APPENDIX 1

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

Date ..... Time .....

Contributors: to MDT – see over

OLDER ADULT MENTAL HEALTH/STAR 1

INITIAL MDT TREATMENT PLAN

Presenting complaint: Medical: Primary focus of treatment: Legal status:	**Assessments:**	**Date:**
	CT Head	
	Cogs	
	Functional	
	Allied Health	

FAMILY MEETING:

Referrals required/requested/completed:

Issue:

Goal:

Actions:

Responsibility:

Issue:

Goal:

Actions:

Responsibility:

BINDING MARGIN – NO WRITING

PATIENT ID LABEL

Issue: Goal: Actions: Responsibility:
Issue: Goal: Actions: Responsibility:

Contributors	
Psychiatrist:	
Medical Officer:	
Associate Charge Nurse:	
Charge Nurse Manager:	
Clinical Nurse Specialist:	
CPN:	
CPN:	
CPN:	
CPN:	
CPN:	
Occupational Therapist:	
Social Worker:	
Supportlinks:	
Ward Nurse:	
Student Nurse:	
Other:	

Proposed discharge destination: Follow up:	Proposed date of discharge:
Signed on behalf of MDT:	

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Name: _____ NHI: _____
Address: _____
Date of Birth: _____ Gender:_____
GP or Consultant: - _____ Area: _____
WHAIORA ID LABEL HERE

INTERDISCIPLINARY PLANNING AND REVIEW MEETING

Mental Health and Addiction Service

Team:	Last review date:	Current review date:

Rationale for Review
□ Sudden major change in Mental State
□ Initial Case Review
□ Routine Case Review
□ Other (e.g. Incident – Please specify)
_____

Interdisciplinary team and whānau wahiora present:

	Name	Discipline/Link		Name	Discipline/Link
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐		

Provisional/Principal formulation/diagnosis:
_____

Other formulation/diagnosis:
_____

Legal status (example, MH Act, Informal, etc.) _____

Leave conditions (inpatient): _____

Cultural identity: _____

Family whānau/significant other unable to participate (rationale):

_____

_____

Current wellbeing recovery plan ☐ Yes ☐ No
Current safety/risk assessment presented ☐ Yes ☐ No
HoNOS/HoNOSCA/HoNOS 65+/ADOM ☐ Yes ☐ No
Whānau whaiora strengths and identified needs:

BARCODE AREA

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Name:_____ NHI: _____
Address: _____
Date of Birth: _____ Gender:_____
GP or Consultant: - _____ Area: _____
WHAIORA ID LABEL HERE

Context and narrative discussion key points only:

Taha wairua:

Taha whānau:

Taiao (environment, housing and income,etc.):

Taha tinana:

Taha hinengaro:

Wellness recovery action plan (WRAP):

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GP or Consultant: - _____ Area: _____
WHAIORA ID LABEL HERE

Please circle:
HoNOS/HoNOSCA/HoNOS 65+/ADOM **RATED 2 AND ABOVE:**

Rating	Item Name	Rating	Item Name	Rating	Item Name

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Identify and state the focus of intervention/therapy and actions required to enable wellbeing recovery and the transfer or care or discharge from the service. Enter these directly into Wellbeing Recovery plan as headed up below.

Date Te Ra	Identified wellness recovery goals	Interdisciplinary plan, agreed therapy intervention	By whom I a Wai	By when Te Rangi kia oti atu	Outcome/comments Ngahuia/Ngakorero	Review Date Te Ra hei Tirohanga ano

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Address: _____
Date of Birth: _____ Gender:_____
GP or Consultant: - _____ Area: _____
WHAIORA ID LABEL HERE

Transition/Discharge Goals	Actions	By Whom?	By When?
Planned Transition/Discharge Date: ____/____/____			
Next IDP Review Date: ____/____/____			

Lead facilitator:_____	Care Coordinator:_____
Name: _____	Name:_____
Discipline: _____	Discipline:_____

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Date of Birth: _____ Gender:_____
GP or Consultant: _____
OR PATIENT ID LABEL HERE

MENTAL HEALTH AND ADDICTION SERVICE DISCHARGE SUMMARY

Phone No:	**Date first seen:**	**Date last seen:**
Referral source:	**Date of discharge:**	**GP/NP:**
Name of Care Coordinator:		**Psychiatrist name:**
Presenting problems:		

DSM IV Principal Diagnosis:

Treatment and Progress:

Smoker: ☐ **Yes** ☐**No** | **Smoking Cessation Programme offered:** ☐ **Yes** ☐**No**

Current Physical Medication (if known): | **Current Mental Health Medication:**

Relapse indicators:

Whānau consulted in discharge plan (if appropriate): ☐ **Yes** ☐**No**

Copy of discharge summary provided to:

GP: ☐ **Yes** ☐**No** **Consumer:** ☐ **Yes** ☐**No**

Whānau: (if appropriate) ☐ **Yes** ☐**No** **Other:** ☐ **Yes** ☐**No**

Follow up recommendations:

Name of person completing discharge: **Designation:**

Signature of person completing discharge: **Date:**

Please tick appropriate service below:

☐ Early Intervention Service Palmerston North Phone: 0800 653 357	☐ Child, Adolescent and Family Service Palmerston North Phone: 0800 653 357	☐ Horowhenua Locality Levin Phone 0800 653 357	☐ Oranga Hinengaro Kaupapa Māori Horowhenua Levin Phone 0800 653 357	☐ Oranga Hinengaro Kaupapa Māori Manawatu Palmerston North Phone 0800 653 357
☐ Manawatu Locality Palmerston North Phone 0800 653 357	☐ Tararua Locality Dannevirke Phone (0800 653 357	☐ Specialist Primary Palmerston North Phone 0800 653 357	☐ Ward 21- Acute Inpatient Unit Palmerston North Phone 0800 653 357	☐ Crisis Resolution Phone 0800 653 357
MidCentral Mental Health and Addiction Service – Te Uru Rauhi **Freephone 0800 653 357** **Private Bag 11036,** **PALMERSTON NORTH**			☐ Ward 21 Interim Discharge Summary	

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Patient label here

CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

My Just in Case Plan

Triggers that increase my distress (i.e., social media, school, home, environment, being bullied):
1.
2.
3.
4.
5.
6.

BINDING MARGIN – NO WRITING

BINDING MARGIN – NO WRITING

Early warning signs or red flags to know that I may be getting worse (i.e., being more alone, irritable, angry, upset, tearful, what I feel inside):
1.
2.
3.

Patient label here

Internal coping strategies which can take my mind off my thoughts and emotions (i.e., deep breathing, grounding, mindfulness, positive thoughts):
1.
2.
3.

External coping strategies to keep me safe (i.e., actions I can take):
1.
2.
3.

People and social settings which can support or distract me:	
Name:	Phone:
Name:	Phone:
Name:	Phone:
Professionals/agencies I can ask for help – do they need a copy of the plan?	
Name:	Phone:
Name:	Phone

BINDING MARGIN – NO WRITING

BINDING MARGIN – NO WRITING

Patient label here

Future Plans:
1.
2.
3.

Reasons for living (if no future plans):
1.
2.
3.

Re-assess risk on:
Appointment scheduled with:
Young person's name:
Caregiver's name:
Clinician's name:
Role:
Date completed:

Acute Crisis Team: 0800 653 357

Youthline freephone 0800 376 633 / Lifeline 0800 543 354 /
Parentline freephone 0800 432 6459 / Need To Talk – free text/call 1737 anytime

CAMHS MidCentral (06) 350 8373

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CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

My Transition Plan

Date:	Client Contact Number:
Keyworker:	Referral Source:
Date first seen:	Date last seen:
Number of sessions:	

BINDING MARGIN – NO WRITING

BINDING MARGIN – NO WRITING

Reason for referral:

The things that I have been working on:

CHILD AND ADOLESCENT MENTAL HEALTH SERVICE
Konini House, Community Village, Te Whatu Ora – Health New Zealand | Te Pae Hauora o Ruahine o Tararua | MidCentral, Private Bag 11036, Palmerston North Phone 06 3508373, Email: cafspn@midcentraldhb.govt.nz

Patient label here

The things that I have achieved since I first came here:

The things that have supported my wellbeing:

Things I can keep doing to support my wellbeing:

My plans for follow-up with other services after I finish here:			
Service name	What they do	Key contact person	Phone number

BINDING MARGIN – NO WRITING

BINDING MARGIN – NO WRITING

Patient label here

What I need from these other services:

My early warning signs:

My just-in-case plans:

If I need support, I can contact:
Urgent:
Non-urgent:

Diagnosis:

BINDING MARGIN – NO WRITING

BINDING MARGIN – NO WRITING

Patient label here

My medications:				
Medication name	What it does	Dose	How to take it	When to take it

My appointments:		
Appointment with	Date	Phone number

BINDING MARGIN – NO WRITING

BINDING MARGIN – NO WRITING

Transition Planning Agreement

Client completing transition plan:		
Name:	Signature:	Date:

Family completing transition plan:		
Name:	Signature:	Date:

Clinician completing transition plan:		
Name:	Signature:	Date:

Copies of the Transition Plan sent to client/family/GP/ Others:
Please name:

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Name:		
Address:	PATIENT ID LABEL	
NHI:	DOB:	Gender:
Consultant:		Ward:

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SPECIALIST COMMUNITY CONSENT AND CONFIDENTIALITY FORM FOR THE CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS)

By signing this agreement I consent to:
Receiving services as per the information and agreements outlined in this document.

- I understand that before any assessments or treatments are conducted, I have the right to be fully informed about what they involve.
- I also understand that trained professionals will be the ones conducting the assessments and treatments, and they will only do so with my consent, except when the law, such as the Mental Health (Compulsory Assessment and Treatment) Amendment Act of 1999, requires otherwise.
- I also understand that with my consent only, my family, whānau, or significant others may be invited to participate in my assessment and treatment.
- If I am under 16 years old, my family, whānau, or legal guardian must give their consent for my assessment and treatment.
- Furthermore, I understand that my treatment will involve a multi-disciplinary approach (MDT). This means that the care I will receive may involve multiple professionals such as Social Workers, Occupational Therapists, Mental Health Nurses, Doctors, Psychologists, a Dietician, Key Workers, and alcohol and drug clinicians.
- I am aware that MidCentral Health protocol requires CAMHS staff to consider notifying the appropriate authorities in situations where the safety of myself or others is at serious risk. These situations can include cases of immediate risk of sexual or physical abuse.
- Additionally, I understand that when CAMHS staff work with my family where the parents involved in my care are separated (and both are active in providing ongoing support), the staff may share information relevant to my care with both caregivers/guardians.
- Lastly, I am aware that if I am unable to establish a working therapeutic relationship with my key worker or responsible clinician (Dr) , I may request a change. Continuing with an unsatisfactory relationship could impede my recovery.

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Information collected about me will be used to provide health care and treatment and for the purposes of administration. Non-identifying information will be used by MidCentral Health, and the Ministry of Health for statistical purposes.

My health information about me will be accessible by my Primary Care Health Practitioner, (GP) and will be shared with specialist healthcare providers involved in the delivery of my care unless I indicate otherwise.

My health records (electronic and hardcopy) will be stored securely; these include all clinical information, diagnostic results and treatment plans unique to me. Only staff involved in my care will have access to my records.

NB: Full consent must be re-obtained and signed by the service user at each twelve-month anniversary of entry to the MHAS outpatient service

Name:		
Address:	PATIENT ID LABEL	
NHI:	DOB:	Gender:
Consultant:		Ward:

BARCODE AREA

✍ *I (name):_____ have been informed that:*
(This is for either the parent/guardian, or young person age 16 or over to write their full name)

I/and/or my family/ whānau have the right to refuse any treatment or withdraw my/their consent to treatment at any time unless specified by law e.g. Mental Health (Compulsory Assessment and Treatment) Amendment Act, 1999).

I have had this agreement fully explained to me, and I had the opportunity to ask questions and obtain any clarification I might require.

I received information and was provided with the brochure: '*Your Rights and Responsibilities When Receiving Health and Disability Services'* □ YES □ NO.

I have been informed how to access advocacy services □ YES □ NO

I ***do not*** consent to the following people being involved in my care:
*(This is to advise us of whom you **do not** want to be part of your care while you are with this service. You will need to be specific)*

_____

_____

I do ***give*** consent for the following people/agencies (family/whānau/significant other/community support) to be involved in my care: name, contact and relationship to the person
*(This is to advise us of whom **we can contact** for additional information/support as part of your care with this service – we will check with you first if there is any need to link with other services to fnd out if this is okay first, and we will ask you to update this information below as required).*

_____

_____

✍Signature_____ Date_____
This signature is to confirm that this part of the document has been discussed and completed with you.

(This section is providing your consent for treatment via the CAMHS team. For young people age 16 and over you just need to sign and date at the bottom of this box. Parents that sign will need to complete this box in full.

✍I _____(as the *Parent, Legal/Welfare guardian, EPOA)* give

consent for treatment on behalf of _____

✍Signed:_____ Date:_____

Name of Clinician: _____ Signature: _____

Designation: _____ Date: _____
If the Family/Client does not wish to sign the consent form, the clinician responsible for the care is to document the discussion here:

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MidCentral

MINISTRY OF EDUCATION
Te Tāhuhu o te Mātauranga

ORANGA TAMARIKI
Ministry for Children

Attach Patient ID label, or control F1 in box

TE OHU WHAKARAHI WHĀNAU
MENTAL HEALTH MDT CASE REVIEW MEETING

☐ Risk assessment completed ☐Honos / HonoSCA completed ☐My Goals (ITP) completed						
Client Name (NHI):				Age:		
Family/Client Update:				Enter name of participants here:		
Date	Service	Service support plan / Goals	By whom	By when	Outcome / Comments	Review Date
	Ministry of Education support					
	Te Ohu Support					
	Oranga Tamariki Support					

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MINISTRY OF EDUCATION
Te Tāhuhu o te Mātauranga

ORANGA TAMARIKI
Ministry for Children

Attach Patient ID label, or control F1 in box

Date:	Family/Whanau participation:
	Additional information:

Agency sign off for the plan (at least two services):

Te Ohu: Designation:_____ Signature:_____ Date:_____

Ministry of Education: Designation:_____ Signature:_____ Date:_____

Oranga Tamariki: Designation:_____ Signature: _____ Date:_____

BINDING MARGIN – NO WRITING

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MidCentral

Name: _____
Address: _____
NHI: _____ DOB: _____ Gender: _____
GP: _____ Area: ___

WHAIORA ID LABEL HERE

MENTAL HEALTH AND ADDICTION SERVICE WELLBEING RECOVERY PLAN

Te Hotaka Whakapaipa
MAHI AROHA

Date:
Te Ra: _____

☐ START assessment completed
Te Aio Matawai Tupono

☐ Honos/HonoSCA completed

What is recovery for me? (Whaiora Narrative)

Taiao

Environment:

Housing:

Community Connections:

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Te Pae Hauora o Ruahine o Tararua
MidCentral

Name: _____

Address:_____

NHI: _____ DOB: _____ Gender:_____

GP: _____Area: _____

WHAIORA ID LABEL HERE

What I hope to achieve for my recovery and wellbeing

Taha Wairua Beliefs: Values: Tumanako,hopes:	Taha Whānau Connections: Dynamics:
Taha Tinana Nurition: Exercise: Sleep:	Taha Hinengaro: Emotional regulation: Processing my experience: Insight:

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BINDING MARGIN – NO WRITING

Name: _____
Address: _____
NHI: _____ DOB: _____ Gender: _____
GP: _____ Area: _____
WHAIORA ID LABEL HERE

Working to achieve my recovery

Date Te Ra	**Recovery focused actions** **The what**	**Support intervention approaches** **The how**	**By whom**	**Review Date**

BINDING MARGIN – NO WRITING

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Health New Zealand
Te Pae Hauora o Ruahine o Tararua
MidCentral

Name: _____

Address: _____

NHI: _____ DOB: _____ Gender: _____

GP: _____ Area: _____

WHAIORA ID LABEL HERE

If I am starting to get unwell. WRAP

What you may see:

How you can help:

Our agreements: Whaiora, Whānau, IDP team, Others:

Signed:

MidCentral Health Mental Health and Addictions Audit tool

Service Name: CAMHS **(Complete a minimum of 5 files)** **Date: June 2023**

EXECUTIVE SUMMARY – PART 1		
PART 1.1 CONSUMER RIGHTS Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.		
Standard 1.1.1 Consumer Rights During Service Delivery: Consumers receive services in accordance with consumer rights legislation.		
	Evidence/EXAMPLE ANSWERS	
Criteria 1.1.1.1 Providers demonstrate knowledge & understanding of consumer rights and obligations, & incorporate in everyday practice.	**File 1.**	**Evidence** Y
	File 2.	Y
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N

Standard 1.1.2 Consumer Rights During Service Delivery: Consumers are informed of their rights.		
	Evidence	
Criteria 1.1.2.1 The Health and Disability Services Consumers' Rights Code is clearly displayed and easily accessible to all consumers.		
1.1.2.2 Information about the Code and other rights is provided at the earliest opportunity in languages and formats suited to consumers (Is this documented in the service user's file?)	**File 1.**	**Evidence** Y/N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with consumer, family/whanau / legal rep **You will need to Interview staff and consumers:**	**File 1.**	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N

1.1.2.4 Information about Nationwide H&D Advocacy Service is clearly displayed & accessible & brought to the attention of consumers.	

Standard 1.1.4 Recognition of Maori Values and Beliefs: Consumers who identify as Maori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	
	Evidence
Criteria 1.1.4.1 Maori consumers receive services consistent with their cultural values and beliefs.	
1.1.4.4 Maori consumers' right to practise their cultural values and beliefs is acknowledged and facilitated by service providers.	
1.1.4.5 The importance of whanau and their involvement with Maori consumers is recognised and supported by service providers.	
1.1.4.6 Tangata whenua are consulted when meeting the needs of Maori consumers.	
M.H.A only: 1.1.4.7 *The service provides education and support for tangata whaiora, whanau, hapu and iwi, to promote Maori mental well-being.*	

Standard 1.1.10 Informed Consent: Consumers and where appropriate their family/whanau of choice, are provided with the information they need to make informed choices and give informed consent.		
	Evidence	
1.1.10.1 Informed consent policies/procedures identify: (a) Recording requirements; (b) Information (including documentation) provided to the consumer by the service.	**File 1.**	**Evidence** Y
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5	Y/N
1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.		
1.1.10.3 Information is made available to consumers in an appropriate format and in a timely manner.		

1.1.10.4 The service is able to demonstrate that written consent is obtained where required.	**File 1.** Consent form has not been completed	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.1.10.5 Service providers have a thorough knowledge and understanding of how to meet their duties to consumers in relation to Rights 5, 6 and 7 of the Code.		
1.1.10.6 Consumer choices and decisions are recorded and acted on.	**File 1.**	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.1.10.7 Advance directives that are made available to service providers are acted on where valid.		

Standard 1.11.11 Advocacy and Support **Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.**	**Evidence**	
1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person(s) of their choice are to be present.	**File 1.**	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.1.11.2 The service has policies to facilitate the presence of advocates/support person.		
1.1.11.3 Service providers are educated to recognise the right to have an advocate/support person present and identify and appropriately address situations where an advocate/support person is not possible or appropriate.		

EXECUTIVE SUMMARY – PART 3

PART 1.3 CONTINUUM OF SERVICE DELIVERY **Consumers participate in and receive timely assessment, followed by services that are planned, coordinated and delivered in a timely and appropriate manner, consistent with current legislation.**		
Standard 1.3.1 Entry to Services **Consumers' entry into services is facilitated in a competent, equitable, timely and respectful manner, when their need for services has been identified.**		
	Evidence	
1.3.1.1 Access processes and entry criteria are clearly documented, and are communicated to consumers, their family/whanau of choice where appropriate, local communities and referral agencies.	**File 1.**	**Evidence** Y
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.3.1.3 Adequate and accurate information about the service is made available.		
1.3.1.4 Entry criteria, assessment and entry screening processes are documented and clearly communicated to consumers, their family/whanau of choice where appropriate, local communities, and referral agencies.		
MHA only and Acute, secondary or tertiary services only 1.3.1.5 *To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.*	**File 1.**	**Evidence** Y/N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N

Standard 1.3.3 Service Provision Requirements **Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes/goals.**		
	Evidence	
1.3.3.2 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is developed with the consumer, and where appropriate their family/whanau of choice or other representatives as appropriate.	**File 1.**	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. Reference national KPIs – F/F assessment within 3 weeks of referral review weekly	**File 1.**	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	**File 1.**	**Evidence** Y
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N

MHA only 1.3.3.5 *The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whanau of choice where appropriate and other services it has links with.*	**(as applicable)**	Y/N
1.3.3.6 *The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whanau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.* *This shall include, but is not limited to:* *a) Consumer support group referrals;* *b) Education programmes;* *c) Consultation and liaison with community groups or relevant self-help groups.*		
Standard 1.3.4 Assessment **Consumers' needs, support requirements and preferences are gathered and recorded in a timely manner.**		
	Evidence	
1.3.4.2 The needs, outcomes and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.		
Standard 1.3.5 Planning **Consumers' service delivery plans are consumer focussed, integrated and promote continuity of service delivery.**		
	Evidence	
1.3.5.1 Service delivery plans are individualised, accurate and up to date.	**File 1.**	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N

1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	**File 1.**	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.3.5.3 Service delivery plans demonstrate service integration.		
MHA only 1.3.5.4 *The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/whanau if appropriate*	**File 1.**	**Evidence** Y/N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.3.5.5 The service delivery plan is communicated in a manner that is understandable to the consumer and service provider responsible for its implementation and with the consumer's consent, their family/whanau of choice.	**File 1.**	**Evidence** Y/N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N

Standard 1.3.6 Service Delivery/Interventions **Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.**		
	Evidence	
1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		
MHA only 1.3.6.3 *The consumer receives the least restrictive and intrusive treatment and/or support possible.*	**File 1.**	**Evidence** Y/N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.3.6.4 The consumer receives safe and respectful services in accordance with current accepted good practice, and which meets their assessed needs, and desired outcomes.	**File 1.**	**Evidence** Y
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
MHA only 1.3.6.5 *The consumer receives services which:* *(a) Promote mental health and well-being;* *(b) Limit as far as possible the onset of mental illness or mental health issues;* *(c) Provide information about mental illness and mental health issues, including prevention of these;* *(d) Promote acceptance and inclusion;* *(e) Reduce stigma and discrimination* *This shall be achieved by working collaboratively with consumers, family/whanau of choice if appropriate, health, justice and social services, and other community groups.*		Y/N

Standard 1.3.8 Evaluation **Consumers' service delivery plans are evaluated in a comprehensive and timely manner.**		
	Evidence	
1.3.8.1 Evaluations are conducted at a frequency that enables the regular monitoring of progress towards achievement of desired outcomes.	**File 1.**	**Evidence** Y
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.3.8.2 Evaluations are documented, consumer-focussed, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	**File 1.**	**Evidence** N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.		

Standard 1.3.9 Referral to Other Health and Disability Services (Internal and 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.**	
	Evidence
1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.	

Standard 1.3.10 Transition, Exit, Discharge or Transfer **Consumers experience a planned and co-ordinated transition, exit, discharge or transfer from services.**		
	Evidence	
1.3.10.1 Service providers facilitate a planned transition exit, discharge or transfer in collaboration with the consumer whenever possible and this is documented, communicated and effectively implemented.	**File 1.**	**Evidence** N
	File 2.	
	File 3.	
	File 4.	
	File 5.	
1.3.10.2 Service providers identify, document and minimise risks associated with each consumer's transition, exit, discharge or transfer, including expressed concerns of the consumer and, if appropriate, family/whanau or choice or other representatives.	**File 1.**	**Evidence** N
	File 2.	
	File 3.	
	File 4.	
	File 5.	

Standard 1.3.12 Medicine Management **Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.**		
	Evidence	
1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines.		
1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.		
1.3.12.4 A process is implemented to identify, record and communicate a consumer's medicine-related allergies or sensitivities and respond appropriately to adverse reactions or errors.		
1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.		
1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.		
MHA only *1.3.12.7 Continuity of treatment and support is promoted by ensuring the views of the consumer, their family / whanau of choice where appropriate, and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.*	**(As Applicable)** **File 1.**	**Evidence** Y/N
	File 2.	Y/N
	File 3.	Y/N
	File 4.	Y/N
	File 5.	Y/N
ALL Variances: to be written as an Action plan (see next page) Discussed at team quality meeting Presented at MHOLG	**Y/N** **Y/N** **Y/N**	**TOTAL** **/5** **/100%**

MENTAL HEALTH & ADDICTION SERVICE AUDIT ACTION PLAN

ACTION PLAN

TEAM: **DATE: //**

AUDIT IDENTIFIED:

Issue identified as needing plan	Steps Needed to rectify issue	By Whom	Reported to	Follow up audit to be done by
EXAMPLE Standard 1.3.7 *Consumers are kept safe and are not subjected to, or at risk, of, abuse and/or neglect.* Evidence of this occurring is staff completion of family violence screening 3 out of 5 files evidenced	- All staff to be aware of requirement to complete family violence screening - Have all staff completed the revised Family -Violence training? If no, complete a PDSA. Discuss at team business meeting If yes Re Audit in 4 weeks	Jo Bloggs	Monthly business meeting (C.M)	Jo Bloggs 21.5.17
1.				
2.				
3.				
4.				
5.				
6.				
7.				

APPENDIX 2

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

POLICY

TE MĀTĀPUNA O TE ORA, MENTAL HEALTH & ADDICTION SERVICES (MHAS)

INTERDISCIPLINARY PLANNING AND REVIEW

Applicable to: **All registered clinical and non-registered support staff working in Te Uru Rauhī Mental Health & Addiction Services**	Issued by: **Mental Health & Addiction Services**
	Contact: **Operational Executive**

STATEMENT OF COMMITMENT TO TE TIRITI O WAITANGI:

Te Uru Rauhi-Mental health and Addiction Services are committed to ensuring an authentic treaty partnership is upheld.

Article I (Kawanatanga) as tangata tiriti we are kaitiaki (stewards) of the health and disability system.

Article II (Tino Rangatiratanga) we are responsible partners who enable Māori to exercise authority over their own health and well-being.

Article III (Oritetanga) to achieve equitable health outcomes for Māori.

The Ritenga declaration identifies the importance of enabling Māori to thrive live and flourish as Māori by having access to rongoā, supporting access to culturally responsive mātauranga inclusive services and through investing in kaupapa Māori service delivery.

Te Uru Rauhi are committed to working in partnership with Pae Ora Paiaka Whaiora Hauora Māori Directorate to improve health outcomes for Māori are a committed to reducing the significant inequities that exist for Māori. Te Mātāpuna o te Ora is a connected care approach that proactively supports whānau transition seamlessly across teams to best support whaiora recovery outcomes and wellbeing

As part of our commitment Te Uru Rauhi will ensure culturally responsive practices are interwoven across service and delivery design utilising whānau Māori, iwi and kaupapa Māori services are engaged to ensure the voice of Māori is captured and responded to using a whānau centred approach. whānau-centred refers to the idea that service design and delivery must meet the needs of whānau first and foremost. Whānau-centred means delivering a service response that is informed and accountable to whānau aspirations. Whānau-centred ways of working are strengths based, grounded in aroha, and well resourced. Whānau-centred is a commitment to provide a multi-layered approach to whānau requiring support.

All staff are to be always familiar with MDHB Te Tiriti O Waitangi policy MDHB 2031 and work in a culturally aware manner. Improving health outcomes for Māori is a key obligation from an equity perspective. Locally Sir Mason Duries work is embraced to support wellbeing models of care. Te Whare Tapa Wha as a common wellbeing practice model.

1. PURPOSE

To set Te Mātāpuna o te Ora, Specialist Mental Health and Addiction Service expectations for Interdisciplinary Planning and review (IDP) processes. (Kaupapa services align to whānau Ora and Hui for IDP.)

The central aim of the IDP is to improve health outcomes of whānau whaiora accessing Te Mātāpuna o te Ora service and the wider Connected Care Network. The strength of the IDP process is derived from the use of shared knowledge and perspective to best optimise progress to Wellbeing Recovery for whanau whaiora.

IDP meetings are the forum for planning and reviewing interventions to support whānau whaiora Wellbeing Recovery.

2. SCOPE

All registered clinical and unregulated staff working with whānau whaiora, Te Mātāpuna o te Ora, Mental Health and Addiction Services.

3. ROLES & RESPONSIBILITIES

3.1 The Interdisciplinary process

The Connected Care Network is a whole of life/whole system. It provides a whānau whaiora centred approach that acknowledges Te Whare Tapa Wha as a holistic model of care to support inclusive, adaptive, clinically, and culturally responsive service delivery. Whānau whaiora access services within the network where engagement is a central aspect of the Wellbeing Recovery partnership.

The most appropriate service to meet whānau whaiora needs is to be determined clinically and culturally within the interdisciplinary planning and review process. The interdisciplinary process is inclusive of different roles and professional disciplines contributing to connected care in collaborative partnership with whānau whaiora.

The care team consists of the whānau whaiora, clinicians and unregulated support roles directly involved in service provision to whānau whaiora. They form the core interdisciplinary group that supports development and review of the Wellbeing Recovery Plan (WRP) ensuring a strengths-based Wellbeing Recovery focus and clearly identified whānau whaiora goals, timelines and established progress to Wellbeing Recovery.

Recognition of the different professional bodies and the clinician's professional scope and responsibilities is considered during the Interdisciplinary process.

The responsible/accountable/consulted/informed (RACI) matrix is a tool that identifies roles and responsibilities within the Interdisciplinary team and helps formulate the varied level of engagement different professionals have. A description of this model as it applies to Te Mātāpuna o te Ora may be found in the Te Mātāpuna o te Ora Operational Manual.

3.2 Lead facilitator

Facilitates the Connected Care Network model and service response ensuring timely assessment, evidence informed intervention and progress toward Wellbeing Recovery. Ongoing clinical review is applied to understand whānau whaiora experience, engagement, and Wellbeing Recovery. The Lead Facilitator oversees service audits and applies whānau whaiora

feedback to support service quality and improvement. They ensure the IDP and quality process guide service delivery and whānau whaiora goals toward wellbeing recovery.

The Interdisciplinary and review process will be facilitated by lead facilitators or delegates with whanau whaiora playing a significant role.

3.3. The Care Co-ordinator

Care Co-ordination is a process within Te Mātāpuna o te Ora. Care Co-ordinator function may be allocated to any role or discipline based within any team across the Connected Care Network of Te Mātāpuna o te Ora. This may include Primary Care, iwi providers or NGO partners. The Care Co-ordinator is responsible for:

- Build trust and confidence as the main point of contact for whānau whaiora during their Wellbeing recovery journey.
- To ensure that whānau whaiora voice and participation is part of the Connected Care Network on their Wellbeing Recovery journey.
- Ensures that documents and records pertaining to whānau whaiora are maintained and reviewed within required timeframes.

3.4 Medical Staff

Medical staff support the interdisciplinary process, taking responsibility for the care and treatment of whānau whaiora who require specialist medical assessment, diagnosis, treatment and the integration of biological and psycho-social factors relating to their distress. These medically focused aspects of care, support and responsibility are in turn, supported by the interdisciplinary process within the integrated connected continuum of care. In addition to providing medical services based in Locality Mental Health Centres, Doctors will provide consult-liaison services within primary health clinics, NGOs and may undertake assessments in the homes of whānau whaiora in collaboration with other team clinicians.

3.5 Psychologists

Psychologists contribute to the care coordination approach through application of their specialist skills in assessment, case conceptualisation, formulation, as well as diagnosis of mental health and / or addiction presentations. They are trained in using and interpreting psychological tests and integrating that information into assessments to inform care. They can provide a valuable perspective and guidance to the Interdisciplinary Team in treatment, risk assessment and safety planning for complex cases.

Psychologists possess advanced knowledge and skills in delivering evidence based psychological interventions and psychological therapies (eg CBT, DBT, MI, ACT, brief solution focused therapy, family therapies, mindfulness based and metacognitive therapy) to people with a wide range of clinical presentations. These interventions may be provided at the level of the whānau whaiora, or group, across the continuum of severity. Psychologists may deliver psychotherapies directly to whānau whaiora or support other clinicians to deliver these interventions through the provision of supervision, consultation, training, education, or programme design and delivery.

3.6 Nursing

Mental Health and Addiction Nurses are Registered Nurses who hold specialised post-graduate qualifications and post-registration training in talking therapies in the field of Mental Health and Addictions across primary, community and inpatient health services. The nurse provides recovery orientated comprehensive care which includes health education, health promotion and illness prevention, assessment, diagnosis, intervention, treatment and evaluation in a variety of settings along the continuum of care and across the lifecycle. Within the context of Mental Health and Addiction care, the nurse addresses whānau whaiora psycho-social and physical

health care needs and ensures through direct care provision or referral, consultation and co-ordination of care processes, that care is individualised and integrated in the context of whānau whaiora social and cultural context.

Alongside care planned in partnership with whānau whaiora, nurses hold delegated responsibility for enrolled nurses, community and peer support staff and supervision within the credentialled process for Practice Nurses within primary care. Nurses undertake the role of a Duly Authorised Officer and Registered Health Professional under Mental Health and Drug and Alcohol legislation. Within the Interdisciplinary Planning Process, nurses are lead facilitators of the Flexible Assertive Assessment Team (FACT) and unplanned care programmes. They also lead nurse led services within primary and community care settings as well as acute care responses across the continuum. Mental Health Nurses recognise the need for flexibility, adaptability, responsiveness, and sensitivity as they shape their practice to the changing needs of whānau whaiora and communities.

3.7 Social Work

Social Workers mahi in partnership with whānau whaiora using strengths based and non-judgemental interventions which are underpinned by research informed models of practice. They incorporate analyses of current and historical influences including ecological, social, political, economic, spiritual, and psychological factors. They work to empower whānau whaiora to achieve their goals and aspirations for well-being while building on their sense of belonging and connectedness with their whanau, community and wider society. They help whānau whaiora to access the resources they need to construct solutions in their lives. Social Workers are committed to creating mana-enhancing relationships which are congruent with our obligations under Te Tiriti o Waitangi. They strive to challenge injustice, oppression and inequity in all daily relationships as well as in organisational, community and societal structures.

3.8 Occupational Therapy

Occupational therapists /nga kaiwhakaora ngangahau skills involve using occupation to improve, maintain, and restore health and wellbeing by working in partnership with whānau whaiora to connect or reconnect them with the everyday tasks they need and want to do. It is about Whānau whaiora “doing what matters” and “purposeful doing”.

Occupation is defined as “…everything people do to occupy themselves, including looking after themselves, enjoying life, and contributing to the social and economic fabric of their communities”.

Occupational domains include self-care, productivity, leisure, and socialisation Occupational therapy interventions in Mental Health and Addictions can be broadly grouped into the **following themes**:

1. Interventions in employment or education: supported employment, supported education, other employment interventions.
2. Occupational therapy interventions involving psycho-education.
3. Occupational therapy interventions using creative occupation or activity.
4. Occupational therapy interventions addressing time use or occupational balance.
5. Occupational Therapy interventions in skills development (functional assessments), lifestyle modification and occupational engagement.
6. Occupational therapy interventions using group or whānau whaiora approaches.
7. Sensory interventions that support engagement in occupation.
8. Occupational therapy interventions using animals or animal assisted approaches.

3.9 AOD Clinicians

A competent addiction practitioner works effectively within the scope of their practice to support community wellbeing and reduce harm related to alcohol and other drugs. This is demonstrated by working in collaboration with whānau whaiora using evidence informed theory and knowledge of alcohol and other drug addiction and co-existing problems to assess, plan, provide and evaluate intervention tailored to the strengths and needs of whānau whaiora. The intervention may include working in collaboration with the withdrawal management team, residential treatment facilities, and other specialist Mental Health and Addiction Services as required.

A competent addiction practitioner understands the impact of stigma and discrimination and role model strategies to both reduce and challenge stigma and promote social inclusion across Mental Health Services and the wider community. An understanding of group process and dynamics in addiction practice is essential together with the capacity to lead in the facilitation and development of groups to support clients and whānau in their recovery. Can demonstrate an expert level of knowledge in a range of motivational strategies that support the client's treatment goal of either harm reduction or abstinence and is able to work collaboratively with whānau whaiora to achieve their goals.

3.10 Kairaranga

A Kairaranga (Primary whānau whaiora Care Co-ordinator) will follow the whānau whaiora from community to acute and back out to community to ensure consistency and that whānau whaiora will maintain a closer to home approach to their care. The whānau ora methodology will be a key focus to the coordination and treatment pathway in the wellbeing recovery plans supported by the Kaiaraara link and Whanau ora Kaitautoko roles.

3.11 Whānau Ora Kaitautoko

The Whānau Ora Kaitautoko role is a key support for whānau ora centred approach, promoting Māori responsive quality care with particular attention to supporting and facilitating seamless pathways. This role is the link with other established Kaiaraara whānau link roles in the community and DHB supporting senior clinicians and kaimahi with care planning and support to services.

3.12 Responsible Clinician

The Responsible clinician has an enhanced role in IDP reviews for whānau whaiora supported under a Compulsory Treatment Order of the Mental Health Act. For more information about this, please refer below to the Guidelines to the Mental Health compulsory assessment and treatment Act 1992 (2021 Ministry of Health).

https://www.tepou.co.nz/initiatives/guidelines-to-the-mental-health-compulsory-assessment-and-treatment-act-1992

3.13 Interdisciplinary Planning IDP partners

- Present to the IDP in the required timeframe as identified in this Policy.
- Use the IDP review content guide within this Policy as a framework for thinking.
- Follow the procedure and processes for IDP presentation.
- The IDP process is inclusive of key partners to support wellbeing recovery planning.
- IDP partners are responsible for delivery against agreed interventions and therapies as shared responsibility is fundamental to an interdisciplinary model.

- Whānau whaiora presence or voice is an integral part of the IDP process, the Care Co-ordinator function facilitates how this may best to occur, in person, representative, advocate or other medium and document how this has occurred.
- The central aim of the IDP is to bring together key people to ensure best therapeutic interventions and treatments for progress to wellbeing recovery to be achieved in partnership with whānau whaiora.

4. PREREQUISITES

Each service team establishes a culture of regular IDP procedure and meeting schedule that is inclusive of key interdisciplinary professionals, whānau whaiora. In the community localities the Care Co-ordinator is responsible for overseeing and recording attendance at scheduled meetings.

5. POLICY

Key registered and non-registered health professionals in collaborative partnership with whānau whaiora should be present at the scheduled IDP meetings (eg allied health, medical staff, nursing, and whānau whaiora. Whānau whaiora presence or voice is an integral aspect of collaborative planning).

Te Whare Tapa Wha as a wellbeing model will guide the IDP process.

Key health professional staff within Te Mātāpuna o te Ora, have a responsibility to attend scheduled Interdisciplinary planning and review meetings (community and acute care) related to a whānau whaiora in their care unless an emergency/crisis occurs.

5.1 Community Localities, Mental Health and Addiction Services

All clinical staff to ensure they present whānau whaiora to IDP reviews within the following timeframes:

- Initial assessments are presented through the IDP process at the earliest opportunity but not more than seven (7) working days by Care Co-ordinator outlining intervention plan and outcome pathway to wellbeing recovery.
- IDP reviews occur on average every three (3) months or earlier based on safety and need. Outcomes and goal attainment drive interdisciplinary discussion and proposed adaptions to intervention plans.
- The IDP and review process is mindful that safety is a variable feature of mental distress.
- IDP reviews document who is accountable for what action, intervention and therapy to ensure recovery pathways are supported and evaluated against action goals and expected progress toward Wellbeing Recovery.
- Any variation to the three monthly review must be clearly documented with clinical rationale, whānau whaiora inclusion and will include a review date for the next IDP.

5.2 Acute Care Inpatient Setting

- Care Co-ordinators should be involved as much as practical in all IDP even if whānau whaiora are inpatient at the time.
- IDP Reviews for inpatients/ whānau whaiora will occur weekly. Inpatient stays need to plan treatment and interventions as promptly as possible to begin transfer of care back to the community from the day of admission. IDP reviews must therefore be scheduled at time of admission for as soon as practical within each week.
- IDP Reviews are to be documented the same day the IDP occurs.

- Documented IDP reviews will be discussed with all whānau whaiora who have not participated in IDP. They will be able to document any changes to the plan that they require. Whānau whaiora voice must be present and documented in the IDP process to ensure intervention and wellbeing recovery planning is in line with whānau whaiora goals.
- IDP reviews will plan and document intervention, therapy, and transition plans to support seamless service delivery. These will be communicated to the community team / care co-ordinator if they have not been able to participate in the IDP.
- IDP reviews will be communicated to the whānau whaiora and significant others. Responsibility for this will be documented on the IDP form but would usually be the Care Co-ordinator.
- All community transitions from the Acute Care Centre must be able to evidence involvement of whānau whaiora in the transition planning. Where a face-to-face meeting about transition is impractical there should be all reasonable steps taken eg use of technology mediums, and documented to ensure whānau whaiora inclusion.

6. RECORDING IDP PROGRESS TO WELLBEING RECOVERY

- IDP reviews are to be documented on the day they occur.
- IDP reviews are recorded against the whānau whaiora NHI using IDP three monthly or IDP six monthly.
- The Care Co-ordinator presenting the whānau whaiora at IDP review records the 'IDP' against the whānau whaiora NHI and submits this data.
- Individual outcome data as agreed in the outcomes framework must be entered to evidence progress against outcomes.
- Medical, Nursing and Allied health accountability is evaluated against recovery and action goals of the Wellbeing Recovery Plan of care, intervention, treatment and therapy documented through the IDP process.
- The clinical rationale for exceptions to three monthly reviews are recorded.

7. IDP WELLBEING RECOVERY PLANNING AND DISPUTE RESOLUTION

If within the IDP meeting timeframe a consensus could not be reached, further discussions are to occur outside the IDP process. This follow up would be driven by the Care Co-ordinator and/or Lead Facilitator. Flowchart, Appendix 1.

If whānau whaiora are not satisfied with the Interdisciplinary Planning decision process they may be referred and supported to the MDHB complaints process.

8. IDP REVIEW SHOULD INCLUDE THE FOLLOWING CONTENT:

Reason for review	Care Co-ordinator to outline what they are seeking from the IDP review to support whānau whaiora wellbeing recovery.
Who they are presenting	Whānau whaiora details, circumstances relating to the referral, ie how, by who and when, cultural considerations, iwi, hapu, social situation, social support, agencies involved.
Brief background	Past mental health history and /or alcohol and other substance use and involvement with services. Te Whare Tapa Wha model may be used identifying strengths and relationships.
Presenting issues	Presenting health issues – physical health/metabolic screening/monitoring, mental health and/or alcohol & other drug use (duration, severity & impact) and any significant life events that are impacting on the individual currently. Changes within the last three (3) months. All inter-related aspects of wellbeing must be considered for whānau whaiora with multiple identified needs.
Legal Status	Confirm whānau whaiora current legal status identifying which Act the whānau whaiora is under eg Mental Health Act, SACAT, PPPR, IDCCR.
The IDP and review process is mindful that safety and risk is a variable feature of mental distress	Specific actual or potential safety concerns to self or others, either intentional or otherwise and broad contributing factors, eg depression, age, sex, loss, alcohol, relationships.
Clinical impression/formulation	Diagnostic or clinical impression or working diagnosis conceptualised as factors that are: • Predisposing • Precipitating • Perpetuating • Protective Whānau whaiora input and cultural considerations help inform this.

Health Outcome Measure, progress toward wellbeing recovery	Wellbeing score, ADOM, HoNOS, HoNOSCA, Hua Oranga or another outcome measure: • If new to service – what is the score. • If existing whānau whaiora – what change has there been since the last IDP?
Wellbeing Recovery Plan	If whānau whaiora is new to the service then what are the proposed next steps (what does the whānau whaiora want, and what does the presenting clinician think needs to happen) If current whānau whaiora with current intervention, treatment plan (what is working, what isn't, propose what needs to change, who needs to be involved).
Transition Plan – Relapse Plan	Prior to transition whānau whaiora need a wellness recovery plan (within WRP) identifying early warning indicators, relapse indicators and historical interventions that have been helpful.
Intensive/Complex Interdisciplinary Planning	This occurs when a whānau whaiora has multiple layers of need and is considered complex in nature for intervention, treatment/therapy. This may require extended IDP support and timeframes for whānau whaiora who require specific intervention and therapy. Some may not sit naturally within the F.A.C.T model and delivery team. This supports case by case continued support in short to medium care team.
Record of Presence	To be maintained with key actions and timeframes.
Use of agreed IDP template	Clearly documented.

9. PROGRESS TOWARD WELLBEING RECOVERY

Whānau whaiora progress toward wellbeing recovery is a primary focus of Te Mātāpuna o te Ora. For the duration of engagement throughout the Connected Care Network multiple assessment tools and measures will be used to understand the impact of interdisciplinary planning and evidence informed therapy interventions. The monitoring and reporting framework to support the understanding of progress toward wellbeing recovery is to be developed and agreed. This may include existing and new measures.

10. RELATED MDHB DOCUMENTS

MDHB-2031	Te Tiriti O Waitangi - policy
MDHB-5451	Mental Health IDP Review - Form Template
MDHB-7435	Te Mātāpuna o te Ora Mental Health and Addiction Connected Care Network
MDHB-255	Safety planning - Policy
MDHB-6853	Service User, Family Whānau Engagement - policy
MDHB-2767	Care Co-ordinator Roles and Responsibilities -Procedure-
MDHB-248	Te Mātāpuna o te Ora Wellbeing Recovery Planning -Policy-

Te Mātāpuna o te Ora Operational Manual

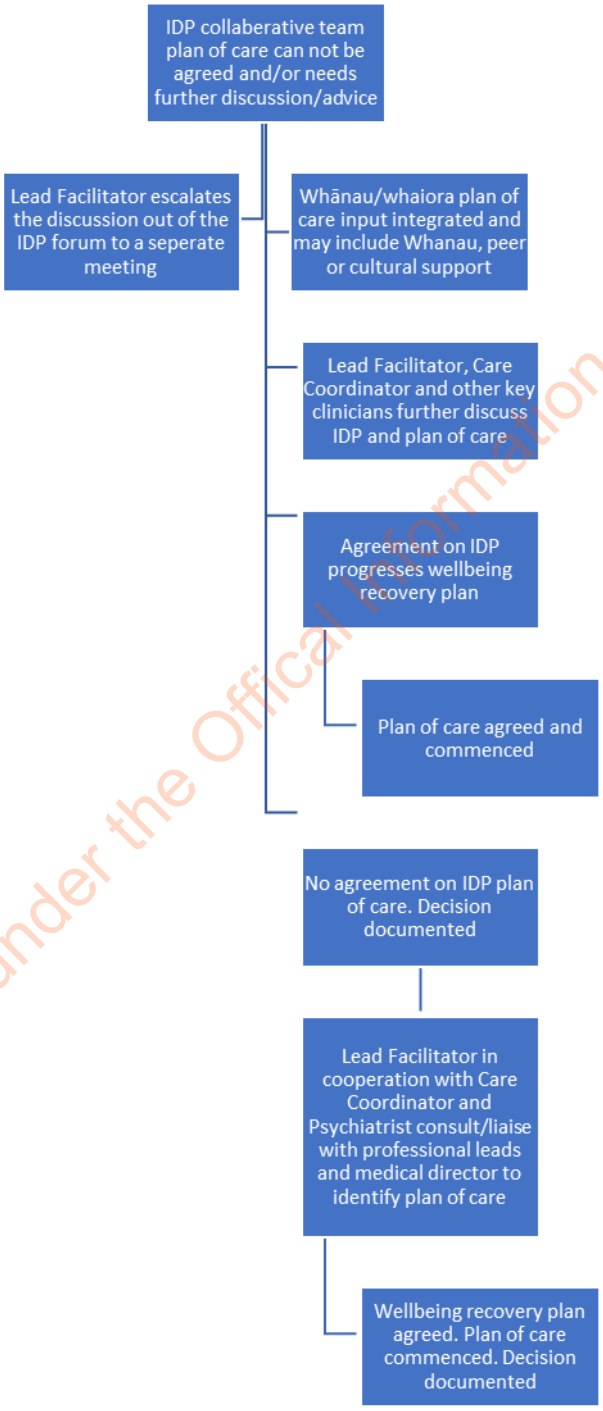
11. FURTHER INFORMATION / ASSISTANCE

Operational Leads
Locality / Service Managers
Lead Facilitators
Acute Care Charge Nurse
Medical Director
Associate Director of Nursing
Associate Director of Allied Health,
Clinical Governance Group

APPENDIX 1

Resolution Flowchart

The flow chart is a quick reference guide to support a process of enhanced professional discussion within the collaborative interdisciplinary team approach. Focusing on shared decision making using a recovery strengths-based focus on solutions and outcomes in partnership with whānau whaiora presentation and needs.



MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

POLICY

TE MĀTĀPUNA O TE ORA
SPECIALIST MENTAL HEALTH AND ADDICTION SERVICES
WELLBEING RECOVERY PLANNING

Applicable to: **All Staff Te Mātāpuna o te Ora.** **Te Uru Rauhī Mental Health and Addiction Services**	Issued by: **Mental Health and Addiction Services** Contact: **Operations Executive**

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As part of our commitment Te Uru Rauhī will ensure culturally responsive practices are interwoven across service and delivery design utilising whānau Māori, iwi and kaupapa Māori services are engaged to ensure the voice of Māori is captured and responded to using a whānau centred approach. Whānau-centred refers to the idea that service design and delivery must meet the needs of whānau first and foremost. Whānau-centred means delivering a service response that is informed and accountable to whānau aspirations. Whānau-centred ways of working are strengths based, grounded in aroha, and well resourced. Whānau-centred is a commitment to provide a multi-layered approach to whānau requiring support.

All staff are to always be familiar with MDHB Te Tiriti o Waitangi policy MDHB 2031 and work in a culturally aware manner. Improving health outcomes for Māori is a key obligation from an equity perspective. Locally Sir Mason Duries work is embraced to support wellbeing models of care. Te Whare Tapa Wha as a common practice model.

1. PURPOSE

To outline the requirement of Wellbeing Recovery Planning for all whānau whaiora accessing Te Mātāpuna o te Ora Mental Health and Addiction services.

The Wellbeing Recovery Plan (WRP) is the foundation of the interdisciplinary collaboration of all people in the whānau whaiora wellbeing recovery journey and clearly identifies evidence informed interventions, therapy, treatments, aspirations, and recovery goals.

2. SCOPE

All staff in Te Mātāpuna o te Ora, Te Uru Rauhī Specialist Mental Health and Addiction Services. Te Mātāpuna o te Ora is a philosophy and approach that facilitates a whole of service/system integrated and Connected Care Network. This supports transition seamlessly across teams to best support whānau whaiora wellbeing recovery goals and outcomes.

3. ROLES AND RESPONSIBILITIES

3.1 The role of the Interdisciplinary Team in Wellness Recovery Planning

Whānau whaiora access services within the Connected Care Network based on age other factors that identify the need for flexible, adaptive, and responsive service delivery.

The most appropriate service to meet whānau whaiora needs is to be determined clinically and culturally within the interdisciplinary planning process. The interdisciplinary process is inclusive of different professional disciplines contributing to the connected care in collaborative partnership with whānau whaiora.

The care team consists of the clinicians and support roles directly involved in service provision to whānau whaiora. They form the core Interdisciplinary Group that supports the development and review of the WRP to ensure strengths-based wellbeing recovery focus. Whānau whaiora goals, timelines and progress toward wellbeing recovery are clearly identified.

Recognition of the different professional bodies and the clinician's professional responsibilities is considered within wellness recovery planning. The RACI matrix is a tool that identifies roles and responsibilities within the Interdisciplinary team and helps formulate the varied level of engagement different professionals have. A description of this model as it applies to Te Mātāpuna o te Ora may be found in the Te Mātāpuna o te Ora Operational Manual.

3.2 The Care co-ordinator

Care Co-ordination is a process within Te Mātāpuna o te Ora. The Care co-ordinator function may be allocated to any role or discipline based within any team across the connected care network of Te Mātāpuna o te Ora. This may include Primary Care, iwi providers or NGO partners. The Care Co-ordinator is responsible for:

- Build trust and confidence as the main point of contact for whānau whaiora during their Wellbeing recovery journey.
- To ensure that whānau whaiora voice and participation is part of the Connected Care Network on their wellbeing recovery journey.
- Ensures that documents and records pertaining to whānau whaiora are maintained and reviewed within required timeframes.

Kairaranga:

A Kairaranga (primary whānau whaiora care co-ordinator) will follow whānau whaiora from the community to specialist services and back out to the community. Kairaranga aim to ensure consistency and that whānau whaiora will maintain a closer to home approach to their care. The whānau ora methodology will be a key focus to the coordination and treatment pathway in the wellbeing recovery plans supported by the Kaiaraara link and whānau ora Kaitautoko roles.

3.3 The Lead facilitator

Facilitates the connected care network model and service response ensuring timely assessment, evidence informed intervention and progress toward wellbeing recovery. Ongoing clinical review is applied to understand whānau whaiora experience, engagement and wellbeing recovery. The Lead Facilitator overseas service audits and applies whānau whaiora feedback to support service quality and improvement. They ensure the IDP and quality process guide service delivery and whānau whaiora goals toward wellbeing recovery.

The Interdisciplinary and review process will be facilitated by lead facilitators or delegates.

3.4 The Responsible clinician

The Responsible Clinician has an enhanced role in IDP reviews for whānau whaiora supported under a Compulsory Treatment Order of the Mental Health Act. For more information about this, please refer below to the Guidelines to the Mental Health Compulsory Assessment and Treatment Act 1992 (2021 Ministry of Health).

https://www.tepou.co.nz/initiatives/guidelines-to-the-mental-health-compulsory-assessment-and-treatment-act-1992

3.5 Other roles

Key responsibilities and accountabilities for each role in relation to wellbeing recovery planning can be found in the relevant job description and in the Te Mātāpuna o te Ora Operational manual.

4. POLICY

Wellbeing recovery plans must be used across the Connected Care Network and are inclusive of:

- strengths based approach that support autonomy and self determination
- Whānau whaiora as a central part of the collaborative partnership
- developed in partnership with Interdisciplinary Planning (IDP) and whānau whaiora
- developed with clinical and cultural safety and advocacy support as appropriate for the whānau whaiora
- consideration of Kaupapa Māori pathways to support wellbeing recovery planning
- clinically and culturally safe evidence informed practice delivery of planned interventions and therapies inclusive of safety planning
- Documented on the day developed and shared with agreed partners (connected care record)

Where wellbeing recovery plans can not be agreed as part of the Interdisciplinary process refer to the IDP resolution flowchart (MDHB 6431-Interdiciplinary Planning and Review -policy) to support decision making and agreement on WRP.
If whānau whaiora are not satisfied with the wellbeing recovery planning they may be referred and supported to the MDHB complaints process.

Please refer to the Te Mātāpuna o te Ora Operational manual for a detailed description of the WRP process.

5. DEFINITIONS

Refer to Glossary in the Te Mātāpuna o te Ora Operational manual.

6. REFERENCES

Transition Planning:
http://www.health.govt.nz/publication/transition-planning-guidelines-infant-child-and-adolescent-mental-health-alcohol-and-other-drugs

Guidelines to the Mental Health Act:
https://www.tepou.co.nz/initiatives/guidelines-to-the-mental-health-compulsory-assessment-and-treatment-act-1992

7. RELATED MDHB DOCUMENTS

Mental Health and Addiction Services

MDHB-2031	Te Tiriti o Waitangi policy
MDHB-7435	Te Mātāpuna o te Ora Mental Health and Addiction Connected Care Network policy
MDHB-255	Safety planning and risk Policy
MDHB-7173	Risk Assessment Review - Mental Health and Addiction Service -Form-
MDHB-6853	Service User, Family Whānau Engagement Policy
MDHB-2767	Care Coordinator Roles & Responsibilities Procedure
MDHB-6431	Interdisciplinary Team Planning and Review
	Te Mātāpuna o te Ora Operational Manual

MidCentral District Health Board

MDHB-2031	Treaty of Waitangi

8. KEYWORDS

Assessment, Wellbeing Recovery Plan, Lead Facilitator, Care co-ordinator, Te Mātāpuna o te Ora, Mental Health Service, Safety planning and Risk.