

# **Needs Assessment and Service Coordination Project Report**

**Midland Region  
Mental Health and Addiction  
Services  
December 2010  
(Draft)**

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## Executive Summary

This report describes the project that was commissioned to gather information about the current models of Needs Assessment and Service Coordination (NASC) being delivered for people that experience mental health and addiction problems; in the Midland region and in other DHBs in New Zealand.

Data collected from a Midland region stock take, and from interviews with key informants from NASC services in other regions was analysed. It was found that there was significant variation in the way NASC services were delivered nationwide including workforce invested, service model implemented and scope of services access managed.

Staff also faced challenges in NASC service delivery. Those challenges were explored and opportunities to collaboratively tackle the challenges were proposed. This included achieving some consistency in service, through implementing standards, guidelines, service specifications and workforce competencies.

The following recommendations have been made:

### **Service Model**

- DHBs understand and confirm the NASC model that they have chosen (combined or separate needs assessment and service coordination functions). This service model is strengthened to enhance service user responsiveness and improve the matching of needs and aspirations to services.
- DHBs examine the range of community based services available to service users region wide and confirm what may be accessed nationally, regionally, sub regionally and locally for their service users. This information is retained and updated regularly.

### **Scope**

- DHBs extend NASC responsibilities to incorporate access management to Community Support work and packages of care. This is a growing component of the service continuum.

## **Funding**

- DHBs recognise the value of NASC in the prioritisation of limited resource and therefore invest in NASC workforce to meet service requirements.
- NASC budget holding for aspects of service such as packages of care is further explored for implementation.

## **Systems and Processes**

- DHBs work collaboratively to achieve consistency in systems and processes within the region including adopting standards, guidelines, service specifications, data collection and assessment tools.
- Review processes are in place to ensure service users' needs (that may fluctuate over time) are addressed and resources fully utilised.

## **Workforce**

- DHBs confirm the preferred skill mix of their NASC teams and seek to develop NASC expertise using recruitment strategies, training programmes, a competency framework, and establishing a regular networking forum.

# 1. Introduction

The purpose of this project, as described in this report, was to gather information about the current models of Needs Assessment and Service Coordination (NASC) being delivered for people that experience mental health and addiction problems; in the Midland region and in other DHBs in New Zealand. This was to increase the level of knowledge and understanding of how NASC services are delivered. The project has been guided by the following documents:

- Ministry of Health: Te Tahuhu, Improving Mental Health 2005-2015, The Second NZ Mental Health and Addiction Plan, 2005.
- Ministry of Health: Te Puawaiwhero, The Second Maori Mental Health and Addiction National Strategic Framework 2008-2015
- Midland Region Mental Health and Addiction Needs Assessment Summary Report 2005.
- Midland Region Mental Health and Addictions Strategic Plan 2008-2015.
- Midland Region Mental Health Draft Workforce Development Plan 2008 – 2011
- Treaty of Waitangi
- Midland DHBs District Annual Plans (DAPs)
- Ministry of Health: (1994). Standards for Needs Assessments for People with Disabilities. Ministry of Health: Wellington.
- Ministry of Health: (1994). The New Zealand Framework for Service Delivery: Disability Support Services. Wellington
- Ministry of Health: (1995). Guidelines for Regional Health Authorities: Service Coordination for People with Disabilities. Wellington

In section two, the New Zealand mental health service context in which mental health NASC services were situated is described. The methodology applied to gather the NASC information is described in section three. Section

four details the current NASC delivery in the Midland region, based on information provided by DHB Planning and Funding Portfolio Managers. NASC service models in other DHBs and internationally are described in section six and seven.

A discussion including the level and type of service and possible options for future mental health NASC services are described in sections eight and nine.

## 2. Background

Mental health services in New Zealand over the past decades have been subjected to significant change. Services within DHB Provider Arms and those in the NGO sector are changing the way services are delivered from a more institutional or treatment based model to a more community based educational model<sup>1,2</sup>.

Needs Assessment and Service Coordination (NASC) services that sit within DHB or NGOs have also been required to adapt their practices to keep abreast with developments and better meet the needs of the service user<sup>3</sup>.

The strategic direction and a context for the delivery of NASC services can be found from a range of national documents, and some of these have already been mentioned in the introduction section:

- The Blueprint for Mental Health Services in New Zealand: How things need to be (Mental Health Commission, 1998).
- The New Zealand Health Strategy (Ministry of Health, 2000).
- The New Zealand Disability Strategy: Making a world of Difference (Ministry of Health, 2001).

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<sup>1</sup> Ministry of Health (2005) TeTāhuhu: Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan

<sup>2</sup> Siris, S & Bermanzohn, P (2003) Two models of psychiatric rehabilitation: a need for clarity and integration. Journal of Psychiatric Practice Vol. 9 No.2.

<sup>3</sup> Ministry of Health (2009) Needs assessment service coordination (NASC) service specification (published on Nationwide Services Framework Library).

- New Zealand Positive Ageing Strategy (Ministry of Social Policy, 2001).
- TeTāhuhu: Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan (Ministry of Health, 2005).
- Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015 (Minister of Health, 2006).
- Te Raukura: Mental Health and Alcohol and Other Drugs: Improving outcomes for children and youth (Ministry of Health, 2007).
- Te Puāwaiwhero: The Second Maori Mental Health and Addiction National Strategic Framework 2008-2015 (Ministry of Health, 2008).

These documents confirmed that there was a wealth of information about the strategic direction and the service delivery of mental health and addiction services. This project sought information specifically about needs assessment and service coordination.

### **3. Methodology**

The methodology and processes used for this NASC project were both qualitative and quantitative including:

- A telephone semi structured interview using a brief questionnaire was conducted with NASC personnel from the other three DHB regions: Northern, Central and Southern.
- A request for stock take data about NASC services from each Midland DHB was made. That data was analysed.
- Key informants were contacted at Midland Clinical Leaders Forum members' request.
- Additional information was received at by stakeholders at Midland stakeholder forums, and the National NASC seminar (2010).

### **4. Current service provision in the Midland region**

The Midland region covers a large area geographically and includes the Bay of Plenty DHB, Waikato DHB, Taranaki DHB, Lakes DHB and Tairāwhiti DHB.

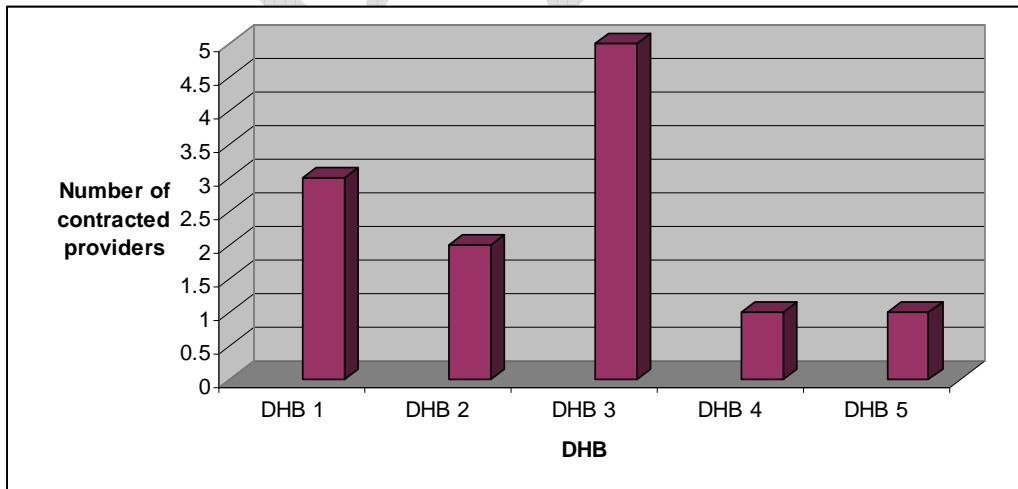
Bay of Plenty DHB serves a population of 200,000. Waikato DHB serves a population of 360,000 people. Taranaki DHB serves a population of 104,280 people. Lakes DHB serves a population of 102,000 people. Tairāwhiti DHB serves 44,499 people<sup>4</sup>.

DHB Planning and Funding Portfolio Managers provided the following information about their current mental health NASC services.

#### 4.1 Contracted Providers

The five DHBs in the Midland region all had a slightly different combination of contracted providers to deliver NASC services. Some had a mix of DHB and NGO contracted providers, others had DHB alone or NGO alone. The most number of NASC providers contracted by a DHB was five with sub contracting arrangements to other providers, and the least number was one. Figure one shows the number of contracted providers by DHB from one to five.

**Figure one: Number of contracted providers**

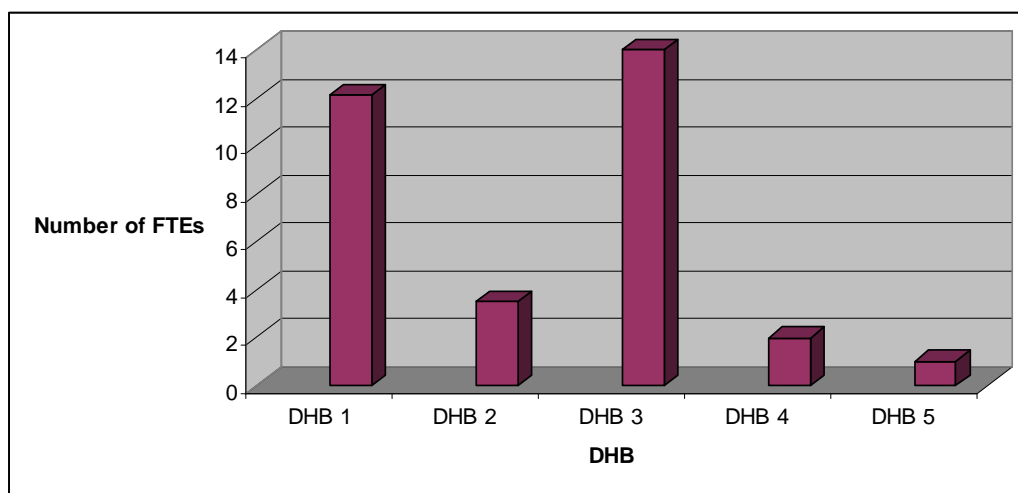


<sup>4</sup> New Zealand Census Data (2006)

## 4.2 Levels of Funding

All five DHBs had invested in NASC specific workforce. In addition, some DHBs had NASC specific tasks being undertaken by other staff within the mental health multi-disciplinary team. Figure two shows the level of investment made by DHBs in NASC specific funded FTEs.

**Figure two: Levels of Funding**



## 4.3 Service Model

All five DHBs delivered NASC services differently, delivering combined or separate functions by one or more providers.

DHB 1 with three contracted providers and 12.1 FTEs staffing used a needs assessment and brokerage model to assess and reassess service users need and match to an appropriately defined scope of services. They also negotiated shared care arrangements with DSL, ID and ACC. One of the provider contracts was under consideration as provision was not consistent with service specification.

DHB 2 with two contracted providers and 3.5 FTEs staffing, used a combined needs assessment and service coordination model. One contracted provider was a Kaupapa Maori NASC service. The role of needs assessor and service coordinator was supported in this Kaupapa Maori NASC pathway

by a Pou Tikanga (Maori Support Worker). This support was considered essential to the development of whanaungatanga links with NASC, the Tangata Whaiora and their Whanau. Te Whare Tapa Wha model was used.

DHB 3 with five Maori contracted providers, including one with subcontracting arrangements, 14 FTEs staffing, delivered services based on Te Whare Tapa Wha model. Additionally, DHB Provider Arm social workers conducted needs assessments of service users and made referrals to residential placements as part of their Community mental health team role. Home based support clients were usually organised via the case manager, however the case manager would sometimes ask the social worker to assist or provide advice. DHB Provider Arm Mental Health of Older People service dealt with two groups of service users. Those people with dementia with BPSD were referred and seen by an organisation called Supportnet. Those people with mental health illness only were assessed by the DHB social worker and referred for services.

DHB 4 with one contracted provider (DHB) and 2 FTEs was only recently reconfigured. This service received interim provision by an NGO provider but moved to a combined DHB Health of Older People and Mental Health NASC. This NASC is now a single point of entry to all community support services within the DHB district.

DHB 5 with one contracted provider (DHB) and 1 FTE had combined the functions of needs assessment and service coordination and brokerage. This NASC was a single point of entry to all mental health community support services within the DHB district.

#### ***4.4 Scope of the Service***

The scope of the service or extent of the services that they brokered access to, fitted one of the four categories below:

- a) Supported Accommodation (Residential rehabilitation)
- b) Supported Accommodation + Packages of Care
- c) Entry point to all community service provision for Mental Health

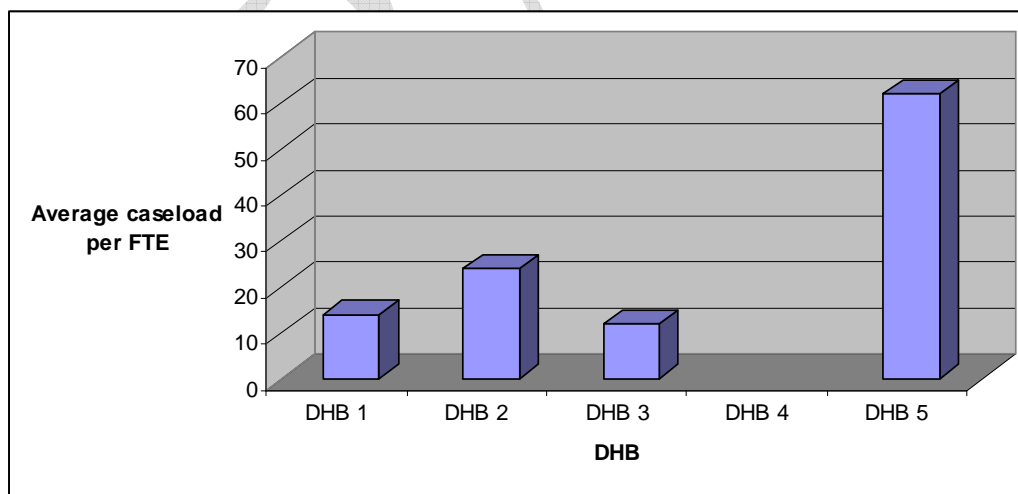
d). Entry point to all community service provision for Mental Health and Health of Older People.

There was some level of budget holding undertaken by NASC but this was very limited and more commonly related to packages of care funding. Advice was given by some DHB NASC to other departments regarding the management of carer respite.

#### **4.5 Numbers of service users and caseloads**

The reporting of the numbers of service users, referrals and caseloads varied across the region. Figure three shows the caseload per FTE though variation may be due to definition issues. It was not always clear whether the caseload recorded was the individual NASC caseload, numbers of assessments or numbers of service users registered. DHB 4 did not provide this information.

**Figure three: Average caseload per FTE**



An example of reporting with a greater level of detail was submitted by DHB 1. This is shown in table one and table two.

**Table one: Numbers of needs assessments completed by a NASC provider (1 July 2009 to 30 June 2010)**

<b>Month</b>	<b>Number of needs assessments completed</b> (this is the same as number of individual clients seen during the period)	<b>Average caseload</b> (Number of assessments divide by number staff 4.5)
July	80	17
August	67	14.8
September	71	15.7
October	56	12.4
November	71	15.7
December	49	10.8
January	41	9.11
February	66	14.6
March	63	14
April	61	13.5
May	58	12.8
June	54	12
<b>Total</b>	<b>737</b>	162.41 /12 = average caseload of <b>14</b> clients per month per FTE

This table shows the number of staff and the numbers of needs assessments completed each month. The average number of needs assessment completed by each FTE of NASC worker was 14 per month. Needs assessments appear to peak in the winter but reduced mid summer (December and January). These results may be consistent with other DHBs.

**Table two: Current NASC workload for a contracted provider**

Current residential review numbers	There are currently 197 funded people in residential services
Reviews due in the current quarter	There are currently <b>95</b> SNA reviews due this quarter. Some have been carried over from last quarter but have not occurred for a range of reasons usually due to periods of unwellness. Service reviews (or other types of case reviews) have occurred instead in some cases.
Caseload per FTE	Each full time clinician is responsible for completing assessments for around <b>50 people</b> on a 6 monthly basis. The number of assessments this equates to varies as sometimes people leave before their 6 monthly review is due

Numbers of first assessments	<b>46</b> first SNAs were completed for the period from 1/1/10 to 30/6/2010. (Estimated annual total would be 90 to 100)
Numbers entering and leaving residential services	This varies from month to month. For the month of September 2010 the total entering is five. ( representing 4 providers) The number of people exiting services for the same time is 5 (representing 5 providers). 13 people left for the quarter ending 30/09/10.
Numbers transitioning to different services	RCS is actively working on transition plans for 8 people to move to a different levels of support.
Waiting list	<b>14</b> people are on the waiting list but not all are ready to enter services (e.g. one person is in prison, others are in hospital and are not ready for discharge. Some people are already receiving a service but have requested a transfer to another provider/location
Joint care clients	Approximately 6 new clients annually requiring joint care funding with other agencies (this is very time intensive work to organise and review) e.g. ACC, DSL etc
POC	Estimated 61 packages of care delivered in this quarter (1/07/10 to 30/09/10). Some may continue into next quarter. This does not include services that were delivered in last financial year but invoiced during the current quarter.

Table two describes in more detail the workload of NASC. It may be useful for other DHBs to look at their NASC workload in this way.

Referrals received by NASC providers across the Midland region appeared to be manageable with small or no waiting lists. But bottlenecks were described particularly for people accessing higher levels of care in supported accommodation.

#### **4.6 Contract Audit Findings**

NASC services were audited in the Midland region depending on whether they were an NGO or DHB provider. The NGO providers in the region had received a contract audit recently or were expecting this to occur. Audit findings were not significant in terms of the corrective actions required; however some providers had been delivering low volumes. One DHB as

already mentioned found the provider was not providing a NASC service as per the contract and this was being looked at.

#### **4.7 Contract Monitoring**

NASC NGO services submitted quarterly reports to Sector Services, at the Ministry of Health, using the performance monitoring report template. DHB Provider Arms NASC personnel contributed to Community Mental Health team reporting performance monitoring and PRIMHD using local internal reporting including financial statements.

#### **4.8 Strengths of the NASC service**

Midland DHBs were asked to identify the strengths of their NASC services. Their responses have been themed under six headings:

- **Promoted collaboration and strong working relationships**

Several DHBs described the good collaboration and strong working relationships that had been achieved between the NASC providers (NGO and DHB) regarding access and assessment of people for residential services (supported accommodation).

- **Fostered a regular review process for service users in residential (supported accommodation)**

NASC services for most DHBs had generated regular review processes and for some DHBs shared recovery plans, resulting in more efficient use of residential services (supported accommodation). Reviews ensured the correct level of care as needed was being provided to a service user and the overall resources used wisely and appropriately. It was suggested that utilising the occupancy of residential accommodation to capacity was more likely to occur when regular review processes were in place.

- **Enabled greater joint working using packages of care**

The access to packages of care by NASC services had allowed for some DHBs, stronger partnership arrangements with other providers in joint care issues. An example of this was when the service user had a complex set of needs that were not easily met by a current service and they had required funding from more than one funding stream such as ACC or Disability Services. Package of care funding was used in negotiation with other funders.

- **Created a single point of contact**

NASC had created a single point of contact in some DHBs for both service users and providers. This was considered useful.

- **Provided a positive experience for Service Users and their families**

Feedback received by some NASC services from service users and their families, was that the assessment and coordination processes were positive experiences. There had been a strong recovery focus and strengths- based approach.

- **Operated as part of the wider multi-disciplinary team**

Contribution to the service continuum was recognised when NASC services were able to operate as part of the wider multi-disciplinary team, working with clinicians, linked to the funding and planning division, able to provide input to other parts of the continuum and activities such as service projects. This was considered useful.

## **4.9 Challenges**

DHBs were asked about challenges in the provision of NASC services. Their responses were themed under a number of headings below. DHBs felt challenged:

- **To effectively manage other community support services within the continuum**

With significant provision of community support, and evidence to suggest future increases in volumes, there was concern that there was no formal assessment process or re-assessment process for this group of service users. One DHB indicated that over 200 service users accessed community support in their district. This was considered to be an area of opportunity for NASC providers to assess need and allocate resource, to achieve greater efficiencies and maximise services more appropriately.

- **To ensure review processes occurred and service users were facilitated to increase or decrease supports safely according to assessed need**

Although contractually there was a requirement to conduct regular review processes, it would appear that these were not always undertaken when due. This impacted the whole system and created system bottlenecks, delaying service users with greater needs accessing services.

- **To embed changes to service structures and processes without negatively impacting service delivered**

One DHB had implemented a significant change process affecting service providers. This was taking time to embed and as such was challenging service operations.

- **To meet the geographical challenges in providing the correct level of care and yet working with the compounding travelling distances and related issues**

It would appear that the tensions between accessing a local service yet the service being of the required level of care and a suitable match were affecting DHBs.

- **To support new ways of funding such as packages of care but without driving up expenditure on other service components**

While packages of care and their associated funding were introduced to provide services for those for whom the current range of services did not accommodate, one DHB had concerns that there was the potential for packages of care to drive up the cost of supported accommodation.

- **To benchmark NASC services with some success, given the DHB variations**

Some DHBs said that they could not benchmark with other NASC services due to variations in service delivery yet it was something that they wanted to do and thought would be helpful.

- **To communicate effectively with other parts of the system to ensure better outcomes for the service user**

Some DHBs suggested it was hard to know what was happening in the NGO services, that roles were not always clear, and that processes within the system were not always consistent (the discharge process was not always inclusive and timely).

Considering these challenges DHBs in the Midland region had considered changes.

## **5. Proposed Changes**

Some Midland DHBs had suggested that they would be considering possible change to their NASC service delivery after this NASC review project, and some DHBs had said that they had already started making changes. Other DHBs indicated that they were looking at aspects of their service to improve.

One DHB had merged their mental health NASC with their older people NASC. Another DHB had reviewed aspects of service that they thought could be improved. Consistent with a major reconfiguration of community provision, one DHB had reconfigured their NASC to support this.

These sections four and five have looked at the current mental health NASC service provision in the Midland region. The next section looks at NASC service provision in other regions nationwide.

## **6. NASC service provision in New Zealand**

NASC service provision has been part of the mental health service continuum and associated processes for sometime, and has been considered necessary in order for the appropriate allocation of resources to be matched with assessed need.

In 2004, mental health NASC services across the country were contacted and asked about their approach to delivering the NASC service<sup>5</sup>. All DHBs responded, indicating that they had a service coordination mechanism in place but that they operated using varied models.

### **6.1 Service Models in 2004**

The two most common models were:

- A separate team providing a combined needs assessment and service coordination;
- Needs assessment by clinical or support staff (social workers or key workers) and Service Coordination by designated service coordinators.

There was also a mix of NASC providers used: Sixteen DHB providers, four DHB contracted NGO providers and two DHB contracted Kaupapa Maori providers. Five DHBs engaged more than one provider to deliver the service.

### **6.2 Scope in 2004**

Most NASC providers in 2004, coordinated a range of service types. Some providers coordinated or access managed three to four service types and other NASC providers coordinated or access managed as many as eight service types. The most common service types coordinated were:

- Home based support

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<sup>5</sup> Sorensen (2004) NASC survey, Unpublished Data

- Carer support
- Respite
- Community support
- Residential services.

### 6.3 NASC in 2007

In 2007, the Ministry of Health commenced a revision of the mental health and addiction service specifications, including a revision of the NASC service specification. At that time a stock take of the service specifications and purchase unit codes, showed that twenty one service lines had been purchased against the two NASC purchase unit codes.<sup>6</sup>

**Table three: Contracted Mental Health NASC Services**

	All reported use – NGO & Provider Arm	Number of Service Lines Reported
MHCS06A1: Needs Assessment & Service Co-ordination	9	20
MHCS08B1: Needs Assessment & Service Co-ordination – Child & Youth	1	1

This may not reflect accurately NASC service provision at that time, as it would appear that some NASC services were provided as part of the Community Mental Health team. It was also likely that Kaupapa Maori NASC providers were contracted using Kaupapa Maori purchase unit codes.

During the NASC service specification revision process, members of the Adult Mental Health service specification technical group indicated that there was variation in the way Mental Health NASC services were being delivered nationally but agreed on three key core functions of NASC. Those functions were: needs assessment, service planning and coordination. The functions as detailed in the service specification were as follows:

<sup>6</sup> Ministry of Health (2007) Purchase Unit Code Stocktake, Nationwide Mental Health Service Framework, Unpublished

### **Needs Assessment:**

The assessment process meets the requirement of the Standards for Needs Assessment and Service Co-ordination (1994) and utilises a recognised best practice assessment tool. The assessment process includes:

- identification and prioritisation of the service user's needs, both support and developmental needs, within the context of their
- attention to any immediate needs that may interfere with the family and whānau
- independent advocacy, where required person's ability to participate in a support needs assessment
- attention to cultural needs
- attention to the service user's educational requirements and or employment concerns within the family and whānau context
- attention to the service user's housing, social, recreational and financial concerns within the family and whānau context
- further specialist assessments as determined by the service user.

Needs assessments are then repeated and updated at not greater than six monthly intervals.

Family and whānau are engaged (if appropriate) in the assessment process. Where a service user is Māori, assessment will include a cultural needs assessment with their whānau present (in accordance with principles of informed consent) in the assessment process. Providers will ensure that the holistic view of health, as defined by Māori, is included in service provision for Māori.

### **Service Planning:**

This includes:

- access to an up-to-date directory on mental health/community services
- identification of current services involved in meeting aspects of the needs and remaining unmet needs

- identification and documentation of actions that are necessary to address those unmet needs and to achieve agreed goals
- when needs cannot be met from publicly funded services, referrals will be made to a range of community-based services as appropriate in accordance with the assessment.

**Co-ordination:**

This includes:

- facilitation of access to community mental health and disability support services that will enable people with mental illnesses to lead their lives as independently and productively as possible
- development of practical service and support options to address identified needs utilising public, private and voluntary services
- prioritisation of the needs of the service user and management of the demand for available services by determining relative priority between those accessing services
- development of a service or 'lifestyle' plan
- the match of available resource with needs, ensuring resources are used efficiently
- management of an allocation for carer relief or home support
- access management to support services, including residential services.

Needs assessment/service co-ordination services may provide the above services to people with addiction, in addition to those people with severe mental health problems, according to local requirements/agreements between funders and service providers.<sup>7</sup>

**6.4 NASC in 2010**

DHBs throughout the country continued to provide Mental Health NASC services but investigation for this project in 2010 using key informant interviews, confirmed that similar to the 2004 findings there was considerable

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<sup>7</sup> Ministry of Health (2009) Service Specification on the Nationwide Services Framework

variation in NASC service delivery. The variation included the numbers of contracted providers, the scope, and the type of service model used.

### **6.5 Numbers of contracted providers in 2010**

Some DHBs (Northern region) had a single provider for mental health NASC and that was a team within the DHB Provider Arm. They were known as the Local Coordination Service (LCS). Other DHBs had Kaupapa Maori designated FTE NASC providers in addition to DHB Provider Arm (Southern DHB). Canterbury, South Canterbury and Southern DHBs also had more than one contracted provider and these providers were both DHB Provider Arm and NGO.

Key informant stated:

*There are three contracts held to deliver mental health NASC services  
Being part of the DHB has its advantages- the client process is followed which  
involves the client getting a copy of their report to read and amend before it  
goes out to case managers*

*Able to use SAP- the computer system used by the DHBs with the client's  
signed consent. Able to access the notes to view historical knowledge*

### **6.6 Service Models in 2010**

The most common NASC service models delivered in New Zealand according to key informants were a combined needs assessment and service coordination function undertaken by the same person, or a model where these two functions were conducted separately by people within an organisation or two different organisations.

Combined Needs Assessment and Service Coordination service model was in place at Northland, Canterbury, South Canterbury, Capital Coast and Waitemata DHBs. The NASC staff member received a referral, and based on the information received completed a needs assessment and brokered access to services that were required.

Key informant stated:

*The needs assessors and service coordinators have been combined to provide a combined role. This has improved the timeliness in the service Clients only see one person- which they prefer.*

Local Service Coordination only was conducted by NASC or Local Coordination Service (LCS) staff in place at Auckland DHB, Counties Manukau DHB, and Whanganui DHB. Clinicians within the Community Mental Health team undertook the needs assessment before referring to LCS staff for appropriate matching with the required services.

The two functions of needs assessment and service coordination were contracted out, often to separate organisations in the case of Disability Services in the National Health Board.

### **6.6 Scope in 2010**

There was increased variation in the scope of services access managed by mental health NASC services in New Zealand. Some NASC managed access to a full range services while others were limited to supported accommodation. Those services included:

- a) Supported Accommodation (Residential rehabilitation)
- b) Supported Accommodation + Packages of Care
- c) Supported Accommodation + Community Support
- c) Entry point to all community service provision for Mental Health
- d). Entry point to all community service provision for Mental Health and Health of Older People.

Key Informants stated:

*The combined roles respond to need with access to options from all the funded services including- CSW and Respite. Also add in access to voluntary options. No packages of care in this area yet.*

*For specific mental health supports (Supported Accommodation- Level 3&4, Packages); Mental Health clinician assesses and refers to local service coordinator who arranges placement.*

## **6.7 Funding in 2010**

Using Packages of Care as a funding approach was more common in the Northern, Midland and Central regions, and much less common in the Southern region.

Individualised Funding - was a mechanism to fund service users of Disability Services directly for accessing home and community support services. The Individualised Funding Scheme (IF) implemented in Disability Services in New Zealand had been expanded and the benefits of this scheme included the ability for greater ownership of the process by the service user, in designing and managing their own supports, and choosing their preferred support providers.

Despite each DHB nationwide having determined a preferred way of working for NASC services in their districts, key informants identified strengths, challenges and opportunities in NASC service delivery. They confirmed that many of the strengths, challenges and opportunities identified by Midland DHBs were familiar to them. The tensions of a constrained resource and increasing pressure on accessing higher levels of care were common.

Key informants stated their challenges as:

*Over the past five years there has been stricter access criteria applied due to financial pressures.*

*keeping up with changes in NGOs*

*Keeping up with rules and expectations of Ministry of Health*

*Maintaining up to date knowledge – being in the know*

*Individuals have different interpretations of what the role and function of NASC is- this is then reflected in their different actions*

*Challenges can sometimes be managing the personalities and relationships to progress the NASC referral.*

*Also, ensuring that referrals to the external NASC agencies contain all the necessary detail and documented evidence, to be accepted.*

In addition, they reported that the strength of NASC was being able to provide holistic needs assessment for the service user and their family, when often the focus of other assessments had been on the medical or psychiatric needs of the individual.

Key informants discussed the changes in the mental health sector with a trend towards more individualised person centred approaches to care. Some more severely affected service users previously thought limited to supported accommodation options only, were now managing well with community support in more independent housing arrangements. Community support hours were becoming more common but mental health NASC staff seldom had the opportunity to access manage this. In areas where they did (Southern DHB) there were opportunities to be more flexible in matching needs with support and the ability to increase and decrease that support as the level of need changed. In other DHBs this flexibility was managed by the NGO provider as part of a Packages of Care arrangement or by the Local Coordination Service in some cases (Waitemata DHB).

A DHB NASC service, based on their feedback, was continuing to revisit service delivery approaches to be more individualised and match needs with appropriate support. They had noticed increasing complexity in service users and this was challenging tradition service provision such as supported accommodation.

Key informant stated:

*There are difficulties with people who have more than one diagnosis or dual diagnosis (intellectual disability), determining responsibility and options.*

Most NASC stated that they were keeping up with the workload.

Key informant stated:

*Able to see clients within a day*

*Waiting list for a needs assessment (3-4 weeks)*

*Keen to keep on top of the waiting lists.*

## **7. Australian model**

More development in funding models for people with disabilities had been occurring internationally. In Western Australia, a project was undertaken that looked at planning for the needs of people with disabilities. They found that when there was excellence in individualised planning there was a satisfying outcome. However, achieving that excellence was challenging.<sup>8</sup>

This framework in figure three, was adapted from that used in a review of best practice in individual needs planning. Planning processes needed to include the key stakeholders such as the paid providers and those with the disability with needs to be met. Planning processes also were required to connect with all the outside resources including paid and unpaid resources. Authors such as Kendrick and O'Brien have contributed much to the discussion and debate.<sup>9</sup>

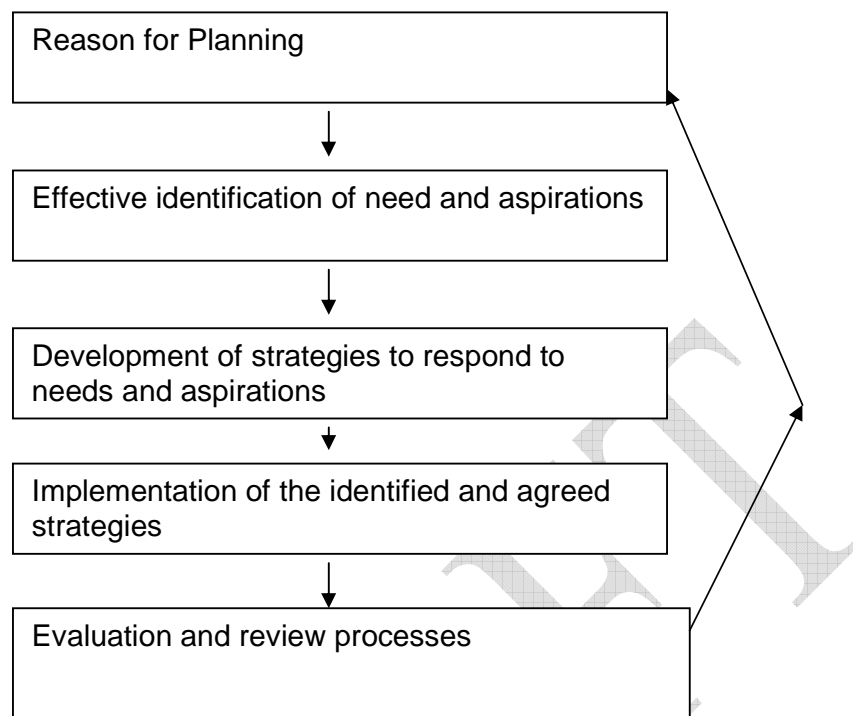
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<sup>8</sup> Parsons,L; Cocks, E; Williamson, M (2009) A review of Best Practice in Individual Needs Planning

<sup>9</sup> O'Brien, J (1993) *Supported Living: What's the difference?* Lithonia, GA: Responsive Systems Associates.

Kendrick,M (2002a) Values, authenticity and integrity. *Values: Cost or investment.* Wellington, New Zealand.

**Figure three: A needs planning framework**



The model suggests that the planning process is focused on need and the aspirations of the individual, and seeks an outcome which is then evaluated and reviewed. Planning is cyclic and considered an important feature in an effective NASC.

## **8. Features of an effective NASC**

Key informants suggested that for service users and their families and whanau, there was an expectation that from the needs assessment and planning processes, they would be fully informed of a comprehensive range of support options that matched their assessed needs, aspirations, preferences and lifestyle. Those options would be accessible and as close to their community of choice. Options would also be personalised, flexible, dependable and responsive.

Key informants also suggested that many providers had expectations of the NASC process; that it would be integrated with other service

components in the service user pathway and operated in a smooth and planned way.

In order for all stakeholder expectations to be met including provider, service user and family and whanau, key informants suggested that NASC services needed to have:

- **Systems** that reported both against the individual and the services, across the district and region, to support operational management, and strategic planning.
- **Protocols and Processes** that were clear and understood, accepted and used consistently by NASC, and with boundaries, yet able to be innovative and flexible. Standards for Needs Assessment and Service Co-ordination were useful<sup>10</sup>.
- **Relationships** that were ongoing and formal with the relevant providers strengthened by operating policies and protocols.
- **Workforce** made up of clinical staff with appropriate sector experience and training in NASC service delivery. Strong facilitative skills were considered necessary for NASC staff to bring providers together to develop and implement an appropriate care package. Effective presentation skills were also needed to be able explain and promote the NASC role to the community including the client (and family/Whānau).
- **Management and administrative support** strengthening both NASC capability and capacity.

This NASC project looked at the current NASC service delivery in the Midland region and heard from key informants from other DHBs in New Zealand about how their NASC operates. What this means to the Midland region and the potential opportunities for NASC service improvement are discussed in the next section.

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<sup>10</sup> Ministry of Health (1994) Standards of Needs Assessment and Service Coordination.

## **9. Discussion**

This discussion focuses on the issues that have been raised about NASC service delivery and suggests potential opportunities for improvement in service model, scope and funding based on key informant information and the literature. It also seeks to address the challenges affecting NASC services as raised by Midland DHBs in their stock take.

### **9.1 Service models**

In the Midland region, and nationwide, the service models of NASC varied. It had been suggested that the different service models each had their own advantages and disadvantages, yet the functions of needs assessment and service coordination maybe the same.

The combined needs assessment and service coordination model is thought to provide a comprehensive approach with reduced duplication of information. The needs assessor having assessed the needs then matches them with a directory of services and refers and links the individual to those services which are selected. It is suggested that the service user only needs to deal with one person using this combined model and the NASC pathway is more timely.

Where the needs assessment and service coordination functions are separate, it has been suggested that the advantages are a more focused needs assessment often undertaken by a clinician or a trained needs assessor, and then a greater scope of services are offered by a service coordination service. The disadvantages of this model have been suggested as having created extra processes requiring the needs assessor to hand over the information to the service coordinator. There is the potential for information to be lost. However some services have suggested that this is an efficient approach directing the appropriate skills to the parts of the NASC pathway.

In some DHBs clinicians conduct the needs assessment. While this provides detail about the needs of the individual from the clinical perspective,

it has been suggested that other perspectives need to be added to ensure a holistic needs assessment is undertaken. Other DHBs have remedied this by asking clinicians to commence the needs assessment with the clinician's perspective, and then adding the perspectives of the other members of the multi-disciplinary team until it is completed.

Kaupapa Maori models were offered in a number of DHBs in the Midland region and nationwide. Feedback from service users was that they valued the cultural assessment which was part of an overall assessment. However it appeared that some Kaupapa Maori NASC providers were more limited in the services that they could offer, rather than the full range.

It would seem based on the information from NASC services that regardless of the particular model chosen, what is important is a person centred holistic and comprehensive needs assessment process that engages the service user and their family. The purpose of NASC (according to the national service specification) is to facilitate access to services based on need. To ensure fairness in facilitating access, a recognised best practice assessment tool should be used. Service users, regardless of the NASC provider (Kaupapa Maori, NGO or DHB) should all be able to access a range of prioritised services if their needs indicate. The service options may be local, sub regional, regional or national.

## **9.2 Scope**

Midland region NASC providers managed access to a variety of services. This also applied to NASC providers nationwide. Where there was greater scope, it would seem that a greater pool of community resources were consistently managed and allocated, based on a consistent criteria. Historically, the focus of NASC had been supported accommodation as this had been a significant component of community support. However with increasing volumes of community support hours and packages of care and financial investment in these levels of care, for service users with severe and enduring mental illness, it would be worth considering a consistent assessment of service users to confirm appropriateness of access and ensure prioritisation of the resource. There have also been concerns that packages of

care could be a mechanism that could drive up the cost of supported accommodation. When allocation of this resource is managed as part of the service continuum, this concern would be more transparent and action could be taken.

With an increase in shared care, and integrated primary and secondary care models, in some DHBs primary care were referring service users for mental health community support. Where this was occurring community support was managed through a NASC process.

Access management for NASC should be extended to include community support and packages of care which now form a significant component of mental health community based care and support in most DHBs.

### **9.3 Funding**

Midland DHBs allocated different levels of resource to the NASC function. This was comparable with the allocation nationwide. It would seem that some work has been done to understand the complexities of caseloads for NASC workers. One DHB had considered the tasks and determined an average caseload but this information was not available for all DHBs. There needs to be an indication of expectations regarding needs assessments and frequency of reviews, for providers. The national service specification states “*Needs assessments are then repeated and updated at not greater than six monthly intervals*” For this review process to be maintained it means commitment to resource.

In some DHBs NASC manage a budget. This has been effective in terms of allocating resource more flexibility by those who are in the frontline and familiar with the operating aspects of the service. With increased emphasis on community support hours and packages of care, budget holding would be a reasonable expectation and has the potential to better manage costs.

## **9.4 Geographical challenges**

Midland DHBs described the tensions in achieving the right fit service for a service user's need that was locally accessible. The preferred service may well have been located in another district but to access it would have been challenging with an out of area transfer and other processes requiring negotiation.

Other DHBs had similar challenges with some previously regional supported accommodation services being devolved to be local and therefore reducing the wider pool for services and reducing choice for some service users<sup>11</sup>.

For more specific types of needs it seems unlikely that specific services would be established locally in each DHB. Therefore it would benefit DHBs to collaborate to provide regional or sub regional services that are designed for specific types of need, including lower volume and high costs services, for example mental health problems with intellectual disability, perinatal mental health, and youth forensics.

## **9.5 Monitoring and benchmarking for better outcomes**

Midland DHBs Mental health planning and funding portfolio managers reported on their understanding of NASC services in their districts. There was limited information reported by most DHBs on the inputs, outputs or outcomes of the DHB NASC services. However there is an imperative that DHBs are more aware of what is being achieved and how NASC can achieve better outcomes.

Some suggested measures from other DHBs include:

- Percentage of individual packages and as a proportion of total available community places
- The number of placements that were changed (unplanned) within three months of commencement.
- Referral source including from inpatient services.

<sup>11</sup> Northern region DHBs

- The number of reassessments and as a proportion of total assessments
- The number of bed days used once medically cleared for discharge and waiting for an appropriate discharge option
- Service User satisfaction survey

Performance indicators are included in the Standards for Needs Assessment for People with Disabilities.<sup>12</sup>

## **9.6 NASC systems and processes**

Midland DHBs in their stock take information suggested that there were variations in their systems and processes. These variations made it difficult for service users to access similar levels of service if they moved districts within the Midland region. Other DHBs nationwide also had variations and had sought some alignment within their regions. It has been suggested that adopting the Ministry of Health Standards (1994), the specific guidelines and the national service specification for NASC would assist with improving consistency thereby reducing variation. Considering shared assessment tools, electronic data collection and prioritisation criteria within the region would also be useful.

Central region NASC personnel met regularly to discuss systems, processes and their NASC issues. They suggested that this created positive networking for them as individuals and collectively, with new opportunities to problem solve and seek possible solutions beyond their own districts.

Formalising NASC networking in the Midland region in look at systems and process alignment may be helpful.

## **9.7 NASC workforce**

The Midland region did not specifically report for this NASC project on the qualifications of their NASC though some stated that having a registered nurse in the role had made a difference in terms of credibility with other health professionals. Kaupapa Maori services referred to the community support worker as:

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<sup>12</sup> Ministry of Health (1994) Standards of Needs Assessment for People with Disabilities.

*the employment of a Maori Support Worker (Pou Tikanga), has been essential to the development of whanaungatanga links between NASC, the Tangata Whaiora and their Whanau. The Pou Tikanga provides supports during the assessment process as well as provide practical supports to Tangata Whaiora or whanau as required. Engagement all based on Tikanga.*

Nationwide it seemed that the NASC workforce was usually made up of qualified health professionals from backgrounds such as nursing, or social work with the support of other team members such as cultural workers. The national service specification states as a key input:

“The Service is provided by a multi-disciplinary team, including people with qualifications in assessing, planning and co-ordination, Service users, people with experience of disability, cultural workers and health professionals”<sup>13</sup>.

Key informants suggested that in brokering access to services NASC staff must be proficient at developing and maintaining strong sector relationships. At times they may be required to advocate on behalf of the service user or negotiate with other providers or agency representatives in shared arrangements.

Competencies have been developed for NASC staff which cover three levels, from beginning to advanced. Specific training with recognised qualifications in NASC has been developed at certificate and diploma levels.

There are opportunities and support therefore to ensure the NASC workforce are recruited and trained to meet the current and future needs of NASC services.

Although there are challenges in delivering NASC services, there are opportunities to tackle those challenges and deliver a service that enhances the service continuum and service user outcomes.

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<sup>13</sup> Ministry of Health (2009) Needs Assessment and Service Coordination Tier Level Three Service Specification. Nationwide Services Framework

## **10. Conclusion**

This project has looked at mental health NASC services in the Midland region and nationwide. It has confirmed that there is a clear purpose for the NASC function within the mental health service continuum, and that it can improve utilisation of limited community based resource through appropriate prioritisation.

There was considerable variation in service delivery found on analysis of stock take data, and while this may not directly affect service outcome, service users found accessing similar services difficult when moving across the region. It was also likely that some variation did affect efficiency and effectiveness.

This project found potential opportunities for service improvement commencing with a greater understanding of the benefits of a NASC service within the service continuum and how NASC can be developed to enhance service user outcomes. Implementing the following recommendations will achieve this.

## **11. Recommendations**

### **Service Model**

11.1 DHBs understand and confirm the NASC model that they have chosen (combined or separate needs assessment and service coordination functions). This service model is strengthened to enhance service user responsiveness and improve matching of needs and aspirations to services.

11.2 DHBs examine the range of community based services available to service users region wide and confirm what may be accessed nationally, regionally, sub regionally and locally for their service users.

### **Scope**

11.3 DHBs extend NASC responsibilities to incorporate access management to Community Support work and packages of care. This is a growing component of the service continuum.

## **Funding**

11.4 DHBs recognise the value of NASC in prioritisation of limited resource and therefore invest in NASC workforce to meet service requirements. NASC budget holding for aspects of service such as packages of care is further explored for implementation.

## **Systems and Processes**

11.5 DHBs work collaboratively to achieve consistency in systems and processes within the region including adopting standards, guidelines, service specifications, data collection and assessment tools.

11.6 Review processes are in place to ensure service users needs that may fluctuate over time are addressed.

## **Workforce**

11.7 DHBs confirm the preferred skill mix of their NASC teams and seek to develop NASC expertise using recruitment strategies, training programmes a competency framework and establishing a regular networking forum.

## 12. References

Kendrick, M (2002a) Values, authenticity and integrity. *Values: Cost or investment*. Wellington, New Zealand.

Ministry of Health (2007) Purchase Unit Code Stocktake, Nationwide Mental Health Service Framework, Unpublished

Ministry of Health (2009) Needs Assessment Service Co-ordination Service Specification, Nationwide Services Framework.

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## 13. Appendices

### Appendix One: NASC Service Specification

**NEEDS ASSESSMENT AND SERVICE CO-ORDINATION  
TIER THREE  
SERVICE SPECIFICATION  
MHA18A, MHA18B, MHA18C, MHA18D, MHA18E, MHA18A**

This tier three service specification for Needs Assessment and Service Co-ordination (the Service) is linked to tier one Mental Health and Addiction Specialist Services and tier two Adult Mental Health service specifications.

#### 1. Service Definition

The Service will work with the service user, their family and whānau and significant others, to assess their needs and plan and co-ordinate appropriate services.

Needs assessments will be undertaken to identify individual strengths and supports/activities required that are likely to lead to resilience and recovery outcomes for the service user and their family and whānau.

#### 2. Service Objectives

The Service facilitates the access of adults, to a range of community-based resilience, recovery and support-focused services. Access to those services is facilitated through the processes of comprehensive support, needs assessment and prioritisation of access according to identified needs.

##### 2.1 Māori Health

Refer to the tier one Mental Health and Addiction service specification.

#### 3. Service Users

The Service users are eligible adults as detailed in the tier two Adult Mental Health service specification.

#### 4. Access

##### 4.1 Entry and Exit Criteria

Referral to the Service is from community mental health services or inpatient mental health and addiction services.

#### 5. Service Components.

##### 5.1 Processes

The Service includes needs assessment, service planning, and co-ordination.

##### Needs Assessment:

The assessment process meets the requirement of the Standards for Needs Assessment and Service Co-ordination (Ministry of Health 1994) and utilises a recognised best practice assessment tool. The assessment process includes:

- identification and prioritisation of the service user's needs, both support and developmental needs, within the context of their
- attention to any immediate needs that may interfere with the family and whānau
- independent advocacy, where required person's ability to participate in a support needs assessment
- attention to cultural needs
- attention to the service user's educational requirements and or employment concerns within the family and whānau context
- attention to the service user's housing, social, recreational and financial concerns within the family and whānau context
- further specialist assessments as determined by the service user.

Needs assessments are then repeated and updated at not greater than six monthly intervals.

Family and whānau are engaged (if appropriate) in the assessment process. Where a service user is Māori, assessment will include a cultural needs assessment with their whānau present (in accordance with principles of informed consent) in the assessment process. Providers will ensure that the holistic view of health, as defined by Māori, is included in service provision for Māori.

#### **Service Planning:**

This includes:

- access to an up-to-date directory on mental health/community services
- identification of current services involved in meeting aspects of the needs and remaining unmet needs
- identification and documentation of actions that are necessary to address those unmet needs and to achieve agreed goals
- when needs cannot be met from publicly funded services, referrals will be made to a range of community-based services as appropriate in accordance with the assessment.

#### **Co-ordination:**

This includes:

- facilitation of access to community mental health and disability support services that will enable people with mental illnesses to lead their lives as independently and productively as possible
- development of practical service and support options to address identified needs utilising public, private and voluntary services
- prioritisation of the needs of the service user and management of the demand for available services by determining relative priority between those accessing services
- development of a service or 'lifestyle' plan
- the match of available resource with needs, ensuring resources are used efficiently

- management of an allocation for carer relief or home support
- access management to support services, including residential services.

Needs assessment/service co-ordination services may provide the above services to people with addictions, in addition to those people with severe mental health problems, according to local requirements/agreements between funders and service providers.

## 5.2 Settings

The Service is community based.

## 5.3 Key Inputs

The Service is provided by a multi-disciplinary team, including people with qualifications in assessing, planning and co-ordination, Service users, people with experience of disability, cultural workers and health professionals.

## 6. Service Linkages

Linkages include, but are not limited to those described in tier one Mental Health and Addiction Specialist Services and tier two Adult Mental Health service specifications.

### 6. Service Linkages

Linkages are not limited to those described in tier one Mental Health and Addiction Specialist Services and tier two Adult Mental Health service specifications and include the table below.

Service Provider	Nature of Linkage	Accountabilities
Providers of other needs assessment and service coordination services	Referral Liaison	Work with the relevant professionals and agencies in the care and support of the Service user

## 7. Quality Requirements

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

## 8. Purchase Units and Reporting Requirements

Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service.

PU Code	PU Description	Unit of Measure	Reporting Requirements
MHA18A	Needs assessment and service coordination – Senior medical staff	FTE	PRIMHD

PU Code	PU Description	Unit of Measure	Reporting Requirements
MHA18B	Needs assessment and service coordination – Junior medical staff	FTE	PRIMHD
MHA18C	Needs assessment and service coordination – Nursing and/or allied health staff	FTE	PRIMHD
MHA18D	Needs assessment and service coordination – Non-clinical staff	FTE	PRIMHD
MHA18E	Needs assessment and service coordination – Cultural staff	FTE	PRIMHD
MHAK18A	Needs assessment and service coordination - Kaupapa Māori - Senior medical staff	FTE	PRIMHD

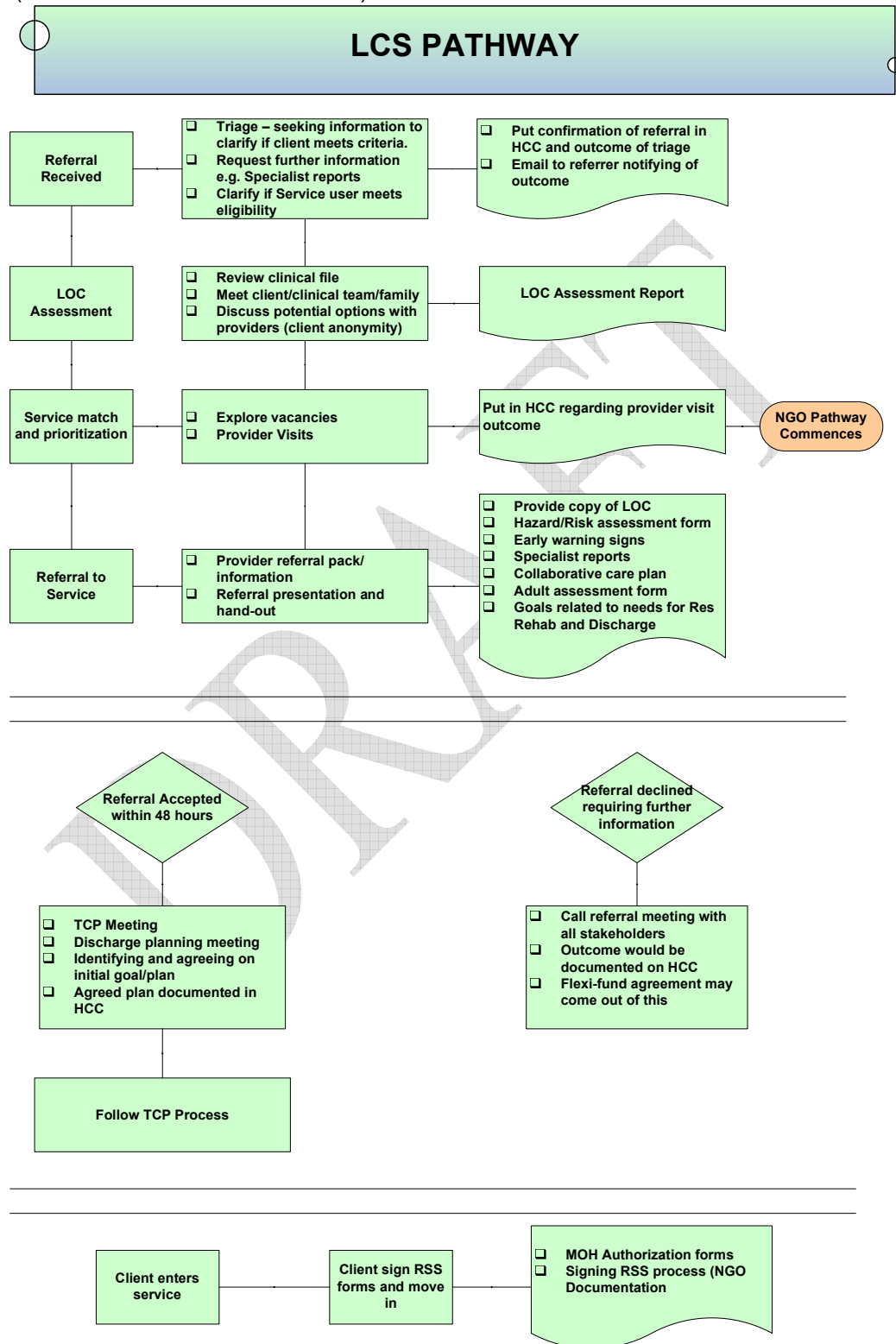
The Service must comply with the requirements of national data collections: PRIMHD.

**After PRIMHD Reporting to Information Directorate, Ministry of Health:**

Frequency	Data
Monthly	Monthly expenditure for flexi fund with a breakdown of information re utilisation.
Quarterly	Senior Medical FTEs
Quarterly	Junior medical FTEs
Quarterly	Nursing and allied FTEs
Quarterly	Non clinical FTEs
Quarterly	Cultural FTEs
Quarterly	Peer Support FTEs
Quarterly	Staff turnover ratio
Six monthly	Number of NGO Board member changes (NGOs only)
Six monthly	Number of NGO Governance meetings held (NGOs only)
Annually	Number of FTEs in each of these groups: <ul style="list-style-type: none"> <li>• Medical</li> <li>• Nursing</li> <li>• Psychology</li> <li>• Occupational Therapy</li> <li>• Social Work</li> <li>• Maori Mental Health</li> <li>• Other</li> </ul>

# Appendix Two: Coordination Service Pathway

(Waitemata District Health Board)



## Appendix Three: Collaborative Reassessment Form

(Waitemata District Health Board)

Date of previous Assessment:

Domain/Section	Goals Identified from LOC Assessment on Entry to assisted/supported living placement	Recommendations Agreed to	By who and when
1. Support with Daily living	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	
2. Education, Work, socialising and Leisure	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	
3. Medication	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	
4. Community Mental Health Support	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	
5. Support with my illness	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	
6. Keeping me safe	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	
7. Living with other people	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	
8. Other special requirements that I may need support with	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	

### Questions to think about when completing this form:-

- ✓ To what extent have your goals been achieved?
- ✓ Have your expectations regarding what was planned been fulfilled? If 'YES', what has been helpful? If 'NO', what do you think you/others could have done differently?

- ✓ Do other parties have additional views?
- ✓ Any concerns regarding your current placement?
- ✓ If you can imagine things going really well for you in the next 3-6 months, what would that look like?

## **Reassessing Level of Need**

### **1. Support with daily living**

*(What level of Support is needed with meals, laundry, cleaning, personal care, money issues?)*

<u>Service User View:</u>
<u>Family/Whanau/Significant other view:</u>
<u>Supported Facility staff view</u>
<u>Community Clinical Team view:</u>

### **2. Education, Work, Socialising and leisure**

*(What level of support and assistance is needed to join groups, get involved in leisure activities and hobbies, education courses and jobs you might be interest in? What have you done in the past?)*

<u>Service User View:</u>
<u>Family/Whanau/Significant other view:</u>

Supported Facility staff view

Community Clinical Team view:

### 3. Medication

*(What medication are you on at the moment? Do you need support remembering to take it and does someone support you take it? Is it helpful? Are there any problems with taking medication (side effects etc)? What is your understanding of medication? What other types of treatment have you had that is effective?)*

Service User View:

Family/Whanau/Significant other view:

Supported Facility staff view

Community Clinical Team view:

### 4. Community Mental Health Support

*(Who are your community workers and what do they do? How often do you see them? Is this enough or not enough? Do you need staff to be around for you to have access to 24-hours a day? What kind of face to face contact do you think you need?)*

Service User View:

Family/Whanau/Significant other view:

Supported Facility staff view

Community Clinical Team view:

## 5. Support with my illness

*(How do you know when you are becoming unwell? What kinds of things happen? What do you do when you realise that you are feeling unwell? How quickly do you become unwell? What is your sleep pattern like? What assists you sleep?)*

Service User View:

Family/Whanau/Significant other view:

Supported Facility staff view

Community Clinical Team view:

## 6. Keeping me safe

*(What support/assistance is needed to keep you feeling safe? Are these supports currently in place? Do you ever do things that people think is unsafe for you or puts you at risk? Do you ever feel like hurting yourself or that life is not worth living? Do you ever feel that others are at risk when you are unwell?)*

Service User View:

Family/Whanau/Significant other view:

Supported Facility staff view

Community Clinical Team view:

## 7. Living with other people

*(How do you feel you get on with other people you live with? Have you had any problems in the past or currently? If yes, what caused the problems? What annoys or upsets you when living with others? Is there anything that you do that you feel upsets other people who you live with? What about when you are unwell? What do you find useful when you are in a stressed situation around other people?)*

Service User View:

Family/Whanau/Significant other view:

Supported Facility staff view

Community Clinical Team view:

**8. Other special requirements I have that I may need support for**

*(Any physical Conditions or disabilities? Do you smoke/drink alcohol/use illicit drugs? Are you willing to cut down or quit? What resources and/or support if any would you like to support you achieve this? Do you have a GP? Any other conditions that may affect your daily living?)*

<u>Service User View:</u>
<u>Family/Whanau/Significant other view:</u>
<u>Supported Facility staff view</u>
<u>Community Clinical Team view:</u>

**Any of these apply to you? (Please tick)**

<b>Personal health conditions</b>	<input type="checkbox"/>	<b>Physical/sensory disabilities or development disorders</b>	<input type="checkbox"/>
<b>ACC eligible conditions</b>	<input type="checkbox"/>	<b>Intellectual disability</b>	<input type="checkbox"/>
<b>Substance abuse</b>	<input type="checkbox"/>	<b>Antisocial conditions</b>	<input type="checkbox"/>

**9. My Culture/Spirituality**

*(Have you got any special Cultural needs (food, language, traditional healing practices?) Is your family supporting you at present? If yes, in what way? Would you like us to be more involved with family? Do you require any additional support or assistance in meeting your spiritual or religious needs?)*

<u>Service User View:</u>
---------------------------

Family/Whanau/Significant other view:

Supported Facility staff view

Community Clinical Team view:

***Reviewing Service matching (to be completed at the end of the Review)***

If this is a review, and the person's assessed level of care is the same as the last assessment or review:

- What are the views of the involved parties on how well-matched the person is to the current service? Is the person's match better or worse than it was when they first entered the service?

**Other Comments**

*(Is there any other information that has not been covered above?)*