WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

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25 January 2022

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Tēnā koe Andrew

Official Information Request- OIA 14032 Transfer H202116573 Procedures and Guidelines

The Whanganui District Health Board (WDHB) has received the transfer of your request from the Ministry of Health on 9 December 2021 under Section 14 of the OIA. You requested the following information:

1. Please provide Guidelines/Procedures for the management of postoperative Urinary Retention (POUR).
2. Please provide Guidelines/procedure for the management/prevention of persistent Postsurgical Pain.
3. Please provide Guidelines/procedure in the treatment of patients after a suicide attempt and/or suicidal ideation.
4. Please provide Guidelines/procedure differentiating subtypes of primary (idiopathic) constipation.

The Whanganui District Health Board response:

1. **Please provide Guidelines/Procedures for the management of postoperative Urinary Retention (POUR).**

   Post-operative urinary retention is usually managed with placement of an indwelling catheter.

2. **Please provide Guidelines/procedure for the management/prevention of persistent Postsurgical Pain.**
   Appendix 1 Ward analgesic ladder procedure

3. **Please provide Guidelines/procedure in the treatment of patients after a suicide attempt and/or suicidal ideation.**
   Appendix 2 Operational procedure Mental Health Assessment and home treatment team

4. **Please provide Guidelines/procedure differentiating subtypes of primary (idiopathic) constipation.**
   Constipation is a common complaint and is routinely managed in the community by General Practice.

Should you have any further queries about the above information, please contact our OIA co-ordinator Anne Phoenix at anne.phoenix@wdhb.org.nz

Ngā mihi

Russell Simpson
Kaihautū Hauora –Chief Executive
Whanganui District Health Board

Appendix 1:

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Procedure

Ward Analgesic Ladder	
Applicable to: Whanganui District Health Board	**Authorised by: Head of Anaesthetics**
	Contact person: Head of Anaesthetics

1. Purpose

The WDHB Analgesic ladder is designed for use in patients presenting with acute pain, either post-surgical or as a consequence of acute illness. In principal it follows the **WHO three-step "ladder" for cancer pain relief in adults,** and is designed to provide good analgesia while minimizing systemic side effects of opioids and the potential for opioid addiction.

2. Scope

This policy applies to all Wanganui District Health Board (WDHB) employees (permanent, temporary and casual), visiting medical officers, and other partners in care, contractors, consultants and volunteers.

3. Procedure

If pain occurs, there should be prompt oral administration of drugs using the WHO Analgesic ladder:

Step 1: Non-opioids (Paracetamol and NSAIDs). If tolerated these should be continued throughout treatment.

Step 2: **Add** mild opioids (tramadol or codeine)

Step 3: **Change** from weak to strong opioids such as morphine, until the patient is free of pain.

Regular Paracetamol reduces opioid consumption in the post-operative setting.

If the patient is unable to tolerate oral medications then IV formulations of simple analgesics should be used instead. To maintain freedom from pain, drugs should be given "by the clock", that is every 3-6 hours, rather than "on demand".

Pain Score	Treatment	
1 - 4 *No pain at rest* *Slight pain on movement*	Regular	Paracetamol 1g PO/IV Q 6H ***If no contraindications:**** Non-Steroidal Anti-inflammatories (NSAIDs) Diclofenac, Ibuprofen, Naproxen
	PRN/Rescue analgesia	Weak Opioid Tramadol 50-100 mg PO/IV Q6H ***OR*** Codeine 30-60mg PO Q6H
4 - 6 *Intermittent pain at rest* *Moderate pain on movement*	Regular	Paracetamol 1g PO/IV Q 6H ***If no contraindications:**** Non-Steroidal Anti-inflammatories (NSAIDs) Diclofenac, Ibuprofen, Naproxen Weak Opioid Tramadol 50-100 mg PO/IV Q6H ***OR*** Codeine 30-60mg PO Q6H
	PRN/Rescue analgesia	Morphine Sulphate Immediate Release (Sevredol) 10-30mg PO Q2H
6 - 10 *Continuous pain at rest* *Severe pain on movement*	Regular	Paracetamol 1g PO/IV Q 6H ***If no contraindications:**** Non-Steroidal Anti-inflammatories (NSAIDs) Diclofenac, Ibuprofen, Naproxen Weak Opioid Tramadol 50-100 mg PO/IV Q6H ***OR*** Codeine 30-60mg PO Q6H
	PRN/Rescue analgesia	IV Morphine titrated to analgesic effect (see IV morphine titration policy) **Consider PCA - contact Anaesthetist on call**

(Adapted from the WHO Analgesia Ladder, 2009)

****Contraindications to NSAIDS***: anaphylactic or adverse reactions, renal impairment or advanced age.

****Contraindications to Tramadol:*** allergic or adverse reactions, SSRI use, regular Ondansetron - reduces the overall analgesic effect of tramadol, probably blocking spinal 5-HT_3 receptors. Maximum of 300mg/24 hours > 75 years of age. Reduce dose and frequency in renal and hepatic impairment.

General rules for weak opioid use are

- A weak opioid should be added to, not substituted for a non-opioid
- There is no advantage of changing between weak opioids.
- If a weak opioid is inadequate when given regularly, change to a strong opioid e.g. morphine

Approximate equivalent morphine doses of weak opioids

	Typical dose (oral)	Total 24 hour dose	Equivalent morphine 24 hour dose
Codeine	60mg, four times a day	240mg	24mg
Dihydrocodeine	120mg, twice a day	240mg	24mg
Tramadol	50mg, four times a day	200mg	40mg

Strong opioids

First line: Morphine

Second line (if unable to tolerate morphine): Oxycodone, Fentanyl

Morphine or Oxycodone may not be suitable

- If patients have significant renal impairment, as it can accumulate.
- Multiple drug interactions – see NZF or contact pharmacy for further details

Fentanyl is safer option with patients with eGFR < 30ml /min/1.73m^3

To move a patient from a weak opioid to a strong opioid e.g. morphine, because there pain is not controlled, work out what their current equivalent morphine dose is

> e.g. 60mg of codeine, four times a day is equivalent of 24mg of morphine in 24 hours. A reasonable starting dose of morphine, given pain was not controlled at this dose would be 20mg twice a day.

Titrate morphine until pain is controlled or adverse effects are intolerable.

To move a patient from a strong opioid to another strong opioid

See Morphine Initiative and Dose Titration Guide (Appendix One) or call the pharmacy department.

ABC for Prescribing Opioids - Managing Adverse Effects

Almost all patients taking strong opioids with experience on going constipation.

Nausea, vomiting and drowsiness are also common in people taking opioids, but are often transitory. Regular follow-up is important to monitor adverse effects, particularly during the titration stage of treatment

For infrequent opioid dosing (PRN), prophylaxis with laxatives is usually not necessary.

Remember ABC when prescribing opioids

A - **Antiemetic** for nausea
B - Prescribe **Breakthrough pain** doses
C- Prescribe laxatives for **Constipation**

A - Opioids may produce nausea at the beginning of treatment. In some cases it may be on going. Opioid related nausea is produced through

- Reduction in gut motility
- Direct stimulation of the chemoreceptor trigger zone
- Enhanced vestibular sensitivity

Action	Medication	Dose	Cautions
Reduced gut motility	Metoclopramide (PO, SC or IV)	10mg TID, half an hour before food	Reduce dose by 50% in significant renal failure Avoid if complete intestinal obstruction
	Domperidone (PO)	10-20mg QID, half an hour before food.	Avoid in GI obstruction
Direct stimulation of the chemoreceptor trigger zone	Haloperidol (PO, SC, IV)	0.5 – 1mg PO at night Can be increased to BD	
Enhanced vestibular sensitivity	Cyclizine (PO, IV, SC)	50mg (12.5-25mg in older patients) TID	Avoid in GI obstruction
	Hyoscine patches (Transdermal)	1 patch (1mg/72hrs) behind the ear	Do not use with Metoclopramide or Domperidone
$5HT_3$-receptor antagonist.	Ondansetron (PO, IV)	4-8mg 2-3 times a day (Precaution: Reduced dose if IV)	May exacerbate constipation

B - Breakthrough pain. Analgesics work best with regular dosing but pain may still break through. When a regular dose of a strong opioid is prescribed, a short acting formulation should also be prescribed at one sixth of the total 24 hour dose, to cover any breakthrough pain. E.g. a 24 hour dose of morphine of 60mg would require a breakthrough dose of 10mg

C - Constipation. "The hand that prescribes opioids should always prescribe a laxative".

	Medication	Dose	Time to Action
1st line	stimulant plus softener combination laxative docusate sodium 50mg with sennoside B 8mg (Laxsol)	1-2 tablets bd	8-12 hours
	If constipation occurs and there is no gastrointestinal obstruction, increase the dose to 2 – 3 tablets TWICE a day		
2nd line	Osmotic laxative i.e. Lactulose	15-30ml bd	Up to 2 days
	Some people find it unpalatable. Common side affects are bloating and flatulence.		

If constipation persists consider stopping medicine that exacerbates constipation e.g. Ondansetron, tricyclic antidepressants and encouraging adequate fluid and fibre intake and mobility if appropriate.

If GI obstruction or perforation is not suspected, the Macrogol 3350 laxative powder (Lax sachets/Movicol) may be added. This medication is restricted for use in inpatients that have

- "Problematic constipation requiring intervention with a per rectal preparation despite an adequate trial of other oral pharmacotherapies including lactulose where lactulose is not contraindicated" or
- "For short-term use for faecal disimpaction".

4. Related WDHB Documents

WDHB – 938 Medication Procedure
WDHB – 1034 Adult Intravenous Opioid Practice Guidelines
WDHB – 1039 Management of Patient Controlled Analgesia (PCA) Procedure
WDHB – 5300 Controlled Drugs Procedure

5. References

- IV Administration of Opioids for Acute Pain Control in Adults (Otago)
- The Royal United Hospital Bath NHS Trust Opiate Administration via Patient Controlled Analgesia policy.
- Waitamata District Health Board (2011) Palliative Care Morphine Initiation and Dose Titration Guide.
- WHO World Health Organization.(2009).WHO's Pain Relief Ladder www.who.int/cancer/palliative/painladder/en/

6. Key words

Opioid intravenous adult practice bolus pain analgesia

7. Appendices

Appendix 1: Morphine Initiation and Dose Titration Guide

Appendix 1:

Waitemata District Health Board — Te Wai Awhina

Morphine Initiation & Dose Titration Guideline

WHANGANUI

Start with SHORT-acting morphine....

What to use	RA Morph ® liquid or Sevredol ® (Prescribe by brand name)
Suggested dose	2.5 - 5mg every four hours[1]

Titrate up short-acting morphine dose as needed....

Suggested dose	↑ dose by 30 - 50% every four hours until effective dose is reached [2]
Example	5mg → 7.5mg → 10mg → 15mg

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Once patient has been on stable regimen of short-acting morphine for 2- 3 days

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Change to LONG-acting morphine....

What to use	LA Morph® or M-Eslon ® (Prescribe by brand name)
Dose conversion	Add up the total daily dose of short-acting morphine.
	Divide by two and give as 12 hourly long-acting dose.
Example	20mg (short-acting) every four hours = 120mg/day
	Give as 60mg (long acting) every 12 hours

ALSO - add PRN dose of SHORT-acting morphine for any breakthrough pain

Breakthrough dose calculation	Use one sixth of the total daily morphine dose.
Example	If patient is on regular 60mg every 12 hours = 120mg/day morphine
	Give 20mg short-acting morphine for breakthrough pain[3]
	Do not use long-acting morphine for breakthrough pain

↓

INCREASE LONG-acting dose if patient requires several 'breakthrough pain' doses

Dose calculation	Add up total breakthrough doses needed in 24 hours, divide by two
	and add to each twelve hourly regular morphine long-acting dose
Example	Patient currently on 60mg (long-acting) every 12 hours
	Patient also needed three 20mg (= 60mg) short-acting doses per 24 hours
	Add 30mg to each long-acting dose → 90mg (long-acting) every 12 hours
	Remember to increase next breakthrough dose too

↓

If patient needs to be changed to a morphine subcutaneous syringe driver....

Dose calculation	Use half of total daily morphine oral dose

(refer to BPAC Guidelines for more information about syringe drivers and dose adjustments)

Notes

1) Dose for opioid naive patients. Elderly, renally impaired, very cachectic patients usually start with 2.5mg every four hours.
2) As the dose increases the incremental dose increase should be closer to 30% than 50%.
3) If there is no response to the breakthrough dose after one hour then it can be repeated. The next regular (long-acting) dose can be taken at the normal time without waiting for the breakthrough dose to wear off.

Other ► All patients on regular morphine should be prescribed a combination laxative (stool softener and stimulant).

Important: The information contained herein is intended solely to assist clinicians with the management of patients. It is not intended to replace the consultation process of clinicians with their patients. Clinicians must consider current best practice when making clinical decisions with each individual patient at all times.

Appendix 2:

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Operational Procedure

Mental Health Assessment & Home Treatment Team	
Applicable to: Mental Health and Addiction Services Whanganui District Health Board	**Authorised by:** Clinical Manager Mental Health and Addiction Services
	Contact person: Clinical Nurse Coordinator Community Mental Health and Addiction Service.

1. Purpose

The purpose of this policy is to define the role and responsibilities of the Mental Health Assessment & Home Treatment (MHAHT) service with explicit operational standards of service delivery. The objective is to ensure the Whanganui District Health Board (WDHB) Mental Health and Addiction Services (MH&AS) as providers are clear about our responsibilities for facilitating safe outcomes for service users/tangata whaiora, their family/whānau and the general public when urgent mental health situations occur in the community.

The operational procedure provides a framework based on the NZS8134:2008 Health and Disability Standard for the Mental Health Assessment & Home Treatment service to translate the requirements of the He Ara Oranga, report of the New Zealand government inquiry into the mental health and addiction 2018, into practice so that people who are experiencing mental distress or addiction challenges or both can access high quality, safe and responsive mental health advice, assessment and intervention in order to support recovery and crisis resolution.

The document will inform the expectations of various stakeholders including service users/tangata whaiora, family/whānau, carers, non-government organisations (NGOs) providers, both inpatient and community Whanganui District Health Board services e.g. acute inpatient facilities, general practitioners, primary health care teams, Community Mental Health and Addiction Services teams including forensic team, Alcohol and other Drugs Service (A&OD), Maternal, Infant, Child and Adolescent Mental Health and Addictions Service, (MICAMHAS), Police and Emergency Department (ED).

The procedure is aligned to the tier three mental health and addiction services service specifications for crisis intervention service and adult acute home based treatment that clearly define the expectations for the delivery of the service and is a point of reference for measures of the quality of the service provided.

2. Scope

This policy applies to all Whanganui District Health Board employees (permanent, temporary and casual including medical officers). This incorporates employees of community organisations with whom the WDHB has relationship agreements.

In scope

- 24 hour, 7 day per week urgent phone triage, advice, assessment and intervention to support crisis resolution across the age continuum including youth, for people with serious disruption to their mental health and associated risk issues who may have other co-existing alcohol or drug problems
- Referral to appropriate other agencies as required
- Advice and consultation to other health care providers and Police
- Advice to family/whānau within the parameters of the Privacy Act and He Ara Oranga aspirations
- Advice and facilitation on the Mental Health Act (MHA) (1992)

- Redirection of non-urgent referrals to the Community Mental Health and Addiction Services triage clinician or single point of entry (SPOE) or MICAMHAS triage clinician or when indicated navigation to the most appropriate provider
- Advice and or support to community teams to manage in hours urgent assessment and intervention
- Acute home treatment
- Fair, reasonable and responsive support to community teams in terms of workload distribution and vice versa.

Out of scope

- The MHAHT service is not an emergency service. Police, ambulance and fire brigade are emergency services
- Attendance to dangerous or violent situations as an emergency service
- Where issues relate to social problems such as housing, relationships or financial issues without serious disruption to mental health
- Intellectual impairment alone
- Intoxication alone
- For behavioural, anger issues, intervention or management of same where there is no identifiable mental disorder
- Assessment or intervention during office hours where the usual keyworker or more appropriate service is available to the service user/tangata whaiora e.g. CAMHS.

3. Key definitions and service descriptors

Crisis intervention service
As defined by the service specification is to provide rapid assessment and intervention for people experiencing a mental health crisis. The services are highly mobile and available in the setting and at the time that the crisis is occurring.

Adult acute home based treatment
As defined by the service specification is to provide acute responsive services that are highly mobile and available at the service user's/tangata whaiora home setting as an appropriate alternative to an acute inpatient hospital based setting.

Mental Health and Addiction Services
Is the service of the Whanganui District Health Board comprising of specific services providing mental health assessment, treatment and care to the service users/tangata whaiora as outlined by the Ministry Of Health (MOH) service specifications.

MHAHT alert
Is the notice to MHAHT of any service user/tangata whaiora at potential risk of relapse in the community, service users/tangata whaiora who are absent without leave from an inpatient unit or any other potentially acute concerns about services users/tangata whaiora that the MHAHT service may encounter or may be asked to follow up after hours (See Appendix 1). The MHAHT alert process is one of negotiation between MHAHT and the service provider making the request. If the MHAHT alert is not negotiated it is not accepted.

Service user/tangata whaiora criteria
MHAHT provides an urgent 24/7 service to all adults over 18 years of age who may be experiencing an acute/serious disruption to his or her mental health and/or pose a serious risk to self and/or others, secondary to presence of an acute mental disorder. Outside of the hours of 0830hrs to 1630hrs Monday to Friday, weekends and public holidays MHAHT service users/tangata whaiora will include any person of any age.

Mental Health Assessment and Home Treatment Team
MHAHT is a service of the Whanganui District Health Board comprising of appropriately qualified/ registered health professionals. The team also includes duly authorised officers as defined in the Mental Health Act (1992). MHAHT is a 24/7 service that provides responsive phone triage, comprehensive assessment, planning and treatment for people experiencing a serious disruption to their mental health with associated risk implications.

Emergency
A serious unexpected and often dangerous situation requiring the immediate action of emergency services, Police, ambulance or fire service 111, or 105 for a serious concern.

Urgent
Needs a prioritised response, assessment and intervention. Target for response is within four hours or as soon as practicable. Target for response time is within three hours for assessment at the Police Station and as soon as practical for assessment at the Whanganui Hospital Emergency Department. A MHAHT consultation/assessment of risk and advice on level of observation with the ED medical team may be required while the service user/tangata whaiora is still awaiting medical clearance. It is an expectation that MHAHT will assess the patient if alert and to the extent that they are able to engage in an assessment while waiting for medical clearance and be prepared to re-evaluate the situation and provide advice and support to the ED team, service user/tangata whaiora and family/whānau during this time.

Crisis intervention/resolution may include:
- Triage/screening
- Assessment and formulation
- Provision of advice, information and referral to support the person and their family/whanau
- Early intervention
- Acute home treatment
- Crisis case management
- Admission to crisis respite facility
- Admission to an inpatient facility.

Crisis/urgent assessment
Is assessment required for urgent referrals where the person of concern may:
- Deteriorate to the extent that there is risk related to the physical or psychological safety of the person or to others unless there is urgent mental health service intervention
- Require acute inpatient admission, crisis respite admission or home based treatment
- Have an application for compulsory assessment and treatment commenced under the MHA and/or there is a clear need for the management of serious risk to self and/or others.

Crisis/urgent assessment parameters
Crisis assessment/intervention and resolution during normal office hours for current service users/tangata whaiora of the MH&AS are to be undertaken wherever possible by the service user's/tangata whaiora known keyworker or for young people by the ICAMHS urgent roster.

For those new to the adult service or without keyworker MHAHT will undertake assessment during office hours; outside normal business hours are:
(a) Weekdays between the hours of 1630hrs and 0830hrs
(b) Public holidays
(c) Weekends i.e. Friday 1630hrs to Monday 0830hrs.

Triage
Is a clinical process of measuring the acuity of a service user/tangata whaiora or potential service user/tangata whaiora need, and then attributing acuity and risk categorisations in order to determine the prioritisation of actions and required interventions.

Triage acuity levels:
- Emergency: Requires assistance of the emergency services
- Urgent: Requires prioritised response, assessment and intervention. The target is within four hours or as soon as is practicable. Three hour target for the assessment at the Police Station or Emergency Department, with initial communication to police within the hour.
- Acute: for allocation, assessment and intervention within 24–48 hours
- Non–urgent: allocation and assessment within seven to 14 days

Mental Health Act (1992)
Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) is the legislation that defines the legal parameters for compulsory assessment and treatment and establishes rights for patients under the Act. The definition to meet the threshold of the MHA (1992) is *'An abnormal state of mind whether of continuous or an intermittent nature, characterised by delusions, or by disorders of mood or perceptions or volition or cognition of such a degree that it:*

A) poses a serious danger to the health and safety of that person or of others or
B) seriously diminishes the capacity for that person to care for themselves.'

Multidisciplinary team (MDT)
Is the group of health professionals from a variety of roles within the service who, as a team provide assessment, treatment and care, in partnership with the service user/tangata whaiora. The multidisciplinary team are people with skills and experience in mental health intervention, treatment and support made up of:

- Health professionals regulated by the Health Practitioners Competence Assurance Act 2003
- People regulated by a health or social service professional body
- People who interact with service users/tangata whaiora and who are not subjected to regulatory requirements under legislation or by other means.

The MDT works with a partnership approach to other health care providers such as Haumoana (whānau navigators), counsellor, psychology, pharmacy. The team may include community keyworkers/support workers and relevant others (Balance Whanganui, Te Oranganui Iwi Health Authority, Pathways, Mental Health and Wellbeing Support, Supporting Parents Healthy Children (COPMIA) etc).

Clinical Governance
The MHAHT service staff will work within a clinical governance approach to mental health care. Staff will carry both a service and individual responsibility to support and develop the quality of service delivery through clinical governance processes within the Whanganui District Health Board. The following elements are an essential part of clinical governance:

- Recognising the need to balance clinical autonomy with transparent accountability
- Support a systems approach to clinical service delivery
- Subscribe to a team based approach to clinical service delivery
- Acceptance that clinical decisions have resource implications.

Recovery Care Plan
Refers to the individualised and documented treatment/care approach.

Risk factors
Are the particular features of illness, behaviour or circumstances that alone or in combination lead to an increased risk.

Risk assessment
Is an estimation of the likelihood of particular adverse events occurring under particular circumstances within a specified period of time.

Risk assessment tool
Is a collaborative process of assessment and organisation of the risk data and the identification of risk factors and it provides the information base for risk management and relapse prevention.

Risk management
Aims to minimise the likelihood of adverse events within the context of providing treatment and care to the service user/tangata whaiora to achieve the best possible outcome and deliver safe appropriate and effective care.

Relapse Prevention Plan
Refers to the collaborative process of developing a plan with the involvement of clinicians, service users/tangata whaiora, family/whānau and other supporting agencies to monitor, quickly identify and manage the early warning signs of illness, behaviour and circumstances that place the service user/ tangata whaiora at risk. The plan identifies what the service user/tangata whaiora can do for themselves and what the service will do to support the service user/tangata whaiora. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the individual. Each service user/tangata whaiora will know of and (ideally) have a copy of their plan.

Admission criteria
Refers to the appropriate entry of persons to Acute Inpatient Adult Mental Health and Addiction Services.

Inpatient service: An inpatient service is a ward/building/service where service user/tangata whaiora stay as inpatients when they are admitted to hospital (mental health or general health).

Discharge
When a service user/tangata whaiora is no longer in receipt of specific health care services from mental health and addiction services OR where a service user/tangata whaiora is no longer requiring a specific component of mental health and addiction services (e.g. inpatient care) and the service user/tangata whaiora may continue to receive other mental health services (e.g. community services).

Key worker/case manager

Appropriately qualified/registered experienced health professionals responsible for the coordination of care and delivery of services to service user/tangata whaiora alongside the service user/tangata whaiora, their family/whānau (significant other), the multi-professional team and other agencies.

4. Roles

Senior Medical Officer
The senior medical officer (SMO) is responsible to ensure that service users/tangata whaiora receive appropriate psychiatric treatment. The SMO will be responsible for psychiatric assessments, pharmacology and bio-medical intervention including other treatment methods and devise with the greater multi-disciplinary team the service user's/tangata whaiora treatment/care plan. The psychiatrist will be responsible for supervising psychiatric medical officers, registrars and other junior medical staff working in the WDHB Mental Health and Addiction Service. Psychiatric treatment will be provided as part of the service user'/tangata whaiora care plan.

Responsible Clinician
The responsible clinician (RC) will be responsible for service users/tangata whaiora detained or treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and that they are advised, treated and reviewed as appropriate and their rights upheld. The RC will undertake all responsibilities outlined as for the SMO.

Psychiatric Registrar
The psychiatric registrar will be responsible for providing psychiatric assessments and recommending treatment as appropriate in consultation with the psychiatrist/RC. Psychiatric treatment will be provided as part of the service user's/tangata whaiora care plan. The psychiatric registrar will be responsible for supervising psychiatric medical officers and other junior medical staff working in the unit.

Resident Medical Officer
The resident medical officer (RMO) will be responsible for providing psychiatric assessments and recommending treatment as appropriate in consultation with and under the direction of the psychiatrist/RC/SMO. High level interventions such as admission, discharge and seclusion in particular must be under the direction and delegation of the psychiatrist RC/SMO.

Clinical Manager, Community Mental Health and Addiction Service
The clinical nurse manager (CM) will be responsible for the day to day operational and clinical management of the MHAHT service. This includes recruitment and performance management of all nursing, allied and administrative staff, management of operational budget, provision of clinical advice and nursing expertise to the MDT, liaison with families and other health providers, adherence with standards and quality measurement and improvement, strategic development, management of complaints and elevation of risk unresolved to nurse manager, clinical director or associate director of nursing, MH&AS. All staff will be responsible to the clinical manager for matters pertaining to the operational functions of the Community Mental Health and Addiction Service (CMHAS). The clinical manager will be accountable to the Director of Allied Health Scientific and Technical Whanganui DHB. The MHAHT team report to the CM CMHAS.

Medical Director
Has a leadership role and responsibility across the Mental Health and Addiction Services and for the MHAHT service to ensure the delivery of high quality care is provided to service users/tangata whaiora, their family/whānau by the Mental Health and Addiction Services of the Whanganui District Health Board to:

- Ensure that the work environment is conducive to clinical leadership and employee involvement, facilitate open communication, maintain morale and ensure high employee performance

- Monitor the Mental Health and Addiction Services progress toward delivering high quality health care based on national and local frameworks
- Maintain the oversight of process of outcome measurement in delivering high quality clinical care
- Create an environment in which excellence in clinical care will flourish.

Director Area Mental Health Services (DAMHS)

- The director of mental health (the director) oversees administration of the Mental Health Act on a national level, DAMHS must act as a point of contact between the director and local mental health and addiction services.
- A DAMHS has the authority to approve and direct statutory officers (responsible clinicians and duly authorised officers) to ensure that the Mental Health Act can be effectively administered in an area.
- The DAMHS is also the person in charge of maintaining records and reporting to the Director of Mental Health and Director-General of Health.
- DAMHS are required to monitor the quality of clinical decision-making, ensure adequate recording of clinical decisions, and rectify breaches of rights.
- At times, need to veto clinical decisions taken in respect of service users/tangata whaiora and proposed service users/tangata whaiora.

Duly Authorised Officer

A duly authorised officer (DAO) as defined in the Mental Health (Compulsory Assessment and Treatment) Act 1992:

1. For the purposes of this Act, every Director of Area Mental Health Services shall:
   (a) Designate and authorise sufficient health professionals to perform at all times the functions and exercise the powers conferred on duly authorised officers by this Act within the area of that director; and
   (b) Maintain an appropriate directory listing of a telephone number to ring when information or assistance is required under this Act.
2. No person shall be so designated and authorised under this section unless the Director of Area Mental Health Services is satisfied that the person has undergone appropriate training and has appropriate competence in dealing with persons who are mentally disordered.
3. Every person so designated and authorised under this section shall be issued with a document that identifies the holder and states that the holder is a duly authorised officer for the purposes of this Act.
4. Persons so designated and authorised under this section shall carry out their duties under the general direction of the Director of Area Mental Health Services.

Section 93: replaced, on 1 July 1993, by section 32 of the Health Sector (Transfers) Act 1993 (1993 No 23).

Registered Nurses

Registered nurses provide 24 hour rostered and rotating nursing care and therapeutic interventions and are responsible for providing nursing care to meet the needs of service users/tangata whaiora, including assessment and management of risk, medication administration and monitoring and development and evaluation of recovery care plans in conjunction with the multidisciplinary team. All nursing intervention is recorded on the Jade electronic medical record. Registered nurses will be responsible for the safe direction and delegation of appropriate tasks to social workers and student nurses. Registered nurses are accountable to the clinical nurse manager. Risk issues related to operational issues or clinical management unable to be resolved by the registered nurse should be elevated to the duty nurse manager, clinical nurse manager or on duty doctor/responsible clinician.

Clinical Nurse Coordinator, Community Mental Health and Addiction Services

Will ensure that the community mental health team follow the policies and procedures relating to the MHAHT service and ensure interface with the inpatient team and community team health professionals, such as operational policy, keyworker, MDT, MHAHT alerts, crisis appointments in an integrated approach to service user/tangata whaiora care.

Service Coordination/Service Coordinator

Service coordination is the process of service matching and monitoring with a commitment to collaboration between adult mental health and addiction services and community agencies. The role helps to coordinate packages of care, community support work, planned respite and residential services by ensuring all referrals are relevant and appropriate services are engaged to meet the needs identified in the needs assessment and support plan. The service coordinator is the link that forms partnerships to get the best plan and best outcomes for the service user/tangata whaiora.

Occupational Therapist
The occupational therapist will be responsible for occupational therapy, life and social skill level assessments to determine level of service user/tangata whaiora functioning. The occupational therapist for acute services will be accessed through the CMHAS in a coordinated manner and will make assessments to develop and implement care plans as appropriate.

Alcohol and Other Drug Clinicians
To provide comprehensive efficient and accessible quality professional substance related practice and services to service users/tangata whaiora and their family/whānau which meets professional standards, legislative requirements and Whanganui District Health Board policy.

Social Worker
The social worker will be responsible for assessment of all social aspects, including involvement of family/whānau, carers and significant others in the care plan. The social worker for MHAHT will be accessed through the CMHAS in a co-ordinated manner.

Consumer Leadership, Consultancy and Liaison Mental Health and Addiction Services
Provides recovery-oriented, service user/tangata whaiora orientated advice to Mental Health and Addiction Services. The service includes input and leadership in strategic planning and funding, implementation, evaluation and monitoring, quality assurance and improvement activities, staff recruitment, Co-Design projects and policy and procedure development and review.

Senior Family Advisor
Provides support to family/whānau within Mental Health and Addiction Services, participates in Co-Design projects and advises the Mental Health & Addiction Services from a family/whānau perspective.

MHAHT service delivery
Service delivery/ interventions
Standard 8134.1.3.6: Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

The SMO and RMO will meet with MHAHT each weekday morning to discuss all contacts over the preceding 24 hours, discuss/reviews contacts re: any further contact needed. Clinical Portal linked referrals will generally remain open until the service users/tangata whaiora case has been discussed.

The MHAHT service is provided by:
A multi-disciplinary team of people with skills and experience in mental health assessment intervention, treatment and support, made up of:
- Health professionals regulated by the Health Practitioners Competence Assurance Act 2003
- People regulated by a health or social service professional body.

It is the rule rather than the exception that two clinicians attend an assessment/carry out an intervention. Staff will have skills and experience working with mental health service users/tangata whaiora in crisis.

The MHAHT service includes an urgent response to a mental health crisis with assessment, intervention coordination of services, treatment and support/advice and resolution to family/whānau/carers or other health care providers.

Crisis intervention/resolution includes:
- Assessment (clinical, social, cultural, risk issues)
- The collaborative development, with service user/tangata whaiora and family/whānau, and implementation of an immediate treatment and recovery plan including risk management or safety plans.
- Crisis resolution strategies and interventions
- Performance of all tasks necessary in relation to processes required under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (including tasks of duly authorised officer, accessing psychiatrist and responsible clinician)
- Implementation of (including risk management) recovery plans, including referral to other services for ongoing treatment
- Provision of advice, information and support to other carers and family/whānau as appropriate to support crisis resolution

- The MHAHT service will be mobile and able to be provided wherever safely and appropriately at the location of the crisis. Where necessary, the MHAHT service will triage and arrange for, or provide transport of the person to the nearest acute treatment facility or the Police station
- Interventions will be appropriate to the age of the individual concerned, and will be no more restrictive than necessary in each situation. Crisis assessment and intervention will be fully available 24-hours, seven days a week
- There is effective liaison with Police, the Emergency Department, general medical practitioners, NGOs and residential providers, with formal protocols agreed to by relevant parties about when each will be involved and to what extent, where appropriate. Access to crisis respite services is facilitated through the MHAHT service or agreed alternative mechanisms under specific circumstances. The latter is the exception not the rule.

Service delivery will be based on the principles of:
- Service is founded on the principles of the Treaty of Waitangi and with an equity focus.
- Service is responsive, recovery orientated and person/family centred
- Service actively encourages and includes family/whānau and or significant others (whānau is defined by the person)wherever possible and appropriate
- Uses a strengths-based model
- Is co-existing problem(CEP) responsive
- Provides service in the least restrictive environment
- Service complies with legislated requirements and Ministry of Health standards
- Service is based in best practice principles, meets professional regulatory standards and complies with sector standards, professional codes and WDHB policy
- The service provided will assess and mitigate risk issues and escalate as needed.

The provision of services will be centred on the needs and preferences of individual service users/tangata whaiora, their family/whānau and carers wherever possible. The person's right to dignity and choice will be respected.

Service aims and objectives
- Provide a safe high quality mental health assessment and home treatment service to the Whanganui District Health Board community.
- Safely and effectively triage any referral to MHAHT and provide assessment where it is identified that the proposed service user is experiencing a serious acute distress resulting in disruption to his or her mental health and risk factors have been identified.
- Provide the earliest possible assessment (within four hours, three hour target to Emergency Department and Police) to people who meet the service criteria: (see *Service Eligibility for Assessment)* to assess and intervene in relation to the crisis situation in order to facilitate resolution in a safe and supportive manner and/or the service user/tangata whaiora is linked into other more appropriate service/s for ongoing care and support.
- Provide mental health assessment and care in the least restrictive environment.
- Prevent avoidable admission to hospital for those people experiencing a serious disruption to their mental health if it safe to do so through a range of interventions or referrals which may include home based treatment. Facilitate access to and choice of a range of options (including alternatives to acute admission) where possible and according to service user and whānau preference as well as clinical need. Alternative treatment options will be explored and decisions based on the fundamental principles of risk mitigation and management.

Hours of operation
The service operates on a 24 hour, 7 day per week basis, via a dedicated 0800653358 contact telephone number.

Team base
The MHAHT service is based at Community Mental Health and Addiction Service, Te Kopae Building, Whanganui Hospital, Heads Rd, Whanganui.

Geographical coverage
The MHAHT service covers the Whanganui District, including rural areas to Marton, Taihape, Waiouru, Raetihi, Waimarino and Bulls. It is acknowledged that because the MHAHT service is based in Whanganui, then coverage of rural locations for face to face assessments is impacted upon by travel times.

MHAHT roles and functions
Provision of advice and support for service users/tangata whaiora, family/whānau and carers in respect of services available and referral on as required.

- Undertaking and arranging for face to face assessment to be carried out by suitably qualified skilled and experienced mental health practitioners.
- Identifying the needs of the person in crisis and intervening as appropriate to reduce distress and minimise risk issues and find resolution.
- Provision of advice and support to other health providers, organisations in respect of services available.
- Providing and/or arranging for home based treatment for those in crisis who do not require hospital admission – only in Whanganui area or in selected other areas as available.
- Responsive assessment and intervention utilising a range of treatment modalities in the least restrictive environment.
- Providing support, information and education for service users/tangata whaiora, family/whānau and carers and assist their access to other services for ongoing support as appropriate at the time.
- The provision of information in respect of the Mental Health (Compulsory Assessment and Treatment) Act 1992 by the duly authorised officer.
- Facilitate admission to hospital where this is the most appropriate intervention, in the least restrictive manner possible, whilst acknowledging the appropriate use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 by the duly authorised officer.

Linkages and integration
- The MHAHT team acknowledges its need to have strong links with primary and secondary care services, the Emergency Department, non-statutory agencies, the Police, Iwi/Māori providers and service user/tangata whaiora carer groups.
- The appropriateness of referrals to the MHAHT service and successful integrated care offered to service users/tangata whaiora will depend to a great extent on these links and relationships. All services need to have a clear understanding of MHAHT role and function to ensure appropriate referral pathways are taken i.e. urgent/non urgent.
- Liaison with other services is a necessary role for all MHAHT service staff and will be achieved by attendance at appropriate clinical case meetings, with both acute inpatient and Community Mental Health and Addiction Services teams. This will enable individual crisis management plans to be discussed and allow for service changes to be communicated. MHAHT at times attend multi-agency meetings in the wider community for complex cases where a multi-agency approach is required e.g. Police, CYFS, and Ambulance.
- Phone access to the MHAHT service from any source, by the service user/tangata whaiora, their family/whānau, carers and community members directly or upon referral from primary practitioners, emergency departments and general hospital setting. Access to assessment is determined through the triage process. When MHAHT is not the most appropriate service to be accessed staff will reasonably support the service user/tangata whaiora/family member to access the most appropriate service. MHAHT do accept self-referrals and/or via family/friends but as per any referral the referral will be triaged and assessment offered if indicated and/or advice re; more appropriate referral pathway e.g. general practitioner, Police. Walk-ins are an accepted part of referrals MHAHT receive.

5. Procedure

The service that the MHAHT team deliver will meet the expectation of the standards for the continuum of service delivery. The procedure will ensure that it is clear how these standards will be met to ensure a service where people receive appropriate, responsive and timely assessment, followed by services that are planned, coordinated and delivered in a manner consistent with current legislation and practice standards, or if no further service provision from MHAHT is indicated referral to other agencies is made where appropriate. The procedure is laid out under each New Zealand Standards heading and explains the content.

Entry to services
Consumer entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

People across the age range (between 1630hrs and 0800hrs or by negotiation with the MICAMHAS team for children and adolescents) who are experiencing urgent psychiatric crisis with a serious disruption to their mental health and associated risk issues. Risk issues are broadly described as:

- significant risk of self-harm, and/or
- significant inability to care for themselves and/or
- Significant risk to others due to an abnormal state of mind.

If crisis issues are not immediately urgent but the presentation of the person is such that if left without timely assessment and intervention they would deteriorate to urgent, then early assessment and intervention is most appropriate.

Declining referral/entry to services
Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by MHAHT, where appropriate written or verbal information is provided of alternative services that will meet appropriate support and treatment options.

Although the MHAHT service may provide assessment advice and refer onto other agencies the following exclusions are identified as not meeting service eligibility.

- People who best meet the criteria for primary care, mild to moderate disruption to their mental health where issues relate solely to:
    - Social problems such as housing, relationships or financial issues without serious disruption to mental health
    - Intellectual impairment alone
    - Intoxication alone
    - Detoxification alone
    - For behavioural, anger issues, intervention or management
    - People with dementia only
    - People with delirium only
    - Criminal activity.

Service provision requirements
NZS8134.1.3.3: Consumers receive timely, competent and appropriate services in order to meet their assessed needs and desired outcome/goals.

MHAHT triage provides a point of contact for the community and/or health service providers wishing to arrange an urgent mental health advice/assessment and or intervention. MHAHT staff will be available to discuss telephone referrals and requests for advice and support in relation to mental health issues generally. The timeframe for the assessment will take into account the risk presentation of the service user/tangata whaiora and the requested action of the referrer, whilst balancing competing service demand. Those individuals most likely to require the crisis assessment and intervention would be experiencing an acute psychiatric crisis with associated disruption to their mental health. Whilst it is important to achieve such definitions of crisis, there is a need to acknowledge the concept of recovery. A recovery orientation approach focuses on 'improving the quality of life of the individual rather than the elimination of illness's; incorporating recovery, hope, self-empowerment, personal responsibility, self-advocacy, education and support. Many telephone contact referrals received by MHAHT will not be triaged and assessed as being a crisis situation requiring MHAHT involvement or action. It is, however, essential that such calls are dealt with appropriately, ensuring that people experience the service in a responsive manner, that advice and alternative options are offered and where referral to another agency is agreed, that this is actioned accordingly and the next business day the agency is contacted by MHAHT to ensure the referral has been received.

Triage
Is the clinical process of measuring of the acuity of a service user/tangata whaiora or potential service user/tangata whaiora need, and then attributing acuity and risk categorisations in order to determine the prioritisation of actions and interventions.

The minimum information required for phone triage:
- Identification of the caller and relationship to the service user/tangata whaiora of concern
- Whereabouts of service user/tangata whaiora including contact details
- Contact details of referrer
- Specific concerns of the person phoning including safety and risk information
- Exploration of the current situation including precipitating factors
- Exploration of previous history, contact with MH&AS
- Willingness of the service user/tangata whaiora to be seen by MHAHT or MH&AS

- In the event of an assessment being required, location of assessment to be negotiated; information about the assessment location, risks (dogs, other people presentation, alcohol and drug use, isolation, cell phone coverage etc) is essential in determining whether the location is safe and appropriate.

The call is then triaged according to triage acuity levels criteria (see Appendix 2) and intervention is tailored as required.

Phone advice and triage documentation
Collection and recording of accurate and concise information to form an appropriate course of action such as and not limited to:
- Time of call
- Name of person and contact number
- Risk to safety
- Mental health history
- Advice on the application and process of the MHA (1992) where appropriate
- Referral to a more appropriate provider
- Brief/supportive intervention to assist in distress management
- Strengths based problem solving support and crisis resolution.

All contact with MHAHT is documented on the running sheet and in the electronic record, currently Clinical Portal progress notes as per documentation standards.

Assessment
Standard 8134.1.3.4: Consumer's needs, support requirements and preferences are gathered and recorded in a timely manner.

Communication throughout assessment should be delivered in a manner that is understandable by the service user/tangata whaiora and their family/whānau. Interpreters and cultural advisors input should be made available as necessary.

The service user/tangata whaiora will be present at the assessment and encouraged to participate as much as possible in decisions involving their current situation family/whānau, carer or significant others (unless refused by the service user/tangata whaiora) will be present and encouraged to participate in the assessment process. If the service user/tangata whaiora is currently receiving care from mental health services then liaison with the keyworker, responsible clinician or lead medical practitioner during their normal work hours is the desired action. During out of hours, liaison with the on call RMO or SMO may be appropriate.

The aim of the initial assessment will be as follows:
- To assess whether the service user/tangata whaiora has a mental disorder or serious disruption to their mental health
- To determine what immediate action is required
- To determine what the next steps might be
- To identify what further information is required.

The assessment will also contain the following elements:
- Service user/tangata whaiora views and beliefs about current problems and needs
- Mental health history and details of the person's involvement with services
- Personal history
- Strengths and protective factors
- Precipitative factors and psychosocial stressors/issues
- The person's social system, interpersonal relationships, family/whānau and carers involvement in crisis
- Physical/health issues
- Current medication
- Service user/tangata whaiora expectations of service
- Carers expectations of service
- Develop a possible resolution to the presenting problems - MHAHT is a service delivered by nurses and/or allied health staff to provide acute responsive services that are highly mobile and available in the service user's home setting as an appropriate alternative to a service in an acute inpatient

hospital-based setting, (Adult Mental Health- Adult Acute Home Based Treatment Tier Three Mental Health and Addiction Services service specification February 2013 page 4)
- Consider suitability for crisis respite, overnight accommodation
- Consider access to on-call psychiatrist, and access to ED for medical examination
- Health professionals working with MHAHT are to complete the organisation wide Risk Assessment template for every service user/tangata whaiora they assess so that risks that are identified are mitigated and form part of the Recovery Plan of action.

Risk Formulation
Synthesis of the significant factors, which have contributed to the development of the crisis. Guidance management

Assessment documentation
For full entry to MH&AS a risk assessment, HoNOS and recovery care plan is required. The interaction and event will also be detailed in the Clinical Portal progress notes. Any alerts or allergies will be reported in the WebPas as a national or local alert.

Documentation
All contacts are to be recorded on the MHAHT call log and will meet the following standards:
- All entries are to be signed by author
- Time and date of call received is to be documented
- Identification of caller is to be documented (where caller is from another health provider/ NGO/community organisation or Police, this too is to be documented)
- Purpose of call is to be documented (callers identified purpose not the staff members perception as to the purpose)
- Advice/recommendations given by staff or actions taken by staff in response to the call are to be specifically documented
- Where additional documentation is made, for example in Clinical Portal, the MHAHT call log needs to reference the relevant entry
- all calls received from a service user/tangata whaiora, who is a current service user/tangata whaiora of Mental Health and Addiction Services, will be recorded in the service user/tangata whaiora Clinical Portal electronic clinical record.

Assessment at the Police station
If request is made by the Police for assessment MHAHT are to attend with a three hour maximum target to facilitate the assessment at the Police Station. If the service user/tangata whaiora is alert and able to participate MHAHT will complete an assessment using the approved WDHB documentation form: Risk Assessment from the Clinical Portal electronic patient management system. On completion of the assessment MHAHT are to write a synopsis of the assessment for the Police using their Health Professional Record of Examination form (POL387A 07/07) and retain a copy for the service user's/tangata whaiora records. A synopsis may include and not limited to recommendation for level of observation while in Police custody, MHAHT level of involvement and referring onto an appropriate service for follow up.

Contact with Police
When MHAHT are called to assist the Police, either by giving advice or to attend a person in Police custody, MHAHT clinicians must always be cognisant that as health professionals they have a duty to take into account the description of the concern and with their professional clinical judgment ascertain the best course of action to respond to the health needs of the service user/tangata whaiora. Whenever possible, MHAHT assessments is a service that is provided by nurses and/or allied staff to provide rapid assessment and intervention for people experiencing a mental health crisis. The services are highly mobile and available in the setting and at the time that the crisis is occurring such as and not limited to community or hospital/clinical settings (Mental Health and Addiction Services, Crisis Intervention Service Tier Three Service Specification February 2013, page 4)

Mental health assessments in Police stations occur for people already in custody or where Police have intervened to prevent harm to self or others or consider the person to have a serious disruption to their mental health.

All MHAHT staff must proactively manage positive and collaborative relationships with the Police. The Memorandum of Understanding between New Zealand Police and Whanganui District Health Board sets a framework and expectations for both parties to adhere to.

Whilst at the Police station ensure the team's safety during the assessment by having a Police officer in the vicinity of the interview in case intervention is needed and ensure you are not left locked in a room, or in any area that you are unable to safety exit.

The duly authorised officer attending the MHAHT assessment for the service user/tangata whaiora in Police custody will be responsible for overseeing the MHAHT procedures in Police stations including any transportation of the service user/tangata whaiora to health care facilities.

Request for Police assistance
A duly authorised officer can call for Police assistance to transport a person for the purpose of assessment under the Mental Health Act (see Appendix 3). In the event that the Doctor is unavailable to assess the proposed patient in their own home the DAO must accompany the Police when Police are with a proposed patient in their own home in order for that proposed patient to be taken to a place for assessment.

Disclosing information in the interest of safety
WDHB staff will exercise their clinical judgement and health information and privacy rules knowledge when discussing personal or health information in response to a Police request.

Sharing information in situations of risk of harm to the service user/tangata whaiora, family/whānau or members of the public where disclosure is necessary to prevent or lessen the risk. When disclosing information to family/whānau, members of the public, not involved in providing clinical services, where disclosure is necessary to prevent or lessen the risk of harm, consider that:

- Disclosure must be made to a person who can do something to prevent or lessen the threat
- In the absence of consent where a judgement about risk to the service user or public safety considerations must be made is explained clearly in The Health Information Privacy Code; Rule 11, Section 2 sub rule (d) subsections (i) and (ii) and the commentary relating to disclosure to prevent or lessen serious and imminent threat to public health or public safety or the life or health of an individual on page 65 of the Act
- The Service User/Tangata Whaiora Absence & Absent without Leave (AWOL) Policy outlines circumstances in which information may be given to others where they are deemed to be at risk of harm
- The Children, Young Persons and Their Families Act 1989 makes particular provision for the sharing of information to occur.

Consideration should always be given to the amount of information being shared and its relevance to the situation. Service user/tangata whaiora consent should be gained wherever possible when discussing information with Police.

Contacting Police by telephone
When MHAHT staff require an immediate response, dial 111. Any serious concerns can be reported by dialling 105.

All non-emergency telephone calls should be directed through Police communications, these calls are logged by Police. Direct telephone calls to the area Police stations are not logged by Police communications and should only be used to contact MHAHT clinicians who cannot be reached on their cell phones while at Police stations, or to discuss non urgent issues with Police staff.

At all times Police must be notified by telephone of the estimated time for assessment.

Assessment of intoxicated people in Police custody
As part of the initial referral MHAHT must discuss with Police their ability to manage people with immediate risk factors until a comprehensive assessment occurs. Risk management interventions discussed with Police must be documented on the risk assessment and management form of which a copy is left with the Police.

In those cases where the service user/tangata whaiora is too intoxicated to undertake a full mental health assessment, MHAHT should advise the Police on risk management strategies for the immediate situation and a further assessment should be arranged for a later time when the person is no longer intoxicated.

Police requests to change level of monitoring for 'at risk service users/tangata whaiora'

At times MHAHT clinicians may be asked to assess 'at risk service users/tangata whaiora' in Police custody for the purpose of establishing or changing levels of Police monitoring. In all cases a thorough risk assessment should be completed and recommendations from the assessment if there are further concerns these can be discussed with the psychiatric registrar or the consultant psychiatrist on call if required. A synopsis of the assessment is to be completed that may include recommended observation levels such as a jailer for constant monitoring, monitored cell and safety clothing, or regular observations.

MHAHT clinicians must be familiar with the current Police/WDHB Memorandum of Understanding when assessing people in Police stations.

Physical status of service user/tangata whaiora in Police custody
In the first instance the Police doctor on call should be requested to assess if there are physical concerns for service users/tangata whaiora. Transfer of those service users/tangata whaiora requiring further medical intervention by the Emergency Department services are the responsibility of the Police, who will provide assistance based on the individual's presentation and ability to be managed in the hospital setting.

Assessment in ED or acute wards of the hospital

In order to undertake a comprehensive assessment the person should be sufficiently alert enough to participate in the assessment. This may mean a brief initial screen/assessment to establish safety and risk factors and rescheduling a full assessment when the service user/tangata whaiora is able to participate (e.g. not too drowsy or intoxicated). Also, to provide consultation with the medical team as a DAO to discuss relevant legislation responsibilities such as and not limited to:

- Code of Health and Disability Services Consumers Rights (2004) section 7 (4)
- Crimes Act (1961) section 41
- Mental Health Act section 109 in which case the person must be seen by a medical officer
- Mental Health Act section 110
- Mental Health Act section 111
- Mental Health Act section 8b.
- If not able to complete the comprehensive assessment at the time, MHAHT shall advise the treating team regarding safety considerations and risk management in the interim, specifically highlighting the level of observation required.

Referrals
All service users/tangata whaiora should be seen as soon as practical. At all times the referrer, police or ED coordinator must be advised of the estimated time of arrival and kept abreast of any delays.

Criteria for assessment
Prior to mental health assessment the following are to be met:

- organic causes for the presentation have been assessed, investigated, treated or commenced on appropriate treatment.
- the service user/tangata whaiora is alert and able to hold a conversation for a period of approximately 60 minutes although in order to give preliminary advice on risk and level of observations a lesser level of alertness and duration of focus should be accepted.
- the service user/tangata whaiora should not be kept waiting for 'medical clearance' if the above criteria is met. For example, service users/tangata whaiora who are awaiting blood test results to confirm final medical clearance can still be assessed by MHAHT clinicians if they meet the above criteria
- the Mental Health and Addictions services flow chart is available to guide on referral requests (see Appendix 4)
- consult liaison psychiatry can also be referred to particularly to support with advice on medication review and management.

Initial Emergency Department mental health assessment form
This form is to be completed by ED and faxed to MHAHT at the time of the telephone referral to MHAHT. This will assist access to mental health and addiction services by reducing multiple triages, identifying risks and acute mental health issues at the initial contact with ED. It is completed by ED clinicians within one hour of the service user/tangata whaiora arrival.

Interface with Emergency Department and general wards
It is important that there is a supportive and proactive relationship built between MHAHT, ED and the general wards. ED staff and general medical staff and the duty nurse managers have access to Clinical

Portal (CP) and should be actively involved in developing plans for complex high needs service users/tangata whaiora of hospital and mental health and addiction services. It is not the role of the MHAHT team or MH&AS to intervene with people whose presentations constitute solely violence, aggression, challenging behaviour or intoxication however the MHAHT team and or consult liaison psychiatry may provide support and guidance on how to manage complex and challenging behaviour to support their general hospital colleagues.

Emergency Department and the six hour rule
MHAHT will endeavour to support the six hour rule. However this health target must not be used by either MHAHT or ED to override the safe clinical decision-making and actions. Service users/tangata whaiora can only be discharged from ED when it is clinically safe to do so. MHAHT should seek support from the duty psychiatric registrar/consultant psychiatrist if they feel that service user/tangata whaiora safety is being compromised by ED discharge when assessed by MHAHT to require further time to reassess, treat or arrange transfer to an inpatient setting. MHAHT have a time frame target of 2-3 hours to respond to requests from ED.

Assessment/intervention/documentation
It is recommended that all service users/tangata whaiora assessed by MHAHT clinicians following an attempted suicide/self-harm or who present with suicidal ideation are discussed with an appropriate psychiatric registrar or the consultant psychiatrist (on duty registrar or on call consultant psychiatrist after hours)as required before conclusion of the mental health crisis assessment and plan..

Before the service user/tangata whaiora has left the place of assessment there must be a mental health crisis resolution plan (see Appendix 5) completed in consultation with all stakeholders (service user/tangata whaiora, family/whānau, ED clinicians and MHAHT medical clinicians). The team will aim to achieve collaboration with and facilitation of participation of the service user (tangata Whaiora) and whānau to the fullest extent possible. The service user/tangata whaiora must receive a written copy of this plan prior to leaving ED. The MHAHT team will document as per protocol into Clinical Portal a summary of assessment and outcome.

Mental Health Act in Emergency Department
When Section 111, powers of the nurse for up to six hours, is initiated MHAHT clinicians must check that a Section 8a is completed. Section 8b should be completed by a medical officer and the MHAHT DAO will facilitate section 9 and arrange assessment under section 10 & 11 by an SMO. On occasions where Police assistance is required during a Mental Health Act assessment, the MHAHT duly authorised officer should request for Police to remain in ED until no longer required.

Managing service users/tangata whaiora with difficult behaviour in Emergency Department or in general wards
Any service user/tangata whaiora who displays assaultive, aggressive or unpredictable behaviour must be discussed with the allocated registered nurse/doctor and the appropriate management protocols instigated. Hospital wide policy on the management of aggression and/or violent behaviour should guide response.

Absconding from Emergency Department
ED will facilitate self-discharge against medical advice responsibilities for those service users/tangata whaiora who leave the ED before the completion of a mental health assessment.

Intervention for those service users/tangata whaiora that abscond during and after the mental health assessment will be determined on the service users/tangata whaiora risk factors. MHAHT clinicians will inform the psychiatric registrar or the consultant psychiatrist as appropriate Police and family/whānau may be notified for those service users/tangata whaiora with significant risk factors identified.

Rural assessment
The principles and process for assessment remains the same. Urgent and crisis situations are managed by the community team in the first instance in a responsive and person centred way. Late afternoon referrals should be at a minimum screened and triaged by the duty clinician and both the community, Iwi and MHAHT teams will work in a responsive, timely and cohesive way to best meet the needs of the person in crisis. Rural assessments will incur a time delay due to re prioritising work and travel times for MHAHT and have a four hour maximum wait with a 2–3 hour target depending on travel time and other crisis attendance. Through negotiation teams will decide on what is the most timely and responsive way to have their person assessed and this may involve the assessment occurring by community providers or transporting the person for assessment to Whanganui. The principle behind this is in good

faith and person centred care. It is an explicit assumption however that the MHAHT team will provide afterhours rural coverage and will attend as appropriate in the mostly responsive and timely way that they can.

In order to maintain adequate coverage for Whanganui between 1630hrs and 2300hrs in situations where all the following conditions have been met:

- A face to face assessment is required to take place in Marton, Taihape, Waiouru, Raetihi (Waimarino), Ohakune.
- The already scheduled home treatment/follow up appointments with service user/tangata whaiora would be subject to a time delay or cancellation that directly results in a significant increase in clinical risk to the service user/tangata whaiora.

The following arrangements can be implemented via authorisation from the manager or duty nurse manager:

- The MHAHT service will be able to call in an additional staff member to assist if needed
- The staff member who is called in will directly assist with the rural assessment
- One of the MHAHT staff on duty will remain in Whanganui ensuring continued access to the 0800 number is maintained and deliver the scheduled home treatments/follow up appointments as safely appropriate. Otherwise work that can be rescheduled is done so. An additional vehicle for this purpose can be accessed via the telephonist.

Assessment outcomes

Following a comprehensive assessment formulation as to required follow up or interventions. Possible options are:

- No further MH&AS involvement
- No further MH&AS involvement with referral to other more appropriate agency
- Interim short term follow up of current service user/tangata whaiora
- Home treatment and referral to Community Mental Health and Addiction Services team
- Respite
- Admission to inpatient unit.

Contra-indications to community treatment

High suicide risk

- The person is actively suicidal; a suicide plan has been made both incorporating a means and a timeframe for acting on this intent.
- Other indicators of imminence of risk e.g. entrapment, implicit attitude, ruminative flooding, and agitation.
- The person has a poor social support system with the absence of family/whānau and friends that can be involved in a management plan.
- The service user/tangata whaiora would have been assessed and determined to be a high suicide risk along with a high lethality risk.

High level of danger

Service users/tangata whaiora who have been assessed and determined to be a danger to themselves, or to others, even if removed from the conflict situation. Admission to an inpatient facility may provide the service user/tangata whaiora with a safe environment where risk can be better contained.

Need for inpatient treatment

Service user/tangata whaiora are in urgent need of medical treatment, which can only (or best) be given in a psychiatric inpatient facility.

High level of carer fatigue

When carers are no longer able to cope with the person's behaviour and require respite from their caring responsibilities. The absence of an appropriate crisis respite option would mean that admission to an inpatient facility would be the only option.

Assessment of children and young people aged 18 and under

Children and young people aged 18 and with emergency needs will require 111 emergency services, Police, fire and ambulance

Urgent mental health crisis and home treatment needs are met by the Infant Child and Adolescent Mental Health and Addictions Service (CAMHS) from 0830hrs to 1630hrs on weekdays. From 1630hrs

to 0830hrs on weekdays, weekends and public holidays MHAHT will follow the same process and criteria as for adults. A parent, guardian or responsible adult must be present during assessment and treatment

Planning
Standard 8134.2.3.5 Consumers service delivery plans are consumer focused, integrated and promote continuity of service delivery.

The team will at the commencement of each shift review the home based treatment list and plan and coordinate activities for the shift.

- MHAHT home treatments plan: Which is used to plan the team's daily activity including assessment and home based treatment appointments. This will be referred to at each handover period.
- It is the responsibility of individual team members to ensure that recent contacts with service user/tangata whaiora on home-based treatment are updated in the clinical record as well as communicating relevant details within the handover periods.

MHAHT team will attend the Community Mental Health and Addiction Services coordination meeting, communication will consist of:
MHAHT:
- To advise of assessments completed and outcomes
- Service user/tangata whaiora contacts received out of hours requiring keyworker awareness
- Identify any assessments pending.

Keyworkers:
- Coordination of care provision for shared service user/tangata whaiora or activities requiring MHAHT support
- Service users/tangata whaiora of concern who are presenting with specific difficulties that may come to the attention of or require MHAHT involvement
- Red flag service users/tangata whaiora that are presenting specific difficulties that may require MHAHT involvement overnight or follow up the next day or weekend via MHAHT alert requesting follow up
- Details of on call contact personnel with contact numbers.

The keyworker will make all reasonable efforts to make contact with the service user/tangata whaiora and review their clinical needs prior to referring them to MHAHT for out of hours support. It is acknowledged that inability to locate the service user/tangata whaiora may be the reason for the alert, but evidence of attempts to locate them "in hours" will be evidenced in the clinical record.

MHAHT alert process
The alert to MHAHT is in regard to the service user/tangata whaiora immediate clinical needs and possible presentations out of normal working hours, not a request for ongoing interventions:
- When the referrer is requesting assistance for clinical treatment, it must be clearly specified as such, in a verbal conversation with MHAHT team members and subsequently written on the MHAHT Alert Form and submitted to the MHAHT service prior to the finish of a normal business working day. The MHAHT alert is an agreed and negotiated plan between MH&As specialist service provider and MHAHT
- The keyworker is to collect and store any medication in the locked medication cupboard in the clinic if the request is for MHAHT to administer depot or other medication or discuss attendance arrangements with MHAHT
- MHAHT cannot travel outside of Whanganui city area to provide home treatment, but are able to provide services for service user/tangata whaiora in the rural teams or other regions if they are staying in Whanganui (either with family/whānau and friends, or in respite accommodation).

The following documentation needs to be current and complete:
- MHAHT Alert Form
- MH&AS/A&OD/MICAMHAS mental health assessment
- Risk Assessment Relapse Plan and Risk Management Plan
- Progress notes up to date and completed in the Clinical Portal patient administration system
- HoNOS completed or updated as required
- Mental Health Act papers as appropriate.

All risk assessments with service user/tangata whaiora are to be done with face to face contact.. Support offered by phone contact to known service user/tangata whaiora will be based on the service user/tangata whaiora recovery care plans.

MHAHT alerts should not be used to cover keyworker annual leave and study leave; however, the ongoing needs of service user/tangata whaiora will be managed by the team inclusive of MHAHT, through cooperative arrangements between Community Mental Health and Addiction Services clinicians.

For service user/tangata whaiora receiving ongoing MHAHT service interventions, MHAHT should be included in service user/tangata whaiora/ treatment planning meetings.

Acute home treatment - interim short term follow up (whilst awaiting Community Mental Health and Addiction Services keyworker allocation)

All referrals from the acute inpatient unit, Te Awhina, for a Community Mental Health and Addiction Services keyworker, will initially be **accepted** by MHAHT under any of the circumstances following:

- No current keyworker allocated. MHAHT may assume the role of case manager in the absence of a keyworker, for a maximum period of four weeks from date of discharge from Te Awhina and a target time frame of two weeks. At the end of the four week period a transition of ongoing care will be completed to enable a keyworker to take full responsibility. The transition phase must include a period of joint case manager and keyworker involvement to effectively hand over care
- Service user/tangata whaiora discharge plan requires home visits and or follow up at least twice a week from date of discharge
- Service user/tangata whaiora discharge plan requires home visits and or follow up in respect of medication administration and/or monitoring out of hours.

MHAHT service is additionally able to deliver intensive assessment and/or home treatment in respect of a service user/tangata whaiora requiring time limited follow up while transitioning from Te Awhina under the following circumstances:

- Follow up is time limited to a two week period only and the documented discharge plan specifically identifies the requirements and rationale for a time limited intervention
- The service user/tangata whaiora is connected with a Community Support Worker who will assist with the coordination of established goals and transportation.

Home treatment

MHAHT provides ongoing assessment and home based treatment services for people who are currently receiving services from Community Mental Health and Addiction Services and Te Awhina inpatient service. This may be in collaboration with the Te Awhina clinical coordinator and current keyworker or in the absence or unavailability of a keyworker and is case specific.

Each case will be managed by the clinician, who will be responsible for the coordination of care provided to that service user/tangata whaiora. This will be inclusive of the maintenance of clinical records and involvement in case reviews and handovers.

The team will involve the service user/tangata whaiora as much as possible in care planning to help meet the identified clinical needs, and undertake to provide a consistent contact throughout the care provision. The team will work together to ensure that allocation takes into consideration rosters and clinical strengths of the team.

Admission to Te Awhina

Te Awhina is an acute, short-term inpatient service for adults in need of assessment, treatment and care 24-hours a day either as formal or informal clients. Service users/tangata whaiora who are admitted to this service have a serious disruption to mental health and are in an acute state of mental illness. Service users/tangata whaiora are admitted to Te Awhina for close observation and/or intensive investigation, support and/or intervention only where this is unable to be safely provided within a community setting. Admission to Te Awhina is designed to support community driven care by discharging service users/tangata whaiora as soon as they are safe and able to be treated and cared for in a community setting. Comprehensive, culturally safe individualised plans of care and risk management plans are developed and implemented for each service user/tangata whaiora. These plans form a continuum of services and are developed in conjunction with the service user/tangata whaiora, their family/whānau, keyworker, relevant community services and our multidisciplinary team.

All admissions are by a psychiatrist, SMO or under their direction by a designated registered medical officer. Referrals to Mental Health and Addiction Services can be through general practitioners, Iwi, NGOs, Police or self/whānau via MHAHT.

Access is through community mental health teams or MHAHT.
Emergency youth admissions access via MICAMHAS or MHAHT after hours.

If service user/tangata whaiora requires admission ensure all preadmission assessment and care is documented including HoNOS (CA), and risk assessment. Remain with service user/tangata whaiora until admission process is completed and then full handover to Te Awhina nursing staff. Close community case. All NGO/Iwi service users/tangata whaiora with no community mental health and addictions keyworker must have the preadmission assessment and documentation completed by MHAHT.

Evaluation
Consumers service delivery plans are evaluated in a comprehensive and timely manner. Care plans will be evaluated on a regular basis or as objectives are achieved and/or changed then care plans are updated. Evaluation and further planning must be done in partnership with the service user/tangata whaiora and their family/whānau (unless refused by the service user/tangata whaiora) and must address the service user's/tangata whaiora responses, achievements and progress towards their desired outcome. The minimum review and evaluation of documentation suites is three months. The HoNOS review for each service user/tangata whaiora ensures the care plans are reviewed on a three monthly basis or sooner.

Service use/tangata whaiora experience will be evaluated in the MH&AS via the HQSC Marama real time survey.

Referral to other health and disability services (internal/external)
Consumer support for access or referral to other health and or disability service providers is appropriately facilitated or provided to meet consumer choice/needs. MHAHT will support people to access the most appropriate services through a navigation role and offer advice on other services and their contact details.

Transition/exit/discharge or transfer
Service users/tangata whaiora experience a planned and coordinated transition, exit, discharge or transfer from services.
Transition into or out of an inpatient unit or to/from a Community Mental Health and Addiction Services keyworker will be in collaboration with the service user/tangata whaiora where possible. Thorough and clear communication between MHAHT and the receiving/transferring service will minimise risks associated with each service user's/tangata whaiora transition, exit or discharge including concerns that the service user/tangata whaiora and/or their family/whānau have about the change of service. Documentation by providers concerned will ensure the receiving service has knowledge of each service users/tangata whaiora history, risk, strengths, needs, preferences and desired outcomes of treatment.

All cases due to be closed are to be discussed at a Community Mental Health and Addiction Services MDT or individually with the psychiatric registrar before closing.

There may be occasions when MHAHT are required to become part of a management plan for a service user/tangata whaiora at the request of a Community Mental Health and Addiction Services clinician/keyworker. MHAHT will work alongside the service user/tangata whaiora and the relevant community keyworker to clearly identify the nature of the risk factors, current recovery care plan, relapse indicators and interventions proposed. Requests for non-emergency assistance in respect of home treatment are to be actioned through the MHAHT alert form process.

Medicine management
Standard 8134.1.3.12 Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.
MHAHT follow the Whanganui District Health Board medication policy, controlled drugs procedure and medication procedure guidelines including the Writing a Standing Order procedure.

6. Related Whanganui District Health Board documents

- Code of Conduct Policy (Whanganui District Health Board

- Administration, Discharge and Transfer Policy (Whanganui District Health Board)
- Confidentiality Policy (Whanganui District Health Board)
- Quality and Risk Strategy (Whanganui District Health Board)
- Health Professionals Standards of Practice Policy (Whanganui District Health Board)
- Health Records Policy (Whanganui District Health Board)
- Orientation Policy (Whanganui District Health Board)
- Mental Health Services service user/tangata whaiora/tangata whaiora Participation Policy(Whanganui District Health Board)
- Mental Health Services Relapse Prevention Planning Procedure
- Protected Information Disclosures Policy (Whanganui District Health Board)
- Security of Information Policy (Whanganui District Health Board)
- Mental Health Services Key Worker Policy (Whanganui District Health Board)
- Health Strategy Review, Whanganui DHB, May 2013.
- Whanganui District Health Board, (2013) Annual Plan 2013/14, Whanganui: Whanganui District Health Board.

7. References

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- Te Tahuhu, Improving Mental Health 2005-2015
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- Mental Health Foundation (2013) Crossing Boundaries: Improving integrated care for people with mental health problems, Mental Health Foundation.
- Crisis Assessment & Treatment Team (CATT) Home Based Treatment Team (HBT) Procedure Manual – Capital & Coast DHB (2012)
- Emergency Mental Health Service (EMHS) – Hawkes Bay DHB (2012)

8. Appendix

Appendix 1: Mental Health Assessment & Home Treatment Alert
Appendix 2: Triage acuity levels
Appendix 3: DAO Request for Police assistance guide
Appendix 4: General Hospital and Emergency Department Flowchart to access MH&AS
Appendix 5: Mental Health Crisis resolution plan

9. Key words

Mental health assessment home treatment, MHAHT, keyworker, crisis, crisis team, urgent, emergency

Appendix 1:

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Patient Label	
Surname:	**NHI:**
First Names:	**Ward:**
Address:	**DOB:**
	ACC No:

MENTAL HEALTH ASSESSMENT & HOME TREATMENT ALERT FORM

NAME:	**PHONE:**
ADDRESS:	
CONTACT NAME:	**PHONE:**
MENTAL HEALTH STATUS:	
DIAGNOSIS (IF KNOWN): or impression	
REASON FOR ALERT:	
RELEVANT HISTORY:	
CURRENT MEDICATION:	
CURRENT ACTION PLAN: On Jade Yes ☐ No ☐	
TIMEFRAME MHAHT INVOLVEMENT:	
SIGNED: _____ **DATE:** _____	

MENTAL HEALTH ASSESSMENT & HOME TREATMENT ALERT FORM

Appendix 2:

Triage acuity levels

Level of urgency	**Level I = Emergency**	**Level II = Urgent**	**Level III= Acute**	**Level IV = Non-urgent**
Entry	Fulfils entry criteria and eligibility	Fulfils entry criteria and eligibility	Fulfils entry criteria and eligibility	Fulfils entry criteria and eligibility
Assessment	Is an imminent threat to physical safety of self, service user/tangata whaiora and/or others. Is making threats Is actually causing harm to self, others or property. Person has a weapon There is evidence of high lethality	There are immediate concerns about physical safety and wellbeing of the service user/tangata whaiora or others May fulfil the definition of mental disorder under the Mental Health Act There is evidence that if response is not timely negative outcomes for the service user/tangata whaiora or others will occur	Is acutely unwell or deteriorating but not at an imminent risk of harm to self and/or others Has reasonable support systems The service user /tangata whaiora , their supports, are able, willing, to contact the service if their situation changes	Does not fulfil criteria for acute assessment but will benefit from mental health assessment Does not fulfil criteria: give information/ advice re Primary Providers
Action	☐ Contact Emergency Services (Police, Ambulance) immediately	☐ Contact the service user /tangata whaiora /referrer within 15 minutes ☐ MH-ICT assess or ☐ Key worker/duty person of CMHT / Specialist Service to conduct a crisis assessment as soon as possible and/or access MH-ICT for assistance ☐ Put contingency plans in place to ensure safety of the service user/tangata whaiora until crisis assessment can occur ☐ Keep service user /tangata whaiora /referrer informed about processes and time frames ☐ May require police input	☐ Allocation process will be undertaken daily ☐ Assess the situation as soon as possible, 24-48 hours. Key worker for current service user /tangata whaiora. Duty Worker for new referrals, or access MH-ICT for assistance. ☐ Contact the service user /tangata whaiora /referrer and inform them about processes, timeframes ☐ Put contingency plans in place to ensure safety of the service user /tangata whaiora until this assessment can occur.	☐ MH-ICT refer straight to Specialist Service CMHT ☐ To the Community team/Specialist Services allocation system ☐ Contact the service user/tangata whaiora/referrer and inform them about processes and approximate time frames ☐ Refer to, or give service users /tangata whaiora information re contacting primary/secondary providers.
Follow up	☐ Whether further assistance and assessment is required	☐ Ensure service user /tangata whaiora was assessed	☐ Ensure service user /tangata whaiora was assessed	☐ Ensure service user /tangata whaiora was assessed and/or referred to the appropriate service

Appendix 3

Name: _____ NHI: _____

Address: _____

Date of Birth: _____ Sex: _____

GP or Consultant: _____Area: _____

OR PATIENT ID LABEL HERE

DULY AUTHORISED OFFICER (DAO) REQUEST FOR POLICE ASSISTANCE UNDER THE MENTAL HEALTH (COMPULSORY ASSESSMENT & TREATMENT) ACT 1992

I as a Duly Authorised Officer (DAO) authorised by the Director of Mental Health Services do hereby request police assistance - as specified in Section 41(1) of the Mental Health (Compulsory Assessment & Treatment) Act 1992 and Mental Health (Compulsory Assessment & Treatment) Amendment Act 1999 - related to

_____ (Patient name)

DAO: _____ Date: _____ Signature: _____

☐ To assist in the facilitation of a Section 8b Medical Certificate by **entering the premises and giving assistance to take the person to a Medical Practitioner** and to ensure that the Medical Practitioner is able to fully examine the person. This request is made under **Section 38(4)b and Section 38(4)d(i)** of the Mental Health (Compulsory Assessment & Treatment) Act 1992 and Mental Health (Compulsory Assessment & Treatment) Amendment Act 1999.

☐ **A Section 9** Notice to attend has been served which requires the proposed patient to now be assessed by a psychiatrist at a location specified on this notification. The proposed patient has refused to attend and police assistance is required to ensure that this assessment occurs. This request is made under **Section 41(5)a** of the Mental Health (Compulsory Assessment & Treatment) Act 1992 and Mental Health (Compulsory Assessment & Treatment) Amendment Act 1999.

☐ The patient is a compulsory patient on leave. This **leave has now been cancelled**, and the patient is refusing to return to the specified place of treatment. The patient is required to return. This request is made under **Section 40(2)a or 40(2)b** of the Mental Health (Compulsory Assessment & Treatment) Act 1992 and the Mental Health (Compulsory Assessment & Treatment) Amendment Act 1999.

☐ The patient is a **compulsory patient and absent without leave** and is refusing to return to the specified place of treatment. The patient is required to return. This request is made under Sections **40(2)a or 40(2)b** of the Mental Health (Compulsory Assessment & Treatment) Act 1992 and the Mental Health (Compulsory Assessment & Treatment) Amendment Act 1999.

Other:

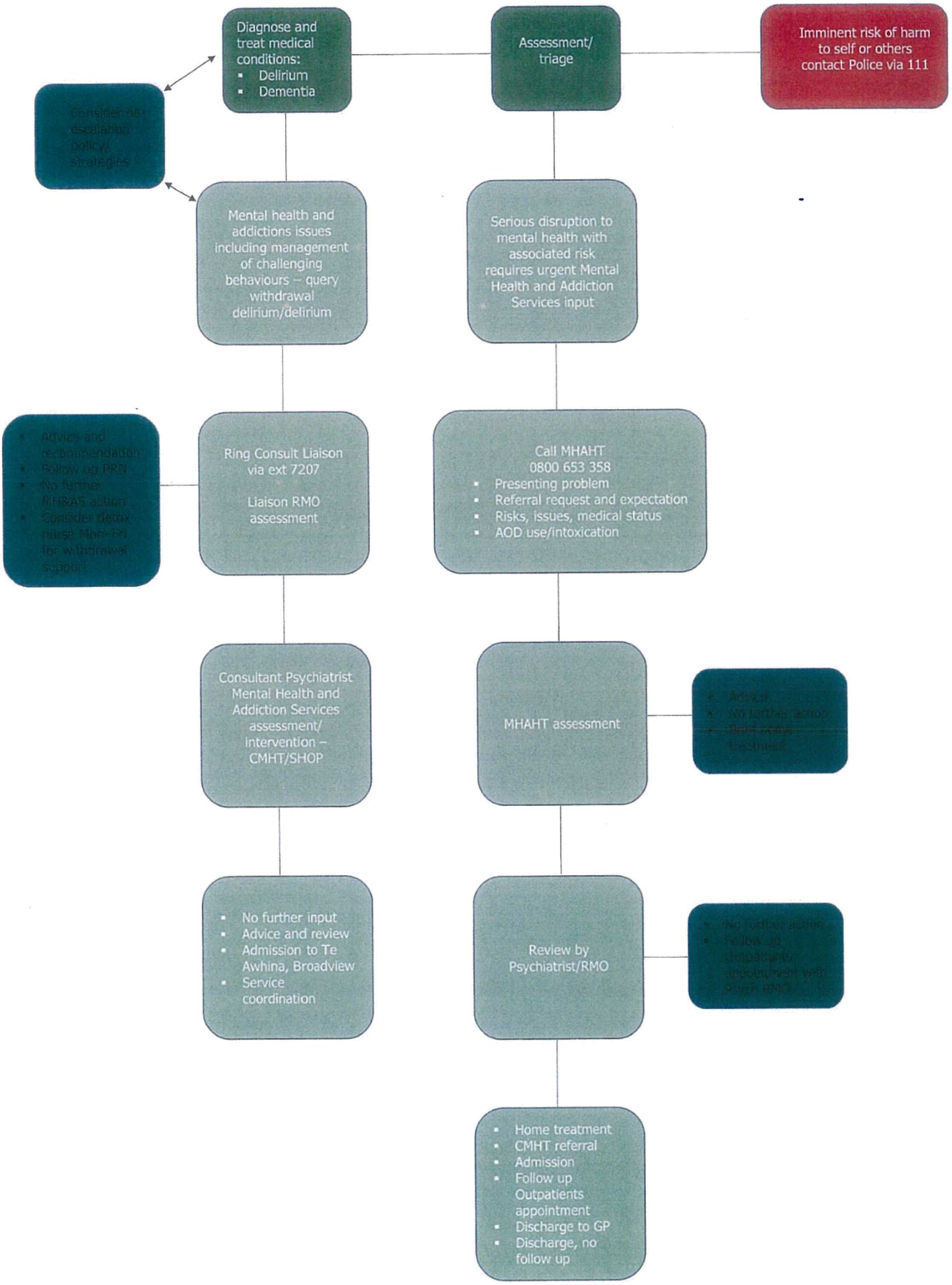
_____

_____

Appendix 4:

General Hospital/Emergency Department

Flowchart to access Mental Health & Addiction Services



Appendix 5:

Date: .....

Service user/tangata whaiora name: .....

You were seen by ..... of the Mental Health Assessment & Home Treatment Team

Address you will be staying at .....

Telephone number at that address ..... Mobile number .....

Agreed telephone support from MHAHT .....

Doctor's appointment: Dr .....

Time: ..... Date: ..... Venue: .....

Level of support required until next MHAHT contact: .....

.....

Name of identified support person: .....

Relationship with support person: .....

Plan discussed:

.....

.....

.....

.....

.....

Whanganui Mental Health & Addictions Services can be contacted for advice. If there are any concerns for your safety or wellbeing contact the Mental Health Assessment & Home Treatment Team on

0800 653 358

24 hours / 7 days a week

If it is an emergency and/or there are imminent safety concerns please contact the emergency services on 111 and state which service your require

eg Police, Ambulance, Fire

Service user/tangata whaiora signature: .....

Support person signature: .....

MHAHT clinician signature: .....

(NB: ensure that you document in service user/tangata whaiora clinical file that this form has been completed)