there is further assessment of this risk.

1.2 Response times for face to face assessment of persons who report self-harm or suicidal intent are as follows: See MHAS.A1.53 Triage Scale

a) **Triage Category A:** Immediate referral to emergency services (111)
   i. Overdose/suicide attempt self-harm in progress

b) **Triage Category B**: 2 hours from referral/notification
   i. Have attempted deliberate suicide/self-harm or who present or are referred with Acute suicidal ideation or risk of harm to others with clear plan and means and/or history of self-harm or aggression

c) **Triage Category C:** 8 hours from referral/notification
   i. Suicidal ideation with no plan and/or history of suicidal ideation

2. ASSESSMENT

2.1 A mental health assessment that follows a self-harm/suicide attempt should be conducted in a separate interview room that allows the person privacy when disclosing sensitive material.

2.2 All people who have made suicide attempts/suicidal ideation/history of suicidal ideation/attempts will receive a comprehensive assessment See Appendix 1: Comprehensive Assessment Guideline.

2.3 All people who have made suicide attempts/suicidal ideation/history of suicidal ideation/attempts will have a Risk Assessment completed, using the risk assessment

form and guidelines, as part of their comprehensive assessment. See: MHAS.A1.44 Risk Assessment

2.4 The assessment of risk will include a formulation of risk, a plan to manage clinically significant risks, and a relapse prevention plan based on the formulation of risk and the management plan.

2.5 Whenever possible clinicians should involve whänau/family/support people/carers of the suicidal person when working with that person. At any time families can give information to the clinician without this compromising the person's privacy.

2.6 Persons possessing firearms and/or a firearms license are reported to the Police as soon as practicable following assessment if the risks of suicide/self-harm indicated that this is warranted.

2.7 If a person who is considered acutely suicidal declines involvement of others, the clinician may override that refusal in the interest of keeping the person safe. In this situation the appropriate legislation to consider is the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992

2.8 All assessments including Comprehensive and Crisis assessments that are not able to be undertaken or completed due to the persons level of substance induced intoxication will be undertaken at the first practicable opportunity as per MHAS.A1.23 Assessment time scales.

2.9 People assessed in emergency departments with suicidal ideation or following a suicide attempt whilst intoxicated should be monitored in a safe environment until they are sober. Assessment should focus on their immediate risk with further assessment of risk when the person is sober.

3. CARE PLANNING AND MANAGEMENT

3.1 A MDT Review of the assessment and treatment plan of the person who has presented with self-harm/suicide will occur within 24 hours. The on-call SMO will complete this on public holidays and at weekends where the regular team does not meet. This MDT is required to be minuted by the crisis service.

3.2 DAO's and crisis service staff must document their clinical rationale for using or deciding to not use the MHA where there is a history of self-harm/suicide.

3.3 Clinicians involved in an assessment of a person who has presented with self-harm or suicide will document the clinical rationale for their decisions with regards to admission/discharge home.

3.4 Contact will be made with the person and their family/whanau (if appropriate) as soon as practicable after presentation to ensure safety and ongoing family involvement in support and treatment.

3.5 Every person who has presented with self-harm/suicide has face to face follow-up within 72 hours following the completion of the comprehensive assessment.

3.6 A Crisis Alert / handover to another clinician, is generated for any person assessed following a self-harm attempt and/or with suicidal intent if the health care professional allocated to their care will be absent from normal duties.

3.7 Structured assessment tools such as The Beck Hopelessness Scale are recommended in addition to the comprehensive clinical assessment of suicide risk.

4. THE DECISION TO HOSPITALISE

4.1 People who report self-harm or suicidal intent should be admitted as an inpatient when:

a) they are acutely suicidal

b) medical management of an attempt is required
c) they require more intensive psychiatric management
d) the establishment of a treatment alliance and crisis intervention fails and the person remains acutely suicidal.

4.2 When no suitable caregivers/support people are available, respite care options may be considered as an alternative to admission.

4.3 If the person is not admitted, appropriate arrangements must be made for follow-up within 72 hours by the relevant health provider (e.g. psychiatrist, case manager, crisis service, GP, other).

5. MANAGEMENT AS AN INPATIENT

5.1 People assessed as being at high risk of suicide have an initial 48 hour care plan commenced on admission that documents the level of observation required to be undertaken by inpatient staff.

5.2 Changes to closer levels of observation may be initiated by any senior clinical team member based on clinical assessment.

5.3 Reduction of the level of observation must be approved by two senior members of the clinical team.

5.4 The mental state of the individuals under observation is reviewed formally at the nursing handover at the end of each shift to ensure that the level of support and observation reflects the person's changing risk.

5.5 Senior nursing and psychiatric staff will review the level of observation at least daily when the overall management plan is reviewed.

5.6 The levels of observation and any changes are documented in the clinical notes by the appropriate clinician. The documentation will include the date, time, clinician's signature and designation, the level of observation and any changes to that level.

5.7 Where possible consistency of clinicians will be promoted between inpatient and outpatient settings to support a reduction in longer term risk.

6. TRANSITION FROM INPATIENT TO COMMUNITY CARE

6.1 Standards for Inpatient Discharge Planning are provide in full in Bay of Plenty District Health Board Mental Health & Addiction Services protocol MHAS.A1.31 Discharge from Mental Health & Addiction Services

6.2 All patients with community mental health case manager involvement will receive a follow up visit within 7 days.

6.3 If the person does not attend their follow-up appointment and is believed to still have a significant risk of suicide, the clinician must make efforts to contact that person immediately to assess their risk of suicide or self-harm and/or take other appropriate action e.g. Contact family/whanau, call Police.

REFERENCES

- Ministry of Health & NZGG The Assessment And Management Of People At Risk Of Suicide. Wellington. May 2003.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M7.3 CMH Intake Procedure
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.9 Admission to Acute Inpatient Unit
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.25 Referral
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.26 Risk Assessment
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.27 Seclusion
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.30 Treatment Plan
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.17 Discharge from Mental Health & Addiction Services
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.34 Triage Scale
- Bay of Plenty District Health Board policy 2.5.2 Health Records Management
- Bay of Plenty District Health Board policy 7.104.1 Protocol 3 Care Delivery – Observing Patients

Appendix 1: Comprehensive Psychiatric/ Psychosocial Assessment

Assessment should include:

- identifying data: name, gender, age, ethnicity, marital status, sources of history and reliability of historian/informants
- presenting problem(s): in the person's own words
- history of present illness/episode
- past psychiatric history
- past medical and surgical history
- current medications and recent past medications
- drug allergies/sensitivities
- medical systems review
- substance use history
- forensic history
- whänau/family history
- psychosocial history
- Mental State Examination
- physical examination
- differential diagnosis
- formulation
- working diagnosis
- treatment plan.

Mental State Examination

MSE should include the assessment and documentation of:

- Behaviour
- Affect/mood
- Thought content
- Orientation
- Memory
- Insight

Family/Whanau Involvement

Seek input from the person's whänau/family/support people if appropriate. Invite them to give a description of their concerns about the person or any changes that they have noticed.

History of Present Illness

Obtain an account of the emergence, duration and severity of all symptoms, as well as any precipitating or aggravating factors, such as worsening of mood symptoms in relation to alcohol or substance use.

As illnesses such as depression are highly associated with suicidality and suicidal attempts, one needs to be alert to symptoms of;

- lowered mood,
- anhedonia,
- sadness,
- tearfulness,

- irritability; and
- hopelessness.

The latter is a frequent indicator of increased risk of suicide. Sleep and appetite changes such as early morning wakening, weight loss, psychomotor agitation and retardation, are all important indicators of underlying depression.

Differential Diagnosis
A list of all relevant possible diagnoses should be made, at least with reference to the first three Axes
of DSM IV-TR.83

Formulation
The formulation synthesises the above information, drawing together an explanation of why this particular person has presented in this particular way at this particular time'. A formulation demonstrates a clinician's understanding of factors that predisposed the person to becoming suicidal (eg, a whänau/family and personal history of depression) and factors that precipitated their present distress (eg, grief over a relationship break up). Factors that perpetuate the person's despair are described (eg, depressive cognitions that they are 'useless') and also any protective factors, both internal (eg, intelligent, insightful) and external (eg, good and helpful social supports). The formulation should put into context the current illness in terms of their past history and social circumstances. This individual's understanding complements a specific working diagnosis or diagnoses, allowing a clear management plan to be developed for the given individual to meet their needs.

Appendix 2: Levels Of Observation In Inpatient Units

Level 1: General Observation
All inpatients will have this minimum baseline of observation to monitor and report on significant changes in the patient's mental, physical and behavioural state.

Level 2: Frequent observations (NB MHS requirement for 15 min observations)
This is required for the person who is considered to be at a significantly increased suicide risk compared with the average psychiatric inpatient, or where the extent of risk is uncertain. It is recommended that the timing of observations be varied to ensure the person cannot predict the exact time of the next observation. If a person is assessed as requiring one of the above levels of observation, details of this must be carefully and systematically documented. People who commit suicide while engaged in mental health services are likely to have had their level of care reduced before they commit suicide (ie, to have been judged as being at decreased risk).

Recommendations
It is vital to review regularly the mental state of the individuals under such close observation. This should be done formally at the nursing handover at the end of each shift. Senior nursing and psychiatric staff should review the level of observation at least daily when the overall management plan is reviewed. The levels of observation and changes to this should be documented separately in the clinical notes, with counter-signatures from senior staff and the responsible clinician. The documentation will include date, time and signature, level of observation, stop date and role of each person signing. Changes to closer levels of observation may be initiated by any senior clinical team member. Reduction of the level of observation must be approved by two senior members of the clinical team.

Level 3: Same room and in sight
This is for the person at high risk of suicide who is expressing active suicidal intent but where there is less concern about impulsive self-destructive behaviour. The person may have recently carried out an act of deliberate self-harm or have unpredictable psychotic states. This requires constant visual observation on a 1:1 basis, with the nurse in the same room and in sight of the person.

Level 4: Constant observation & within reach 1:1
This is for the person at extremely high risk of suicide who is expressing active suicidal intent. He/she may have recently carried out an act of deliberate self-harm, have unpredictable psychotic states and/or be impulsive and aggressive. This requires observation within reach of the person for safety purposes. On some occasions, more than one nurse may be required.

Seclusion Observations
Observation and care of consumers in seclusion are subject to Health & Disability Services (Restraint Minimisation and Safe Practice) Standards NZS 8134.2:2008 and are fully detailed in MHAS.A1.45 Seclusion in Mental Health.

Triage Code/ description	Response type/ time to face-to face contact	Typical presentations	Mental health service action/ response	Additional actions to be considered
A **Emergency**	**IMMEDIATE REFERRAL** **Emergency services response**	• Current actions endangering self or others • Overdose / suicide attempt / violent aggression • Possession of a Weapon	**Triage clinician to notify ambulance, police and/or fire brigade**	Keeping caller on line until emergency services arrive/ inform others Telephone Support
B **Very high risk of imminent harm to self or others**	**WITHIN 4 HOURS** **Very urgent mental health response**	• Acute suicidal ideation or risk of harm to others with clear plan and means • Ongoing history of self-harm or aggression with intent • Very high risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Urgent assessment under Mental Health Act Initial service response to A & E or Police	**Crisis or equivalent face-to-face assessment AND/OR Triage clinician advice to attend a hospital emergency department** (where Crisis cannot attend in timeframe or where the person requires ED assessment/ treatment)	Recruit additional support and collate relevant in formation Telephone support Point of contact if the situation changes
C **High risk of harm to self or others and/or high distress, especially in absence of capable supports**	**WITHIN 24 HOURS** **Urgent mental health response**	• Suicidal ideation with no plan and/or history of suicidal ideation • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Overt / Unprovoked aggression in care home or hospital ward setting • Wandering at night (community) • 'Vulerable isolation or abuse	**Crisis, / Psych Liaison / Community Mental Health or equivalent** (eg. CAMHS urgent response) **face-to face assessmen**t	Contact same day with a view to following day review in some cases. Obtain and collate additional relevant information Telephone support Point of contact if the situation changes
D **Moderate risk of harm and/or significant distress**	**WITHIN 72 HOURS** **Semi-urgent mental health response**	• Significant client/carer distress associated with severe mental illness (including mood/anxiety disorder) but not suicidal • Absent insight / Early symptoms of psychosis • Resistive aggression / obstructed care delivery • Wandering (hospital) or during the day (community) • Isolation / failing carer or known situation requiring priority treatment or review	**Community Mental Health / Psych Liaison** or equivalent (eg. CAMHS case manager) **face-to face assessment**	Telephone support Secondary consultation to manage wait period Point of contact if the situation changes
E **Low risk of harm in short term or moderate risk with high support/ stabilising factors**	**WITHIN 3 WEEKS** **Non-urgent mental health response**	• Requires specialist mental health assessment but is stable and at low risk of harm in waiting period • Other service providers able to manage the person until MHS appointment (with or without MHS phone support) • Known consumer requiring non-urgent review, treatment or follow-up • Referral for diagnosis (see below) • Requests for capacity assessment, service access for dementia or service review / carer support	Outpatient clinic for face-to face assessment, continuing care or equivalent (eg. CAMHS case manager)	Telephone support Secondary consultation to manage wait period Point of contact if the situation changes
F **Referral not requiring face-to-face response from MHAS in this instance**	**Referral or advice to contact alternative service provider**	• Other services (e.g. GPs, private mental health practitioners, ACAS) more appropriate to person's current needs • Symptoms of mild to moderate depressive, anxiety, adjustment, behavioural and/or developmental disorder • Early cognitive changes in an older person	**Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider**	Assist and/or Facilitate transfer to alternative provider Telephone support and advice

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G **Advice, consultation, information**	**Advice or information only OR More information needed**	• Consumer/carer requiring advice or opportunity to talk • Service provider requiring telephone consultation/advice • Initial notification pending further information or detail	**Triage clinician to provide advice, support and /or collect further information**	Consider courtesy follow-up telephone contact as a Telephone support and advice

REFERENCES

- Sands, N., Elsom, S. & Colgate, R. (2015). *UK Mental Health Triage Scale Guidelines.* UK Mental Health Triage Scale Project. Wales

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M7.3 ACMHS Referrals Management Intake and Access
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.10 Assessment
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.25 Referral

PURPOSE

It is the Bay of Plenty District Health Board (BOPDHB) Mental Health & Addiction Service's (MH&AS) policy intent that that all tangata whāiora / service user's receiving care will have a formal Risk Assessment completed and an individualised Risk Management Plan identified within the Treatment Plan.

OBJECTIVE

- To provide clear safe guidelines to assist mental health clinicians to better assess and manage Clinical Risk in MH&AS.
- To minimise the likelihood of an adverse outcome.
- To ensure effective monitoring systems to detect early warning signs and ready access to services if need be.
- To meet the New Zealand Health & Disability Services Standards.
- To ensure compliance with Occupational Health and Safety requirements.

STANDARDS TO BE MET

1. Risk Assessment

1.1. All MH&AS tangata whaiora / service users will have a Risk Assessment completed, based on accurate information, using the risk assessment form and guidelines, as part of their comprehensive assessment (see CPM.M5.10 Assessment).

1.2. Those individuals entering the service in crisis or acutely will have their risk assessed immediately including the risks evident for substance impaired / intoxicated individuals. Full risk assessment will be completed within 4 hours by those people involved in the comprehensive assessment.

1.3. A full Risk Assessment not able to be completed with the tangata whaiora / service users informed consent due to the person's level of substance induced intoxication, will be undertaken at the first practicable opportunity once the level of substance impairment has adequately reduced

1.4. Completion of risk assessment for non-acute individuals is the responsibility of the multi-disciplinary team (MDT) and will be carried out by the most appropriate team member, e.g. Nurse, Social Worker, Occupational Therapist (OT), Psychologist or Medical Officer.

1.5. The Risk Assessment will be based on factual information, informed opinion, clinical assessment and thorough collection of accurate information covering all aspects of the tangata whaiora / service user's mental illness and / or addiction. This is should include presenting symptoms, background, behaviour and individual circumstances and information gathered from whānau and / or support persons.

1.6. Risk Assessments will be easily and quickly accessible at the front of the tangata whaiora / service user's health record and made available on entry to all parts of the service. The risk assessment will follow the service user through the service.

1.7. The risk assessment can be updated at any time. Amendments should be documented on the form and in the tangata whaiora / service user's health record.

1.8. Risk assessments will be reviewed at defined intervals by members of the MDT and the findings documented in the tangata whaiora / service user's health record and on the form. This should take place no less than every 3 months.

1.9. Tangata whaiora / service users will be informed about their rights.

1.10. The Tangata whaiora / service users family / whanau and others nominated by them will be consulted in the risk assessment; if this does not occur then the reasons why will be documented.

2. Risk Management

2.1 All tangata whaiora / service users will have a treatment plan or "My Plan" (includes risk management) that is informed by data gathered in the risk assessment and comprehensive assessment. The aim of this is to prevent escalation of challenging or 'risky' behaviour / situations (e.g. children at risk) by prevention, minimisation and management of risk.

2.2 The management of risk will be part of the individual's treatment plan, and the designated nurse / case manager or other clinician will implement the plan as soon as it is practical to do so.

2.3 The management of risk should address:

a) Immediate risks
b) Identify ongoing management
c) Future preventative actions.
d) Challenging behaviour and strategies to deal with this
e) The context, opportunity, means and motivation of the individual

2.4 Planning of risk management, ongoing care and review will be done in partnership with the tangata whaiora / service user and nominated whānau and / or support person.

2.5 Risk Assessments and treatment plans must be readily available to other teams / individuals involved in the tangata whaiora / service users care to ensure appropriate care and minimisation of risk.

2.6 The risk assessment will be formally reviewed at defined intervals, as part of an ongoing review of the individual risk assessment / treatment plan. The treatment plan will be revised accordingly, and new outcomes identified.

2.7 The risk assessment can be updated at any time and changes noted in the tangata whaiora / service user's health record and on the treatment plan. Entries to the treatment plan must be dated and signed.

2.8 Tangata whaiora / service users are informed of who their plans are available to and the rationale for this.

3. Cumulative History of Risk

3.1 The cumulative risk history will be commenced at the time of initial comprehensive assessment.

3.2 The cumulative risk assessment will be updated with any new hazardous behaviour identified, or prior to new risk assessment form being commenced i.e. after 4 review periods if any further additional information.

REFERENCES

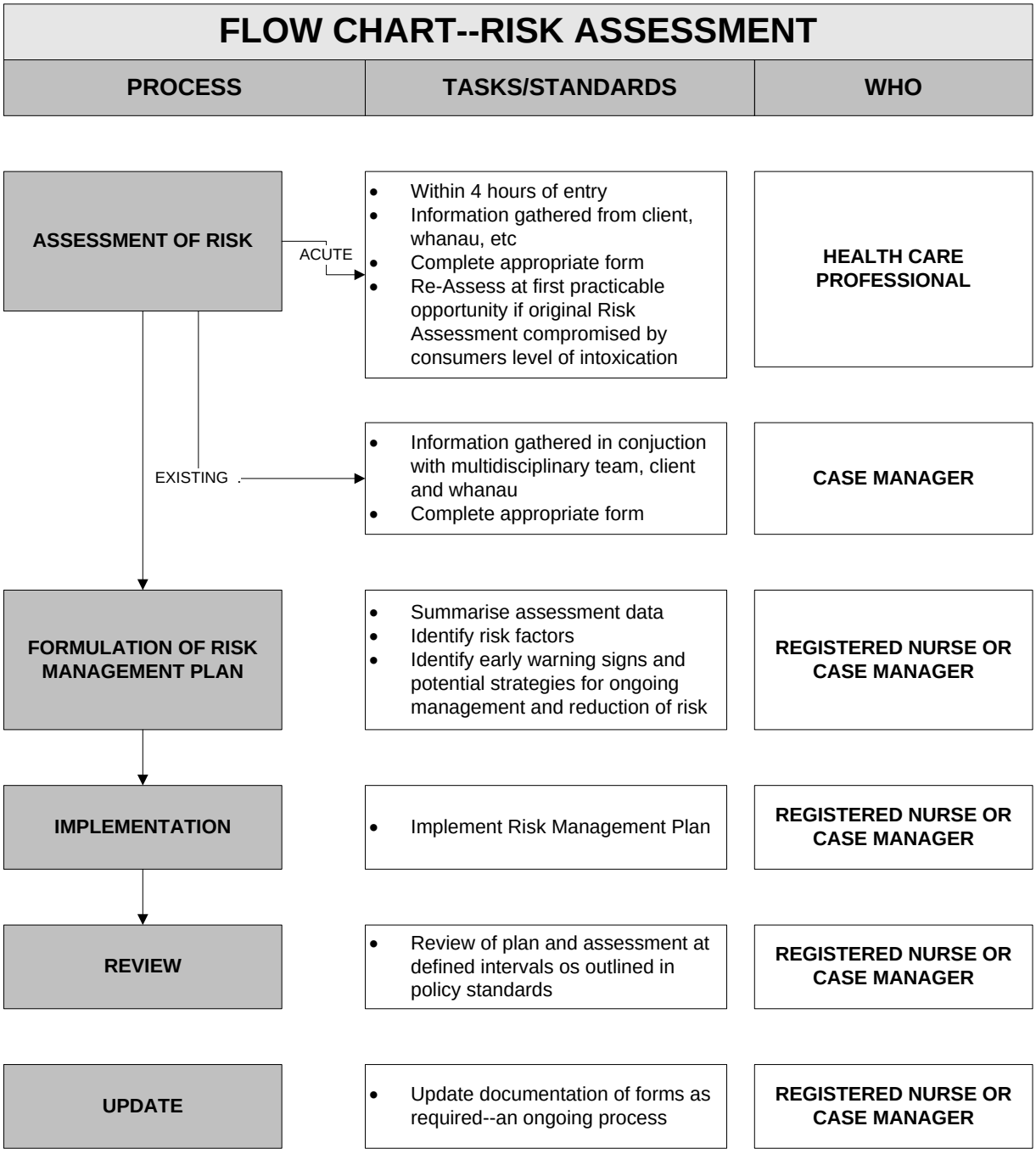
- Health and Disability Services Standard NZS 8134:2008
- Guidelines for Reducing Violence in Mental Health Services, Ministry of Health,1994
- Health and Disability Services (Restraint Minimisation and Safe Practice) Standards NZS 8134.2:2008
- Ministry of Health-Guidelines for Clinical Risk Assessment and Management in Mental Health Services, 1998

- Clinical Risk Management Framework, Mental Health Services, July 2003
- Assessment & Management of Risk To Others: Guidelines & Development of Training Toolkit. Mental Health Workforce Development Programme 2006

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.10 Assessment
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.30 Treatment Plan
- Bay of Plenty District Health Board Comprehensive Assessment Form
- Bay of Plenty District Health Board Risk Assessment Wellness transition Plan
- Bay of Plenty District Health Board Treatment Plan

APPENDIX 1: RISK ASSESSMENT PROCEDURE



PURPOSE

It is Bay of Plenty District Health Board (BOPDHB) Mental Health & Addiction Service's (MH&AS) aim that all mental health care, treatment and support provided to clients is based on a comprehensive assessment and completed by a multidisciplinary team (MDT) with appropriate knowledge and skill.

OBJECTIVE

- To ensure all clients of MH&AS receive a comprehensive assessment, which provides the basis for treatment and evaluation of progress.
- To ensure all assessment in mental health is conducted utilising evidence based clinical practice, tools and processes.
- To ensure specific risk assessment is included as part of comprehensive assessment.

STANDARDS TO BE MET

1. **All clients will receive a comprehensive assessment conducted using accepted evidence-based and culturally appropriate safe methods and tools.**
   1.1. Comprehensive evidence-based assessment tools and processes are in place and endorsed by the Clinical Director in the following sub-speciality services:
      a) Crisis services
      b) Adult community services
      c) Adult inpatient services
      d) Child, adolescent and family services
      e) Older persons community services
      f) Older persons inpatient services
      g) Addiction services
   1.1. Comprehensive assessment in community, outpatient or inpatient services must include risk assessment (Refer to CPM.M5.26 Risk Assessment).
   1.2. Cultural assessment is made available to all clients via access to staff or community providers with specific cultural knowledge.
2. **Community / Outpatient Services (includes Adult, Older Persons, Child and Adolescent Services and Community Alcohol & Drug Services)**
   2.1. Comprehensive assessment is the responsibility of the MDT that provides the service in the sub-speciality or geographic area.
   2.2. Comprehensive assessment will be conducted in a timely manner according to indicated need as identified during referral procedures (refer to CPM.M5.25 Referrals).
   2.3. The CPM.M5.34 Triage Scale provides the criteria and timeframes for urgency of service response that is required. The timeframes should be met for comprehensive assessment. Refer also to protocol CPM.M7.3 Intake.
   2.4. All assessments including Comprehensive and Crisis assessments that are not able to be undertaken or completed due to the consumers level of substance induced intoxication will be undertaken at the first practicable opportunity with reference to the above time scales.

2.5. Service users who are re-referred to secondary MH&AS services after an initial referral has been declined entry will receive a comprehensive diagnostic assessment prior to an MDT case review and finalising treatment plan and / or communication with referrer.
2.6. Assessments are conducted in a setting agreed to by the person receiving the service wherever possible, and is deemed safe for those involved.
2.7. Comprehensive assessment involves the skills of members of the MDT.
   a) All clients who require assessment will have their referral and identified needs reviewed by an intake / triage co-ordinator.
   b) Following intake and triage, a staff member or members will be nominated to complete the comprehensive assessment.
   c) The nominated assessor(s), following completion of the assessment, will provide a summary of the assessment, identified needs and any recommendations to the MDT.
   d) If, following assessment, the client meets criteria for treatment from the MH&AS, the MDT and Team Leader will, nominate the appropriate treating clinicians (e.g. Doctor, Psychologist, Social Worker etc) including the allocation of a case manager, if applicable, for the client and this will be documented in the MDT meeting minutes.
   e) The planned service interventions will be based on the clients assessed needs and reflected in a treatment plan that includes identifying which key members of the team will be directly involved with the client.
   f) The clients assessment and response to the treatment plan will be reviewed by the case manager within 7 days and the MDT within 3 months (90 days) of the client entering the service, or sooner if needed, and at the team's nominated intervals following that.
   g) It is the responsibility of the nominated case manager to ensure follow-up assessment and MDT review occurs.

3. Inpatient Services (Includes Adult and Older Persons Inpatient Services)

3.1. Commencement / completion of comprehensive assessment will occur prior to the decision to admit a client to inpatient services by a Medical Officer and / or appropriately trained mental health professional.
3.2. Assessment of immediate needs, including a risk assessment will be completed within 4 hours of admission to the inpatient facility and is the responsibility of the admitting registered nurse (RN).
3.3. Physical examination / assessment will occur within 8 hours of admission to the inpatient service and / or prior to medication being administered. It is the responsibility of the client's nominated RN to notify and liaise with the medical officer who is responsible for completing the physical examination / assessment.
3.4. Other specialist assessments will be arranged according to client needs e.g. social, cultural, occupational therapist, dietary, etc.
3.5. Reassessment and review will occur within 24 hours of admission and on a daily basis thereafter and is the responsibility of the client's SMO / Responsible Clinician and designated RN.
3.6. Reassessment and review will occur on a daily basis and is the responsibility of the client's designated RN and responsible Clinician.
3.7. MDT review of assessment and treatment will occur weekly for all inpatients.

4. General Standards (Refers to all Community and Inpatient Services)

4.1. Comprehensive assessment, with the consent of the person receiving the service, includes their family, whanāu, other service providers and other people nominated by them or their family, whanāu.

4.2. Diagnosis is made using internationally accepted standards by an appropriately qualified and experienced Mental Health professional.

4.3. At the point diagnosis is made, each person receiving the service and their family, whanāu with consent, is provided with information on the diagnosis, options for treatment and possible prognosis.

REFERENCES

- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendments
- Health and Disability Services Standard NZS 8134:2008

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.53 Triage Scale
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M7.3 CMH Intake Procedure
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.9 Admission to Acute Inpatient Unit
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.25 Referral
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.26 Risk Assessment
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.30 Treatment Plan
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.17 Discharge from Mental Health & Addiction Services I
- Bay of Plenty District Health Board policy 2.5.2 Health Records Management

APPENDIX 1: PROCEDURE

ASSESSMENT - COMMUNITY SERVICES FLOW CHART

PROCESS	STANDARDS/TASKS	WHO
REFERRAL	• Triage to confirm triage category & next steps. • Personal details • Consent & Willingness • Presenting concerns • Risk & Urgency	**Triage/Intake Coordinator**
ARE THE CONSUMER'S NEEDS URGENT/SEMI URGENT?	See MHAS Triage Scale for details	**Designated Health Care Professional as per Triage Scale**
CONSUMER & REFERRER INFORMED	Information will be given to the consumer & referrer including: * Assessment process * Location * Family/whanau involvement * Rights * Advocacy Services	**Designated Health Care Professional who will Complete Assessment**
COMPREHENSIVE ASSESSMENT	• Assessment will follow endorsed evidence based format • Assessment will include risk assessment • Cultural assessment is made available where appropriate • Assessment occurs in a setting mutually agreed where possible • Assessment includes the consumers family, whanau or significant others as appropriate. • Re-Assess at first practicable opportunity if Initial Assessment compromised by consumers level of substance induced intoxication	**Designated Health Care Professional**
MULTIDISCIPLINARY TEAM TREATMENT PLANNING	• A summary and outcome recommendations following initial assessment will be presented to the MDT by the staff member who completed assessment • Initial treatment plan discussed • Members of MDT nominated to act as case manager and clinical roles • Case manager contacts consumer within 7 days.	**Designated Clinical Staff Member(s)**
DIAGNOSTIC CLARIFICATION AND MEDICATION REVIEW	• Diagnosis and treatment recommendations following assessment • Treatment plan discussed • Information to referrer/GP	**Senior Medical Officer Or Registrar**
REVIEW ASSESSMENT	• Assessment review will occur every 3 months or sooner as designated by the MDT	**Case Manager to Co-ordinate**
DISCHARGE CONSUMER IF ALL TREATMENT GOALS ARE MET	• See Protocol CPM.M5.17 Discharge from Mental Health	**Case Manager to Co-ordinate**

ASSESSMENT

INPATIENT SERVICES FLOW CHART

PROCESS	STANDARDS/TASKS	WHO
COMPREHENSIVE ASSESSMENT	• Commences prior to decision to admit client to inpatient service	Medical Officer and/or appropriately trained mental health professional
ADMISSION TO INPATIENT SERVICE	• See Admission Protocol CPM.M5.9	Designated Admitting Nurse and medical Officer
ASSESSMENT OF IMMEDIATE NEEDS AND RISK	• Risk Assessment Protocol CPM.M5.26	Designated Admitting Registered Nurse
PHYSICAL EXAMINATION/ ASSESSMENT	• Will occur within 8 hours of admission and /or prior to medication being administered	Medical Officer
REASSESSMENT AND REVIEW	• Occurs daily • Repeat risk assessment according to Protocol CPM.M5.25	Nominated Nurse Responsible Clinician
OTHER SPECIALIST ASSESSMENTS	• Arranged according to client's needs	Medical Officer Designated Nurse
MULTIDISCIPLINARY REVIEW OF ASSESSMENT AND TREATMENT PLAN	• Occurs weekly • Includes Community Case-manager and Designated Inpatient Nurse	Designated Nurse to Co-ordinate
DISCHARGE WHEN ASSESSED TO HAVE MET INPATIENT TREATMENT GOALS	• Review for discharge should include Senior Medical Officer and designated nurse or delegates.	Psychiatrist & Designated Nurse

PURPOSE

It is the Bay of Plenty District Health Board (BOPDHB) MH&AS aim that service users of the MH&AS will be assisted to plan for their transition from inpatient services or exit from the Service to ensure appropriate and effective ongoing follow-up is available if required.

OBJECTIVE

- To ensure the safe and appropriate transition of service users
- To identify and manage risks related to transition.
- To encourage co-ordination of the transition process using multidisciplinary services as required.
- To encourage effective communication between staff, the person and their family / whānau. Activated Enduring Power of Attorney (EPoA) or court appointed Welfare Guardian.
- To reduce the risk of unplanned, re-admissions.
- To ensure an appropriate length of stay for service users.

STANDARDS TO BE MET

1. Transition Criteria

1.1 Transition from a MH&AS may occur when either:

a) The assessed needs of the service user and goals identified during the assessment and treatment process have been achieved.
b) The assessed needs of the service user are unable to be appropriately met by the treating service or are better met by an alternative service provider.
c) The service user has no contact with the service, has not responded to a minimum of two (2) attempts of different modalities to engage with the service and a decision based on multi-disciplinary team (MDT) discussion and feedback from case manager has indicated that no risk issues have been identified (except patients subject to the Mental Health Act).
d) The service user "self-discharges" by negotiation or against medical advice; (except patients subject to the Mental Health Act). or,
e) The service user moves out of the catchment area.

2. Transition Planning

2.1 All service users who receive MH&AS will have a transition discharge plan.

2.2 The transition discharge plan is commenced during entry to the service and developed during assessment, delivery of care and review of care.

2.3 Details that may be included in a service user's transition discharge plan are as follows (but not limited to):

a) Preferred ongoing health provider (e.g. GP, Iwi health provider)
b) Community resources likely to be required or of benefit to the service user's recovery / ongoing care
c) Other people likely to be involved
d) Other details as identified by the person who receives the service and their family / whānau.

2.4 All service users will have an allocated staff member responsible for transition planning who will ensure that prior to transition:

a) A documented multidisciplinary review of the service user's treatment occurs.
b) The transition plan is developed collaboratively with the service user and family / whānau / caregivers Activated EPoA or court appointed Welfare Guardian (where the service user's consent is given), who will have access to a copy.
c) The transition plan will identify and manage risks associated with the transfer of care including expressed concerns of the family / whānau Activated EPoA or court appointed Welfare Guardian. Evidence of review will be documented in the clinical notes.
d) Arrangements are satisfactory to the service user, their family / whānau Activated EPoA or court appointed Welfare Guardian and to the other providers prior to their transition.
e) Findings from needs assessment, cultural assessment or drug and alcohol assessment are integrated into the transition plan, and have been documented in the clinical notes.
f) Assistance is provided to develop a Wellness and Transition Plan (person centred care plan for MHSOP in- patients with cognitive impairment) that identifies early detection or warning signs of a relapse and the appropriate action to take and staff/services to contact. CPM.M5.36 Wellness and Transition Plans – MH&AS
g) The appropriate Mental Health outcome measures are collected from the service user as specified in policy 2.5.2 protocol 9 Mental Health Outcomes Information (MH-Smart) Collection
h) Referrals have been completed and that contact has been established with the service user's general practitioner or other health care providers.
i) Sufficient health information is shared with the service user's proposed external service provider(s) to ensure that service users have access to appropriate, timely and high quality care that meets their needs and furthers their recovery/care needs.
j) This information will be forwarded prior to transition and should include but not be limited to:
    i. Service User Details (name, age, address, contact details, next of kin)
    ii. Mental health history
    iii. Diagnosis and presenting issues
    iv. Current medication
    v. Risk assessment, treatment and discharge plans
    vi. The results of specialist assessment (A&D or Needs assessment)
    vii. Any other information as negotiated in a Memorandum of Understanding with that provider.

2.5 A copy of the electronic Transfer of Care summary is provided and explained to the service user and is sent to the GP within 24 hours of the service user's transition.

2.6 Service user's will be offered a copy of the Wellness and Transition Plan at the time of their transition or a copy will be sent to them at their listed postal address within seven (7) days of their transition, either from an inpatient ward or from the secondary service to another service.

3. Standards for Inpatient Transition Planning

3.1 Ultimate responsibility for the transition documentation rests with the responsible SMO who is responsible for the service user's management and includes the monitoring of the transition process.

3.2 Where the service user is new to the service or when for any other reason there is no case manager involvement it may be appropriate to appoint an inpatient lead nurse to this co-ordination role.

3.3 Post admission and pre transition planning meetings will be coordinated by the identified lead transition planning clinician. Those in attendance will include the patient, close family / whānau, Activated EPoA or court appointed Welfare Guardian and relevant members of MDT (psychiatrist, case manager, lead nurse etc) and where appropriate support from family / whānau and / or different Lived Experience roles. Other agencies involved (NGO's, Housing agencies etc) will also be invited to these meetings as required.

3.4 When it is known that community mental health follow-up will be required, a referral should be made as soon as practicable so that a case manager can be identified early in the admission.

3.5 The case manager should maintain enough contact with the ward to ensure that effective transition planning takes place (minimum standard one contact per week). The case manager, lead nurse and other members of the MDT work closely together throughout the discharge planning process.

3.6 Consumer and Family information packs are to be provided as soon as practicable on admission and utilised as a working tool throughout the service user's journey through the inpatient service.

3.7 A transition planning checklist will be updated at every juncture of the process. This will be completed collaboratively with the patient and family / whānau if possible. A copy will be kept in the patient's health record and another by the patient to be kept in their information pack.

3.8 A Wellness and Transition Plan will be completed collaboratively with the service user and their family / whānau. A copy of this will be kept in the service user's health record and by the patient in their information folder. Wellness and Transition plan standards are also detailed in CPM.M5.36 Wellness and Transition Plans – MH&AS.

3.9 Where it is not practical to hold a transition planning meeting prior to a transfer of care, a meeting will be arranged for the earliest possible time following the transfer of care.

3.10 All service user's with community mental health case manager involvement will receive a follow up visit within seven (7) calendar days. If this is not possible the reason must be clearly documented in the service user's health record.

3.11 Inpatient Transfer of Care Summaries are completed using the MCP Transfer of Care template by the Psychiatric Registrar or delegated House Officer.

3.12 Administration staff will ensure that the completed electronic MCP Transfer of Care summary for the current inpatient episode of care is printed out prior to the record returning to the community team and:

a) A copy placed in the service user's health record.
b) A scanned copy emailed to the Case Manager and Psychiatrist

3.13 Administration staff will ensure that the patient health record is sent to coding within 48 hours of the transfer of care and returned to the appropriate satellite file storage facility for access by the community team.

4. Transfer of Care

4.1 Transfer of care procedures between responsible clinicians and DHBs are detailed in policy 6.1.2 protocol 6 Transfer of Care

5. Service Exit Against Medical advice

5.1 When a voluntary service user requests to exit the service contrary to the advice of the clinician or MDT review, the standards for transition planning will still be maintained.

5.2 If exit from the service is still requested by the service user, the case manager will arrange a transition planning meeting with the service user, family / whānau, activated EPoA or court appointed Welfare Guardian and other members of the MDT involved in the service user's care and will document the patient's health record as follows **"*Discharged against Medical Advice*"**

5.3 Service users who choose to exit from the service against medical advice will be given information at the time of exit on how to regain entry to the MH&AS.

6. Re-Entry

6.1 Service users and their family / whānau, Activated EPoA or court appointed Welfare Guardian and where appropriate, are given information at the time of transition / exit on how to regain entry should they require it, including whom to contact.

6.2 See also CPM.M5.25 Referral

7. Information Systems

7.1 The designated nurse / case manager / responsible clinician will ensure that the appropriate MH-SMART outcome measures collected from the service user are entered into the MH&AS Information System.

7.2 The staff member responsible for the service users transition planning will ensure that a Linked Referral is closed as per the MH&AS WebPAS User manual (page 38)

7.3 Administration staff / Clinician will ensure that the Primary Referral is closed for service users who are being discharged from the MH&AS entirely as per the MH&AS WebPAS User Manual, page 38.

REFERENCES

- Guidelines for Discharge Planning for People with Mental Illness. MoH. July 1993.
- Health & Disability Service Standards NZS 8134: 2021
- Mental Health (Compulsory Treatment and Assessment) Act 1992 & Amendments 1999
- Mental Health WebPAS Training Manual
- Southland District Health Board Mental Health Service Feb – Mar 2001: A Report by the Health and Disability Commissioner

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.5.1 Inpatient Discharge Planning
- Bay of Plenty District Health Board policy 6.5.1 protocol 0 Discharge Planning - Inpatient Standards
- Bay of Plenty District Health Board policy 6.1.2 protocol 6 Transfer of Care
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.9 Admission to Acute Inpatient Mental Health
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.25 Referral
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.30 Treatment Plan
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.36 Wellness and Transition Plan

PURPOSE

To provide clear guidelines for Bay of Plenty District Health Board (BOPDHB) Mental Health & Addiction Services (MH&AS) staff to follow in the event that they require additional after hours support for a consumer.

To ensure that within the MH&AS a system exists which promptly provides consumers with appropriate treatment and support.

To provide a mechanism by which the MH&AS facilitates access to timely and responsive services that aim to minimize psychiatric illness, prevent relapse and promote wellness for consumers and their family / whānau.

To ensure that the Crisis Service is provided with the necessary information to manage consumers' treatment outside of normal business hours when there is an issue of risk to self or others.

STANDARDS TO BE MET

	ACTION	RATIONALE
1.	• A Crisis Service Alert can be instigated by a MH&AS staff member (referrer) who is requesting extra and / or after hours support for a consumer.	• The Crisis Service Alert is a process for MH&AS Staff who are engaged in an established relationship with a consumer and or the consumers nominated supports.
2.	• A Crisis Service Alert is clearly not a crisis. A crisis is identified by urgency.	• The Crisis Service Alert is available when the Therapist / Case Manager has clearly identified concerns (potential and/or current risk) that the client may need extra support and/or psychiatric intervention out of usual working hours i.e. after 5pm weekdays and anytime on weekends.
3.	• Discuss the issues surrounding the identified concerns with the referrer to clarify the need and extent of the support.	• The Crisis Service Alert is not a transfer of care, but a **negotiated** process.
4.	• Once usefulness of the Crisis Alert is established it should be verbally accepted and signed by a member of the Crisis Service.	• The Crisis Service Alert is actioned and monitored by the Crisis Service once documentation has been completed and verbally accepted and signed by a crisis team member.
5.	• Referrer to fill out The Crisis Alert Form, identifying the time-frame, other issues nominated on the form and copies of relevant recent clinical notes, assessments as required by the Crisis Service. • The referrer will be responsible for emailing the Crisis Alert Form to the Crisis Service.	• The Crisis Service Alert will have a specific time-frame. • The Crisis Alert form has an email link to the crisis team.

	ACTION	RATIONALE
6.	• The referrer will be responsible for informing any affected family / whānau members or the consumers GP that an alternative contact person is in place if they have concerns about the consumer or in the event of a crisis.	• Consumer safety and relapse prevention
7.	• The Crisis Alert will be instigated when the form is signed and accepted by a Crisis Service staff member (preferably the one who verbally accepted it).	• The Crisis Service Alert process will cease if the situation develops into a "Psychiatric Crisis" eg. MHA proceedings, escalating level of dangerousness to self or others.
8.	• The Crisis Service member receiving the Crisis Alert will enter: a) The Crisis Alert in the active crisis and acute follow-up folder's daily running sheet to inform other Crisis Service staff that a Crisis Alert is in place. b) Open WebPAS link for Crisis Service c) Save the alert into the G:drive MHAS / Crisis Team / Alerts / Active Alerts folder.	• To ensure the Crisis Service is aware that a Crisis Alert Plan is in place. • To ensure all Crisis Service contacts are recorded in the consumers WebPAS notes. • To ensure active alerts can be electronically updated and there is a tracking record.
9.	• The Crisis Service to action the request, recording each contact as per established Crisis Service practice.	• The Crisis Alert Plan is available as support for established therapeutic plans.
10.	• Document contact and intervention in the consumers MCP health record.	• As above.
12.	• The referrer will contact the Crisis Service team on completion of the Crisis Alert to handover on Crisis Service involvement. • The Crisis Service shift Coordinator will contact the referrer once the event required date had ended to check if an alert extension is required or if the alert can be closed	• To facilitate the clear transfer of responsibility for continued patient care. • To ensure all Alerts are still active
13.	• The consumer now returns to the referrer's caseload.	• To complete the transfer of responsibility for patient care.
14	• Once closed the Crisis Service team member records the transfer of care in the consumers health record (MCP Progress notes) and closes the Crisis Service link. • The Crisis Service team member saves the Crisis Alert into the G:drive / MHAS / Crisis Team / Closed Alerts folder.	• The Crisis Service Alert is now concluded. • The transfer is recorded in the consumers records • The Alert is saved for tracking

REFERENCES

- Health & Disability Services Standards NZS 8134:2008 Standards New Zealand

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Form FM.C24.1 Crisis Alert

Appendix 1: Crisis Alert Flowchart

TASK	ACTION	Who
Establishing the Crisis Alert	MH&AS staff member (referrer) Completes Crisis Alert Form	**Any MH&AS Clinician**
	Staff member negotiates Crisis Service involvement with a Crisis Service staff member	**Clinician / Crisis Service staff member**
	Establish Timeframe of Crisis Alert	
	Crisis Alert Form emailed to the Crisis Service	**MH&AS Clinician**
Crisis Alert in Place	Referrer responsible for contacting affected family / whānau, GP or principle caregiver that an alternative contact is in place regarding concerns they may have about the consumer	**MH&AS Clinician**
	Crisis Service actions the Crisis Alert	**Crisis Service Staff member(s)**
Ending the Crisis Alert	On Completion of Crisis Alert, Crisis Service will scan documentation to referrer after discussion with referrer	**Crisis Service staff member / MH&AS Clinician**
	MH&AS Clinician continues with the consumer on their caseload	**MH&AS Clinician**

OBJECTIVE

All referrals to Community Mental Health (CMH) are processed expediently and appropriately in keeping with Bay of Plenty District Health Board (BOPDHB) Mental Health & Addiction Service's (MH&AS) policy, Health and Disability Services Standards and Ministry of Health guidelines.

PURPOSE OF THE REFERRALS MANAGEMENT

The Referrals Management protocol has been developed to:

1. Ensure there is a professional, therapeutic, rapid response that is appropriate to the person's level of clinical acuity and risk
2. Provide an easily identified point of entry into the service (at each of the 2 geographical hubs)
3. Be a referral portal that proactively links people to the right assessment, care and/or support
4. Enhance relationships with primary care and other referrers
5. Ensure that there is minimal wait to get into the service
6. Be capable of meeting future service needs (be able to see more people)
7. Manage enquiries which may not result in a referral

EXCLUSIONS

There are no exclusions.

STANDARDS TO BE MET

1. Referrals Management Role And Responsibilities

1.1. Referrals management is a function of the adult service that receives both acute and non-acute referrals to the service, determines the urgency of the response, provides support to the referrer and manages the handing on of the referral to the appropriate component of the service.

1.2. Referrals to community mental health teams are received from self, family/whanau, General Practitioners, Police, Emergency Departments, other mental health services and community sources.

1.3. The Intake Service function in the community mental health teams operates between 8.30am to 5pm, (or 8am to 4.30pm depending on the service) Monday to Friday.

1.4. Outside of these hours referrals will be screened by an Acute Care Team member, following the protocol below. Non-urgent referrals will be triaged by the Intake Service clinician on the next business day.

1.5. All staff performing referrals management functions are expected to use the standard BOPDHB templates for forms and documents.

1.6. Referrals management is a highly specialised function and as such clinicians in this role are expected to:

a) Have considerable skills and experience in mental health assessment and risk assessment
b) Have excellent communication skills with service users and family/whanau

c) Have effective relationship and communication skills with referrers, other agencies and colleagues
d) Seek out others for support where shared decision making is appropriate
e) Maintain up to date knowledge of internal services, local agencies/services and other resources (including skills for using the internet to search relevant information)
f) Have a good understanding of how physical, psychosocial, or social systems issues may impact on service users
g) Provide thorough documentation, including rationale for all decisions
h) Manage their workload to provide a timely response
i) Undertake ongoing training that is relevant to the role

2. Intake And Triage

2.1 The primary function of the Intake Service is to triage and process all referrals to ACMHAS during business hours. The Intake Service provides a clinical first point of contact with a telephonic clinical response and information to referrers and members of the public who request a secondary psychiatric services response. The Intake Service is responsible for the co-ordination of referral information, and ensures continuation of follow-up for incoming referrals.

2.2 Triage information may be collected from a range of sources, including the referrer, the referred person, and their family/whanau where appropriate. In essence, triage seeks information to answer the following questions:

2.3 Is it likely that the person has a mental health problem?

2.4 What type of assessment should the mental health service provide? How urgently?

2.5 If a phone triage cannot determine that a person does **not** have a mental disorder requiring assessment, then an assessment should be arranged.

2.6 The (Revised) MHAS.A1.53 Triage Scale is the scale that has been mandated for use in BOPDHB Mental Health & Addicion Services referrals management (See Appendix 1).

2.7 Mental health triage scale aims to: promote greater consistency in decision making and response; ensure response is appropriate for person's clinical acuity and risk; assist with prioritisation of mental health service resources, and provide a systematic approach to recording outcomes of triage assessments (various authors cited in Sands et al., 2015).

2.8 The triage urgency category is assigned only once the entire triage process is complete. It is assumed that triage clinicians using the mental health triage scale will have the pre-requisite skills and knowledge so that the allocation of scale codes is informed by sound clinical judgement.

2.9 Any issues relating to change of appointments, cancellation or non-attendance at assessments are to be followed up by the team who were planned to do the assessment, not the referrals management

3. Referrals Management Procedure

	ACTION
3.1	• Incoming written referrals are initially date stamped in CMH reception by admin support and passed onto intake. • Non-urgent phone calls and referrals are directed to the Intake service.
3.2	Upon receiving a referral the Intake Co-ordinator will: • Enter information electronically on WebPAS • Check WebPAS / Clinical intranet for past psychiatric contacts and include this information with the new referral. • Integrate any relevant feedback obtained from sector teams regarding previous presentations.
3.3	The Intake Co-ordinator: • Contacts the referrer and client, and using the Triage form, gains further information to clarify the appropriateness, urgency, main presenting issues and assigns a triage priority (refer to Appendix 1. MHAS.A1.53 Triage Scale) • Is supported by the crisis team and clinical leads. • Processes all written referrals, self-presentations, and new-to-service phone calls. • Transfers calls and self-presentations meeting triage category levels A to emergency services • Transfers calls and self-presentations meeting triage category levels B, C to crisis staff. • Transfers triage category D referrals to the relevant CMH Team leader/Clinical lead for allocation to a clinician rostered on for new assesments (electronic diary) • Completes a triage form for triage category E referrals and transfers to Appropriate Sector team Leader for allocation of assessment via sector MDT. • For patients at triage levels F or G, communicates with the referrer and patient regarding the service criteria and the reason that they are not for service; and provides information about appropriate services or treatment options
3.4	• Referrals that meet the MH&AS entry criteria will be discussed with the relevant sector Team Leader for allocation to a healthcare practitioner (HCP) to complete a comprehensive assessment. • Support for comprehensive assessment is available from the duty psychiatrist, crisis staff, clinical leads, and team colleagues. The HCP uses clinical discretion regarding this support considering the patient, assessment setting, and assessment process.
3.5	• Referrals that have been accepted by the sector team will have a standard acceptance letter sent to both the client and the referrer by the sector admin support. • All referral outcomes will be electronically documented on assignment of clinician by sector administration staff.

	ACTION
3.6	• Referrals may be declined if the presenting issue does not meet CMH entry criteria i.e. not a primary mental health concern. • In this case, Intake will broker these referrals by identifying appropriate sub-speciality service or community resources and providing the referrer / client with the information necessary to access alternative treatment options should they chose to. • Intake will attempt to provide information on a range of agencies / services that can cater to the issues identified. • Intake will endeavor to keep an updated register / list of Community agencies as providers can regularly change within the community setting. • MH&AS do not have preferred community providers

4. Access Criteria

4.1 The BOPDHB Adult Mental Health & Addction Service aims to facilitate optimal evidence based care for people with severe mental health and/or addiction problems / disorders, including those with associated risk and/or disability, who require input from specialist mental health services. Further guidance is provided in Appendix 3. below.

4.2 The referral for an assessment will be accepted when the following criteria are satisfied:

a) A person who is:
   i. 18-65 years of age (or service user is already engaged with service prior to age 65 and does not have an age related disorder or service user is between ages 16-18 and not attending school and not living with parents), and
   ii. The service user lives within the geographical boundaries serviced by BOPDHB (refer to MHAS A1.9 Transfer of Care Protocol for variations)
   iii. There are indications of:
b) Severe mental health issues
c) Severe substance use with substance dependency
d) Hazardous Behaviour in the contact of psychosical crisis likely to result in death
e) Assessment and treatment required is beyond the scope of the primary provider

4.3 Consideration is given to referrals where the associated level of risk and/or distress can't be managed by the person on their own or with supports or by the primary care provider.

REFERENCES

- Health and Disability Services Standard, NZS 8134:2008.
- Sands, N., Elsom, S. & Colgate, R. (2015). *UK Mental Health Triage Scale Guidelines.* UK Mental Health Triage Scale Project. Wales

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Mental Health & Addiction Services protocol MHAS.A1.53 Triage Scale
- Bay of Plenty District Health Board Mental Health & Addiction Services protocol MHAS.A1.23 Assessment
- Bay of Plenty District Health Board Mental Health & Addiction Services protocol MHAS.A1.43 Referral
- Community Mental Health and Addictions Triage Intake form

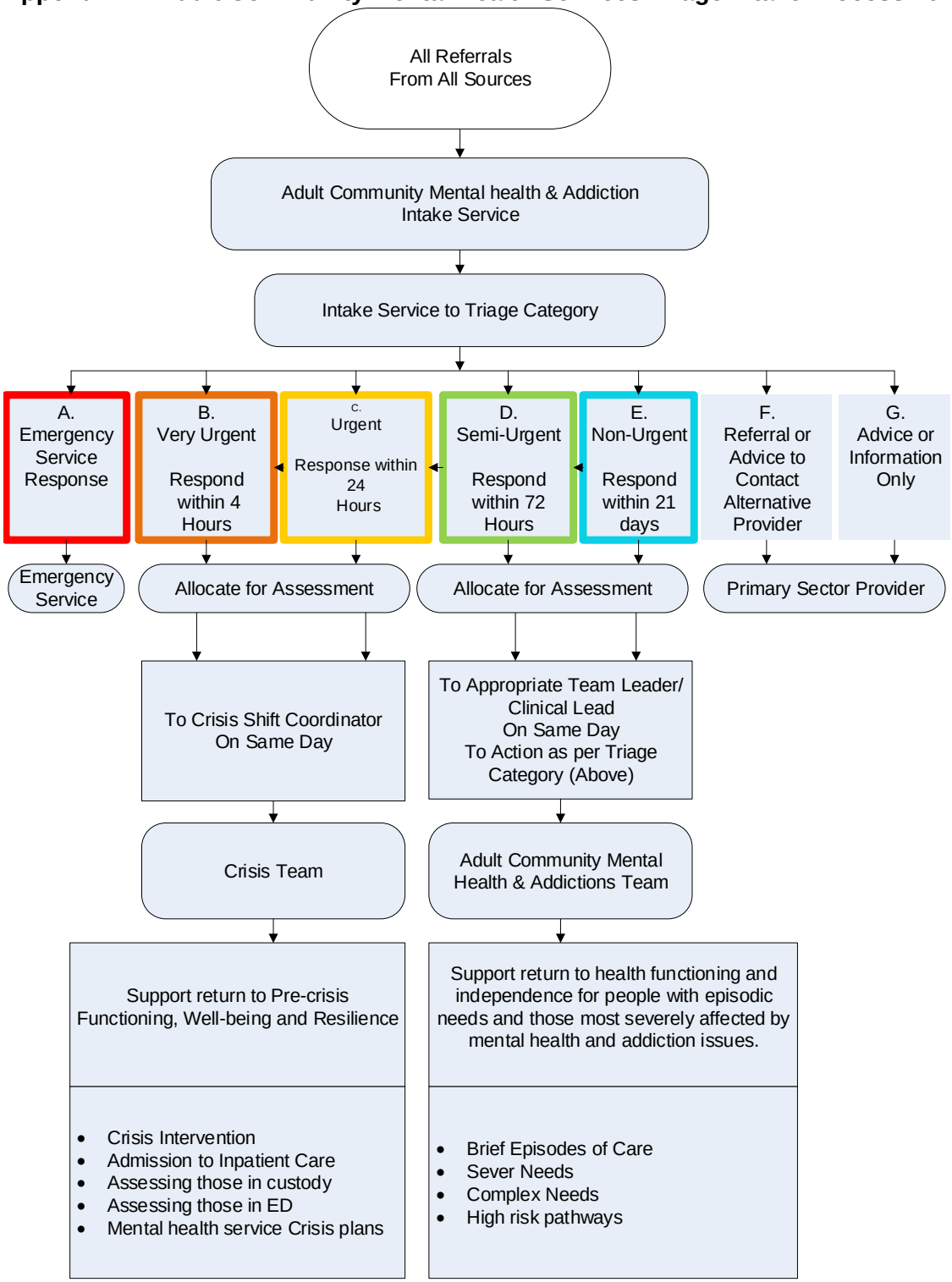
APPENDIX 1. Mental Health & Addiction Services Triage Tool (2015) *From: Sands, Elsom & Colgate, 2015, p.14*

Triage Code/ description	Response type/ time to face-to face contact	Typical presentations	Mental health service action/ response	Additional actions to be considered
A **Emergency**	**IMMEDIATE REFERRAL** **Emergency services response**	• Current actions endangering self or others • Overdose / suicide attempt / violent aggression • Possession of a Weapon	**Triage clinician to notify ambulance, police and/or fire brigade**	Keeping caller on line until emergency services arrive/ inform others Telephone Support
B **Very high risk of imminent harm to self or others**	**WITHIN 4 HOURS** **Very urgent mental health response**	• Acute suicidal ideation or risk of harm to others with clear plan and means • Ongoing history of self-harm or aggression with intent • Very high risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Urgent assessment under Mental Health Act Initial service response to A & E or Police	**Crisis or equivalent face-to-face assessment AND/OR Triage clinician advice to attend a hospital emergency department** (where Crisis cannot attend in timeframe or where the person requires ED assessment/ treatment)	Recruit additional support and collate relevant in formation Telephone support Point of contact if the situation changes
C **High risk of harm to self or others and/or high distress, especially in absence of capable supports**	**WITHIN 24 HOURS** **Urgent mental health response**	• Suicidal ideation with no plan and/or history of suicidal ideation • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Overt / Unprovoked aggression in care home or hospital ward setting • Wandering at night (community) • 'Vulerable isolation or abuse	**Crisis, / Psych Liaison / Community Mental Health or equivalent** (eg. CAMHS urgent response) **face-to face assessmen**t	Contact same day with a view to following day review in some cases. Obtain and collate additional relevant information Telephone support Point of contact if the situation changes
D **Moderate risk of harm and/or significant distress**	**WITHIN 72 HOURS** **Semi-urgent mental health response**	• Significant client/carer distress associated with severe mental illness (including mood/anxiety disorder) but not suicidal • Absent insight / Early symptoms of psychosis • Resistive aggression / obstructed care delivery • Wandering (hospital) or during the day (community) • Isolation / failing carer or known situation requiring priority treatment or review	**Community Mental Health / Psych Liaison** or equivalent (eg. CAMHS case manager) **face-to face assessment**	Telephone support Secondary consultation to manage wait period Point of contact if the situation changes
E **Low risk of harm in short term or moderate risk with high support/ stabilising factors**	**WITHIN 3 WEEKS** **Non-urgent mental health response**	• Requires specialist mental health assessment but is stable and at low risk of harm in waiting period • Other service providers able to manage the person until MHS appointment (with or without MHS phone support) • Known consumer requiring non-urgent review, treatment or follow-up • Referral for diagnosis (see below) • Requests for capacity assessment, service access for dementia or service review / carer support	Outpatient clinic for face-to face assessment, continuing care or equivalent (eg. CAMHS case manager)	Telephone support Secondary consultation to manage wait period Point of contact if the situation changes

Continued over page…

F **Referral not requiring face-to-face response from MHAS in this instance**	**Referral or advice to contact alternative service provider**	• Other services (e.g. GPs, private mental health practitioners, ACAS) more appropriate to person's current needs • Symptoms of mild to moderate depressive, anxiety, adjustment, behavioural and/or developmental disorder • Early cognitive changes in an older person	**Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider**	Assist and/or Facilitate transfer to alternative provider Telephone support and advice
G **Advice, consultation, information**	**Advice or information only OR More information needed**	• Consumer/carer requiring advice or opportunity to talk • Service provider requiring telephone consultation/advice • Initial notification pending further information or detail	**Triage clinician to provide advice, support and /or collect further information**	Consider courtesy follow-up telephone contact as a Telephone support and advice

Appendix 2. Adult Community Mental Health Services Triage Intake Process 2017



Appendix 3.

ADULT MENTAL HEALTH INTAKE TASK

FLOW CHART

PHASE	STANDARDS TASKS	ELECTRONIC ENTRIES	BY WHOM
REFERRAL RECEIVED AND LOGGED	Date Stamp all referrals	In Webpas: Create new primary referral for mental health if none open or re-activate if previous one was closed within last 3 months. Create linked referral for case team if none is open	Admin Support / Intake worker / Crisis Shift Coordinator
TRIAGE / INTAKE	Contact referrer, elicit relevant health history and information Facilitate Consumer engagement Check demographics, address & contact details, consent, expectations Provide information	In Webpas: Enter notes against linked referral of case team	Intake/Triage Worker Crisis worker
TRIAGE A,B,C,D,E,F,G REFER MHAS.A1.53	• A Emergency • B Very Urgent • C Urgent • D Semi-Urgent • E Non-Urgent • F+G Not for service	In WebPAS enter: triage category A-G In primary referral comment field. Contact: use codes T01, T08, T32, T42 Location - phone or physical location for face to face contacts	Intake/Triage Worker Crisis worker
A-CRISIS	REQUIRES IMMEDIATE RESPONSE REFER TO EMERGENCY SERVICES INFORM CRISIS WORKERS /DAO's	Type Assessment & Risk Ass. and email to admin for uploading to CIS. Enter Outcomes scores. Enter encounter in Webpas and make Webpas notes.	Intake refer to Crisis service or Responsible health care professional [if known client] for direct contact and assessment
B- VERY URGENT	Requires direct contact + assessment in 4 hours		
C-URGENT	Requires direct contact +assessment in 24 hours		
D -SEMI URGENT	Requires RHCP allocation by Team Leader RHCP does assessment in 72 hours		Intake refers to Team Leader RHCP does assessment
E- NON-URGENT	Requires RHCP allocation by Team Leader RHCP makes contact in 1 week & does assessment in 3 weeks		
F+G NOT MEETING MENTAL HEALTH SERVICE CRITERIA OR FOR INFORMATION ONLY	Requires written response in 10 days. Provide consumer and referrer with information on alternate services that match health needs	Record against linked referral. Close linked and primary referrals	Intake/ Triage worker
MDT MEETING + FEEDBACK, CONFIRM ACCEPTANCE OR DECLINE INTO SERVICE RHCP / CASE MANAGER DIAGNOSIS TREATMENT PLAN	Use Assessment form for presentation to MDT Record decisions on form Treatment Plan documented Referrer and client summary letter MDT Review Form filed Treatment Plan updated	Declined: Close linked and primary referrals Accepted RHCP transfer in WebPAS	MDT member allocated this task
DOCUMENTATION COMPLETED			

Appendix 4. Criteria For Acceptance Of Referrals:

1. Severe Mental Health and/or Addiction problems or Disorder;
2. Associated level of disability and/or risk (acuity);
3. 1. and 2. to the extent that specialist psychiatric services are required at the time of assessment;
4. The service can provide appropriate treatment/intervention for the person with the disorder.

Criteria 1. Severe Mental Health & Addiction Problems Or Disorder *(Guidelines)*

- Schizophrenic and related psychotic disorders
- Severe personality disorders (emotionally unstable, anti-social, etc.)
- Severe Mood disorders (e.g. bipolar disorder, major depression)
- Severe Anxiety disorders (e.g. severe obsessive-compulsive disorder, post traumatic stress disorder, panic disorder)
- Severe psychiatric disorder associated with head injury (where not covered by ACC)
- Dual diagnosis of severe psychiatric disorder and intellectual disability
- Diagnosis of severe psychiatric disorder and substance use disorder
- Adjustment disorders (including situational crises with risk to self or others)
- Factitious and dissociative disorder
- Disorders with onset usually in childhood (e.g. severe attention deficit disorder, Tourettes disorder).
- Eating disorders (when acute and/or at risk and when able to deliver appropriate service)
- Severe Substance dependency (e.g. Alcohol, Opiates, Other Prescription and illegal drugs)
- Somatization disorders

Cultural Phenomenology

From time to time Maori people and people from other cultures will present with psychopathology, which is the result of cultural phenomenology, such as (for Maori) Matekite, Mate Maori or Makutu. Appropriate assessment and / or consultation will be provided to ensure a suitable service response.

Criteria 2. Associated Level Of Impairment And/Or Risk *(Acuity Guidelines)*

GAF score on Axis IV of DSMIV may be a guideline

- Actual or imminent risk of self harm or suicide
- Actual or imminent risk of harm to others
- Incapacitated judgement
- Inability to take responsibility for self care

Criteria 3. Specialist Psychiatric Service Required

This is defined as:

The severity, urgency of the mental illness combined with the degree of disability and/or risk for the individual is such that specialist psychiatric assessment and intervention is required.

The following must be considered for all referrals:

a) Can treatment/intervention be provided effectively by the primary provider, such as counselling or other service?

b) Can the treatment / intervention be provided by the primary provider with consultation/liaison support and advice from the Specialist Mental Health Service?

EXCLUSION CRITERIA:

ABSENCE *of a mental disorder and:*

- Intellectual Disability
- Autistic spectrum disorders
- Aspergers Syndrome
- Anger Management Issues
- Accommodation Need
- Anti-social behaviour
- Sexual or other abuse
- Uncomplicated bereavement
- Social Issues
- Forensic Issues
- Process addictions e,g, Gaming, gambling, sexual addiction