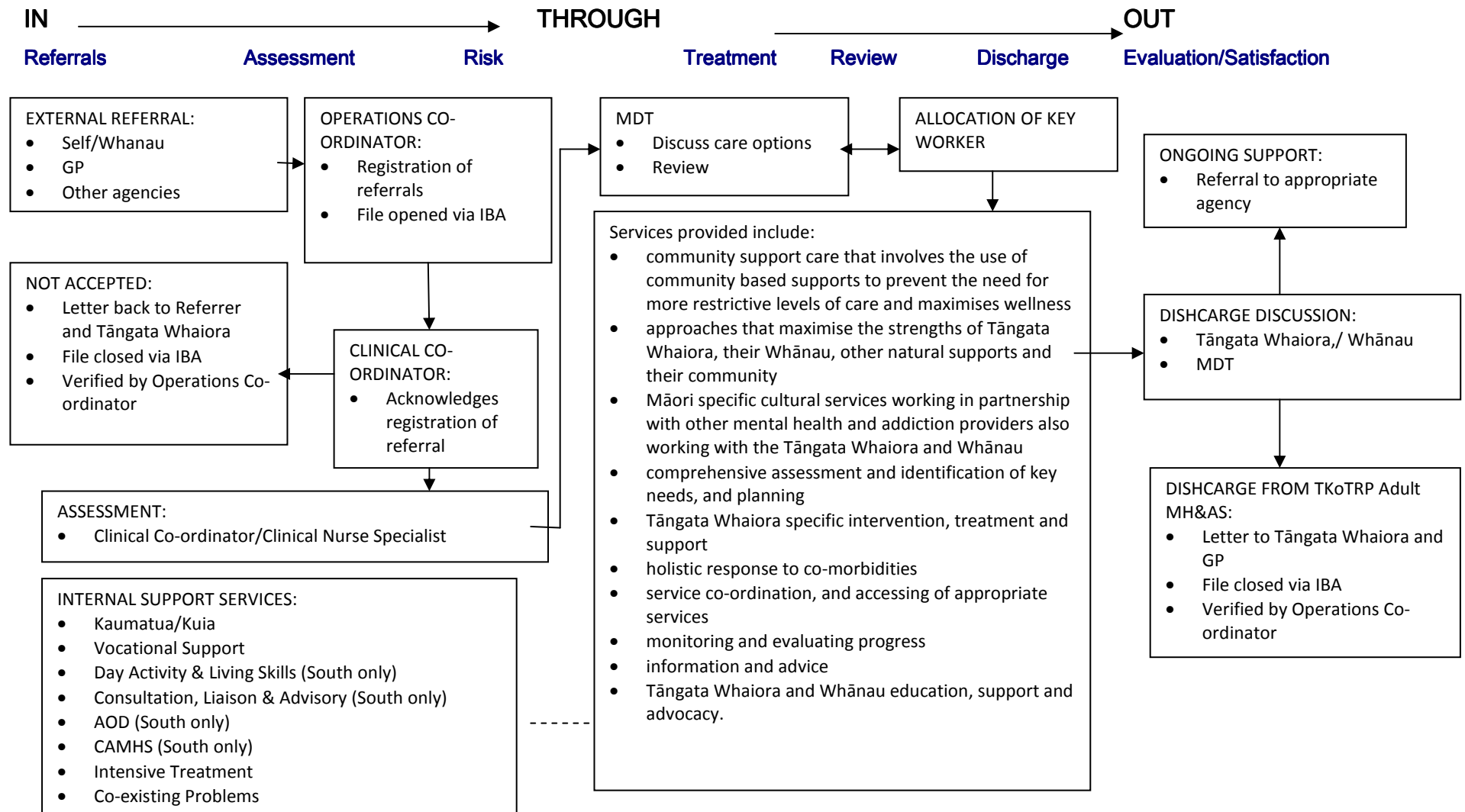


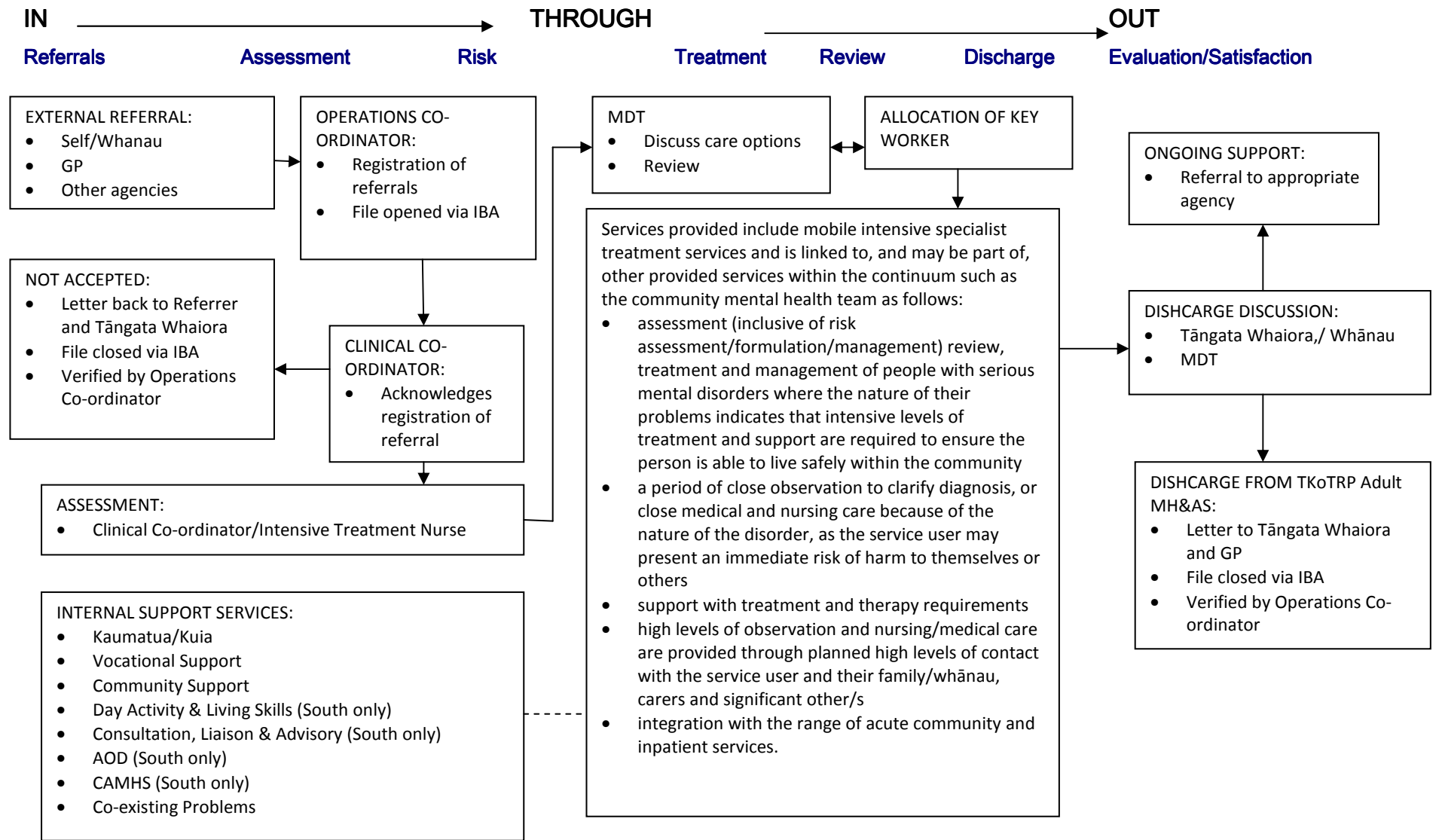
Continuum Project

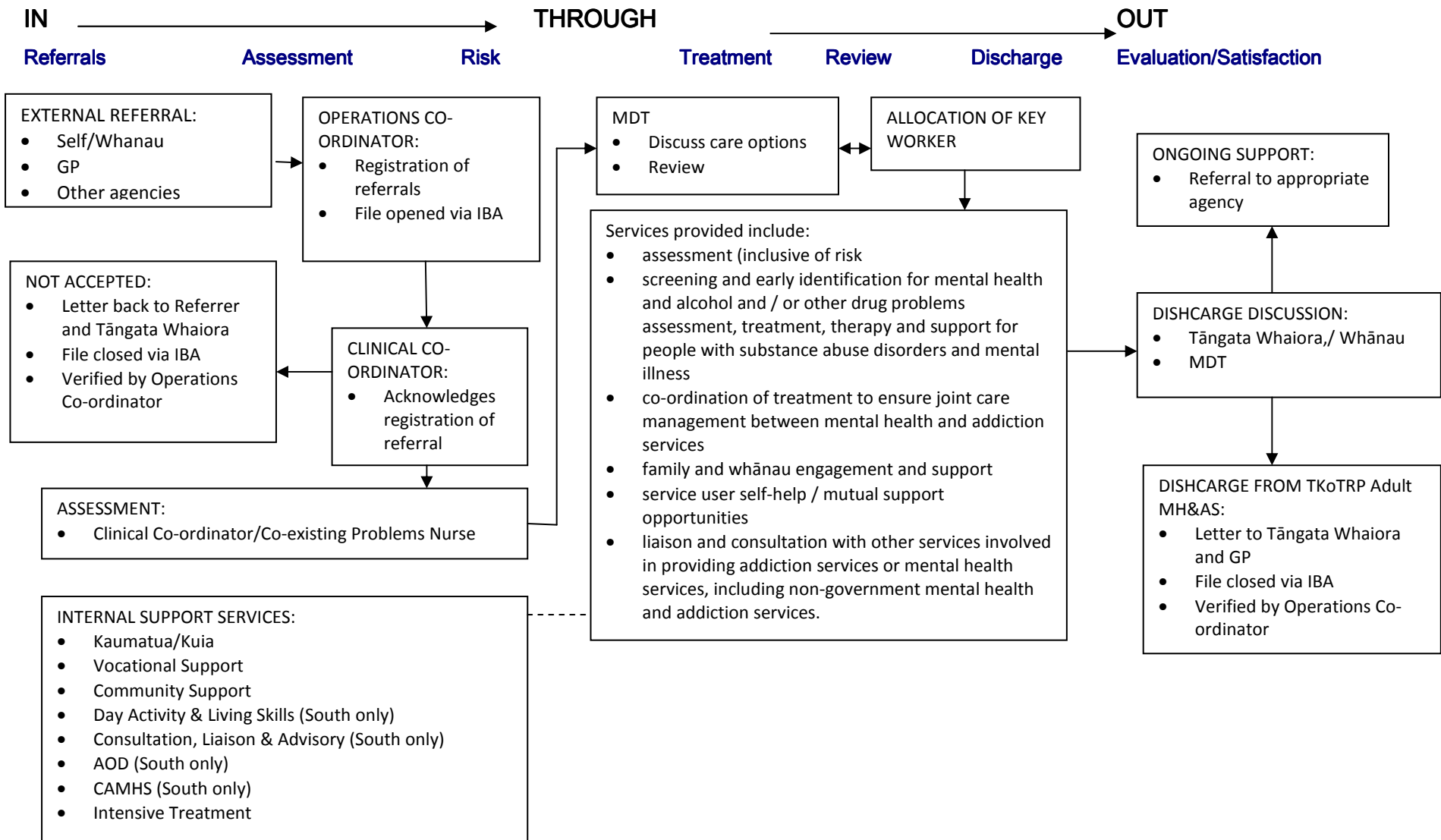
Adult Mental Health and Addiction Services

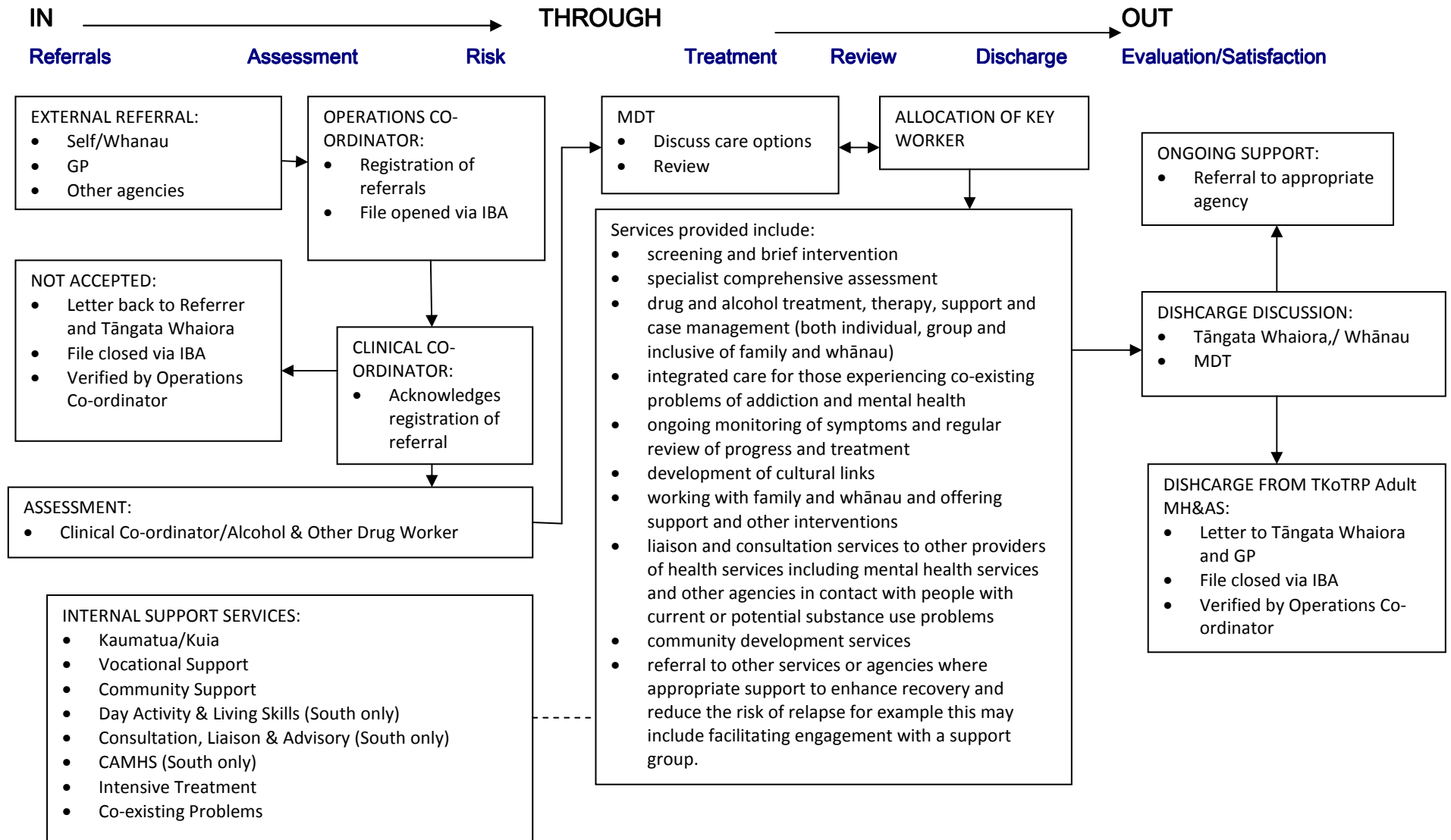
PROVIDER: Tui Ora Ltd / Te Kokiritanga o Te Rau Pani
 SERVICE TYPE (1): Kaupapa Maori – Community Adult MH & AS

1



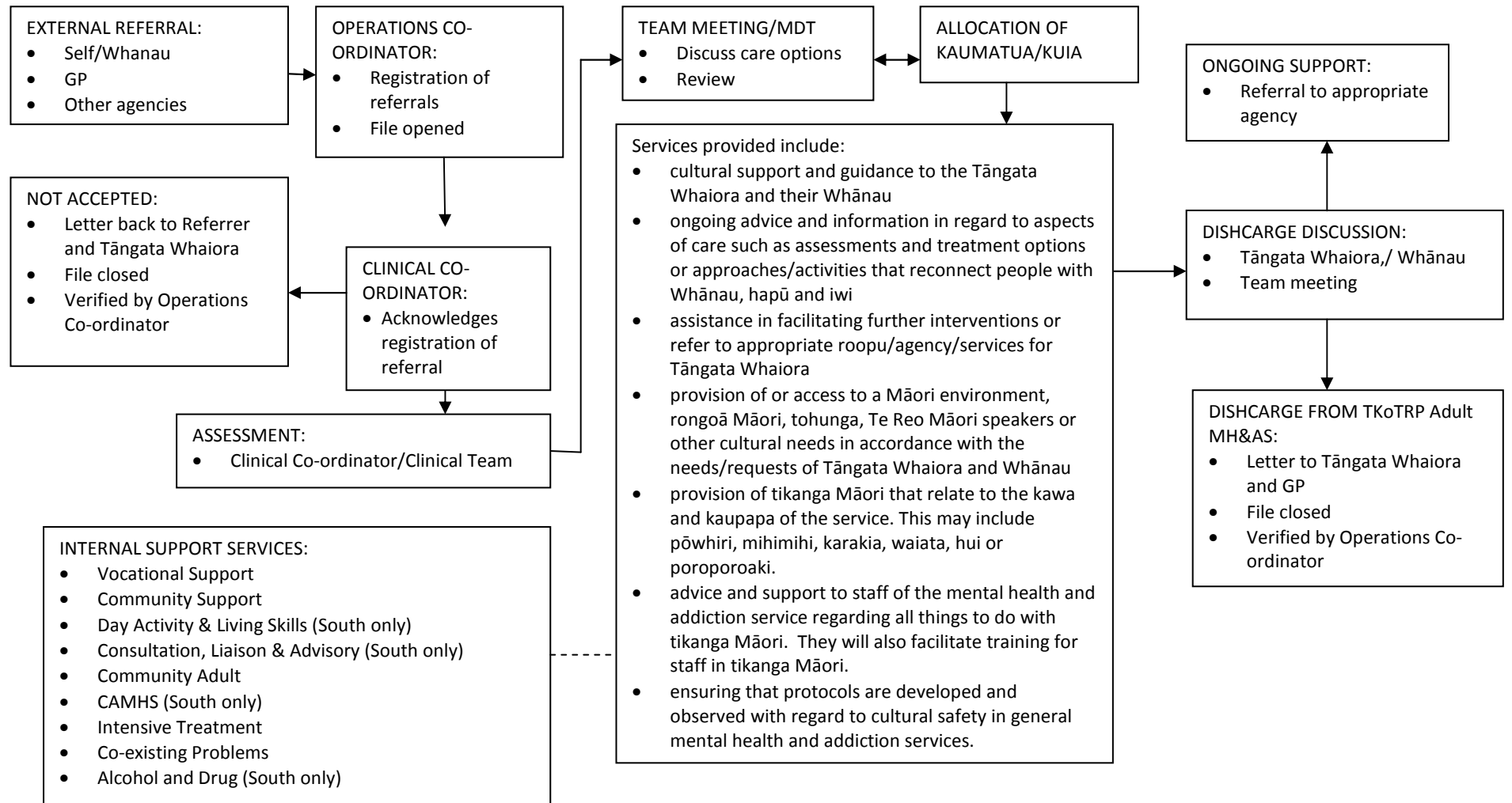






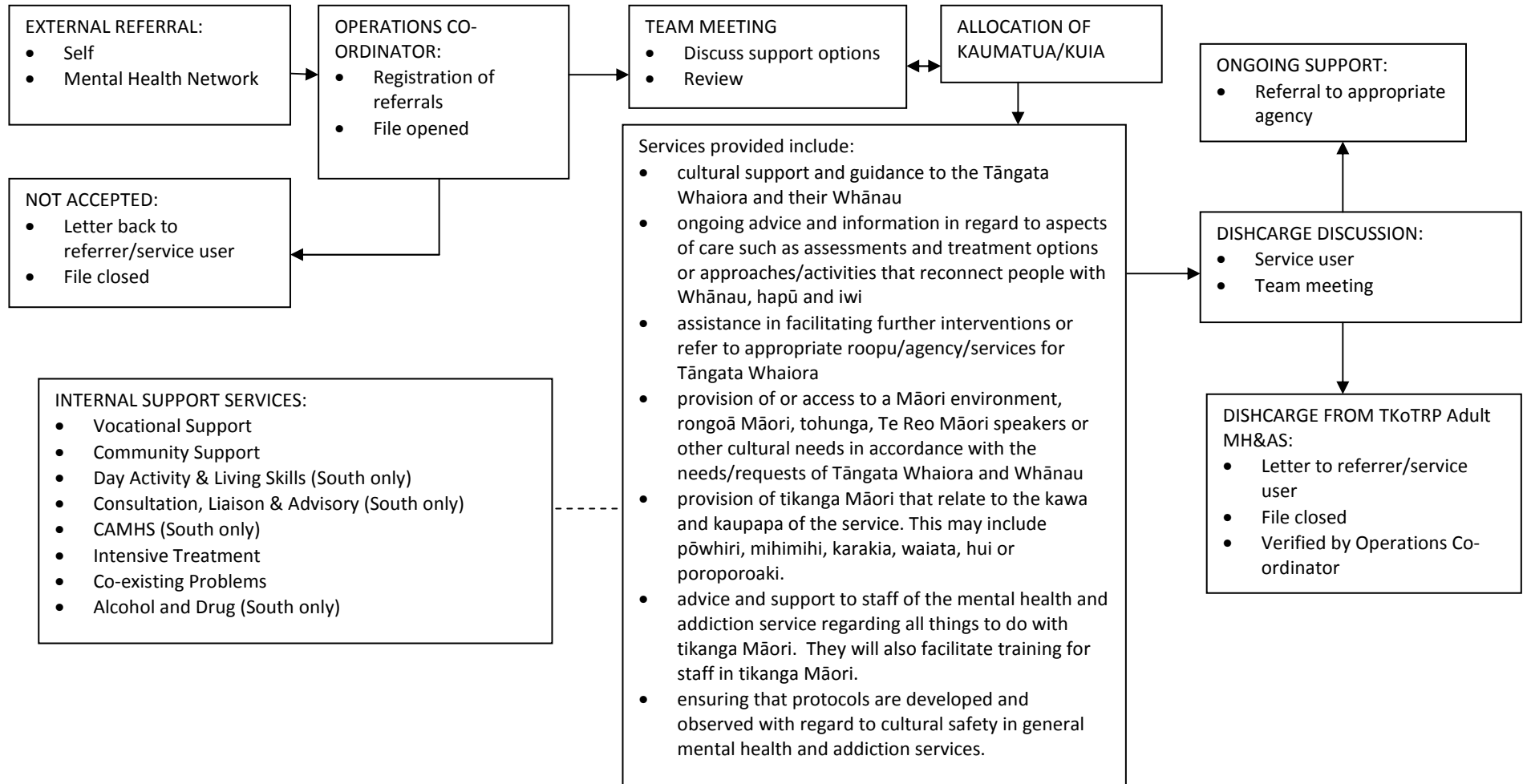


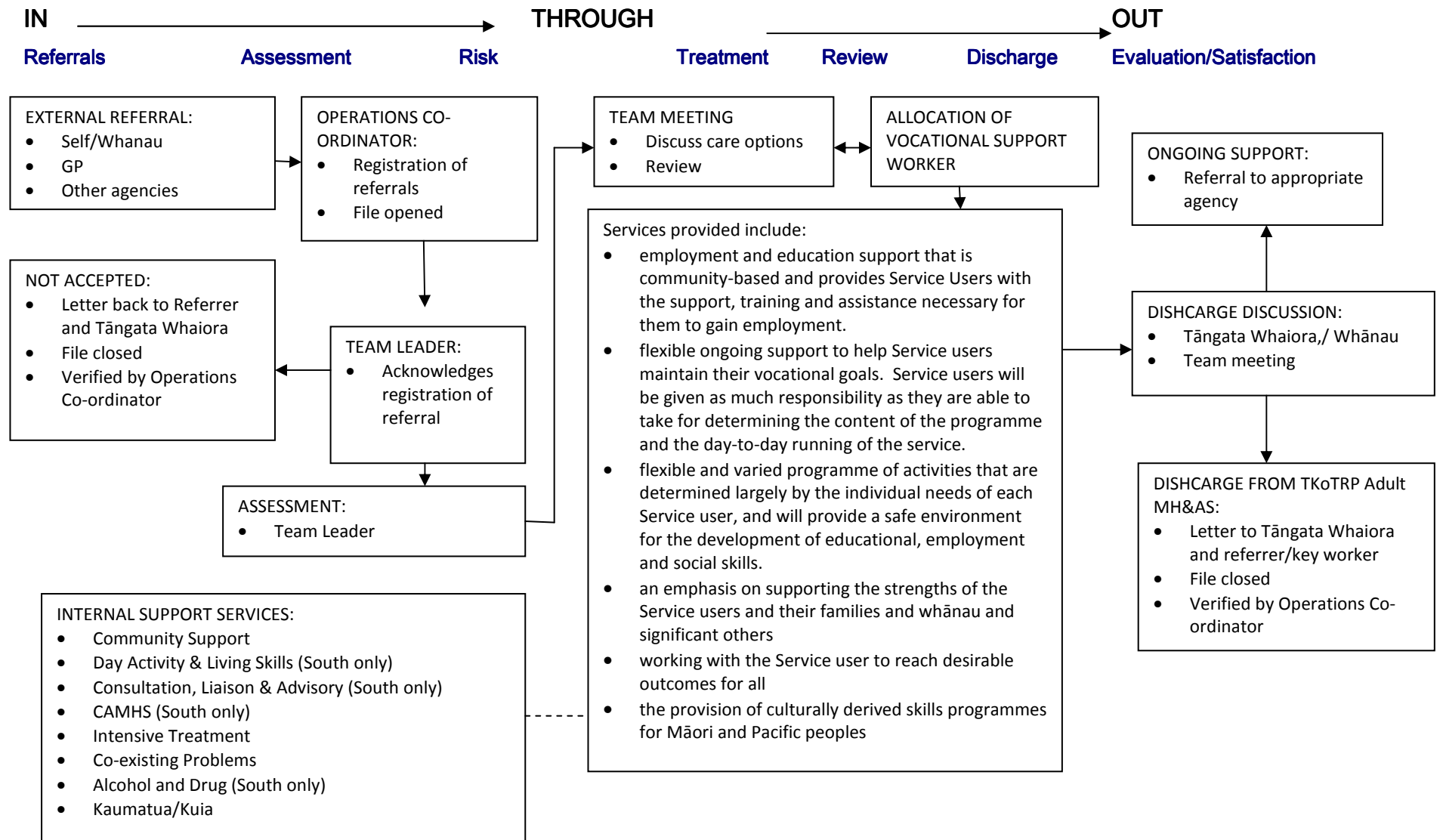
PATHWAY FOR CULTURAL SUPPORT AND GUIDANCE FOR CLINICAL ACTIVITY – Service Description

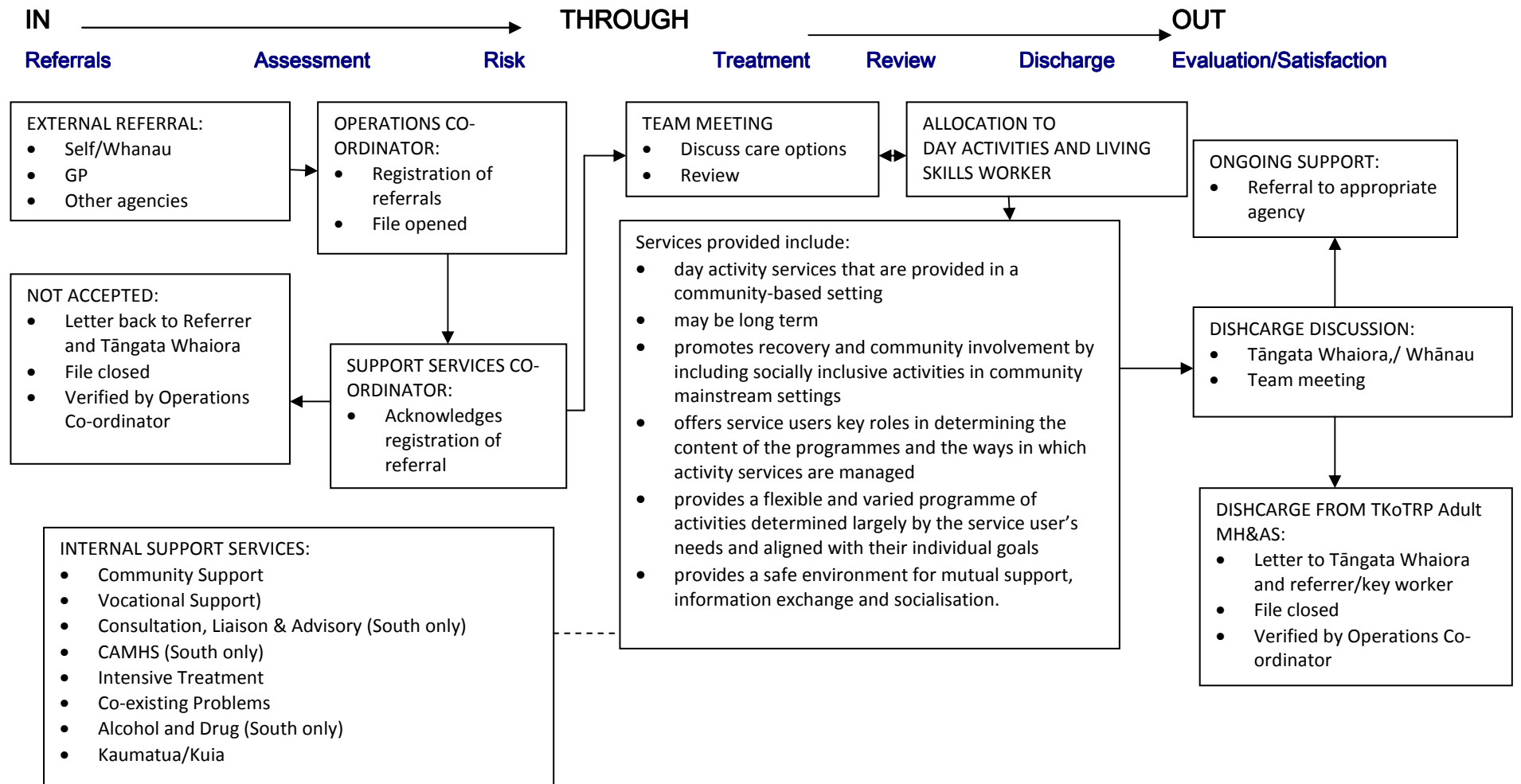


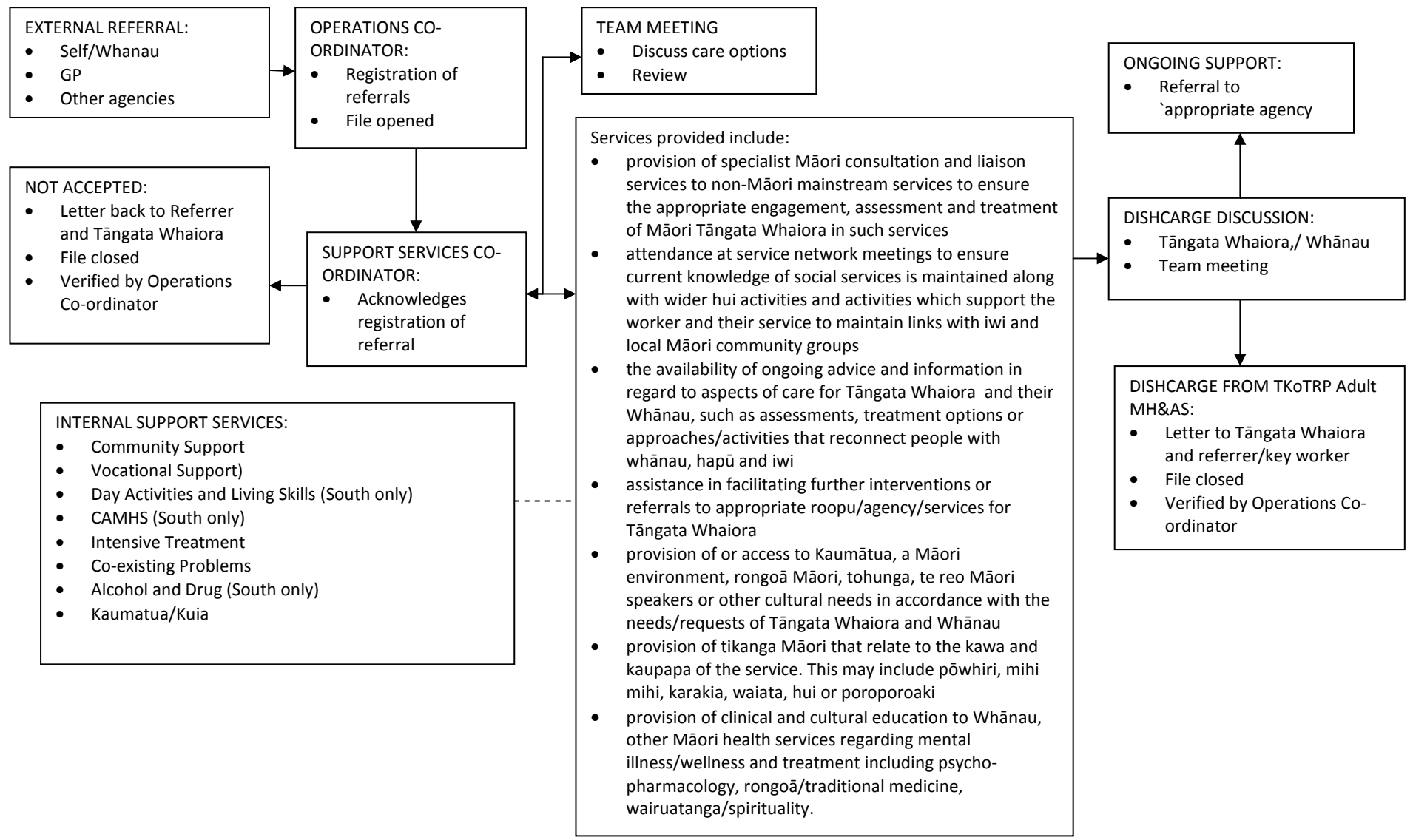


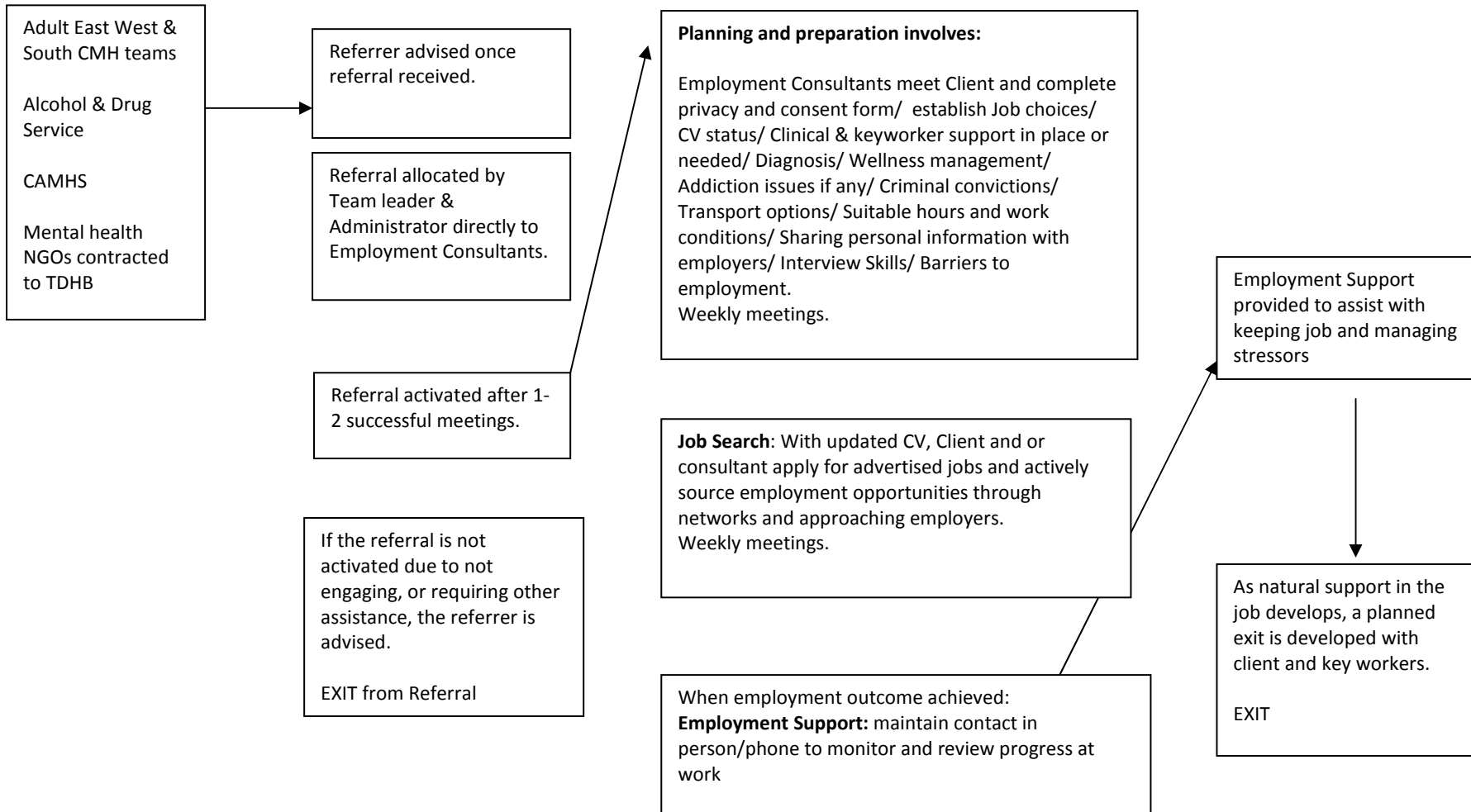
PATHWAY FOR CULTURAL ADVICE AND SUPPORT TO MENTAL HEALTH NETWORK – Service Description





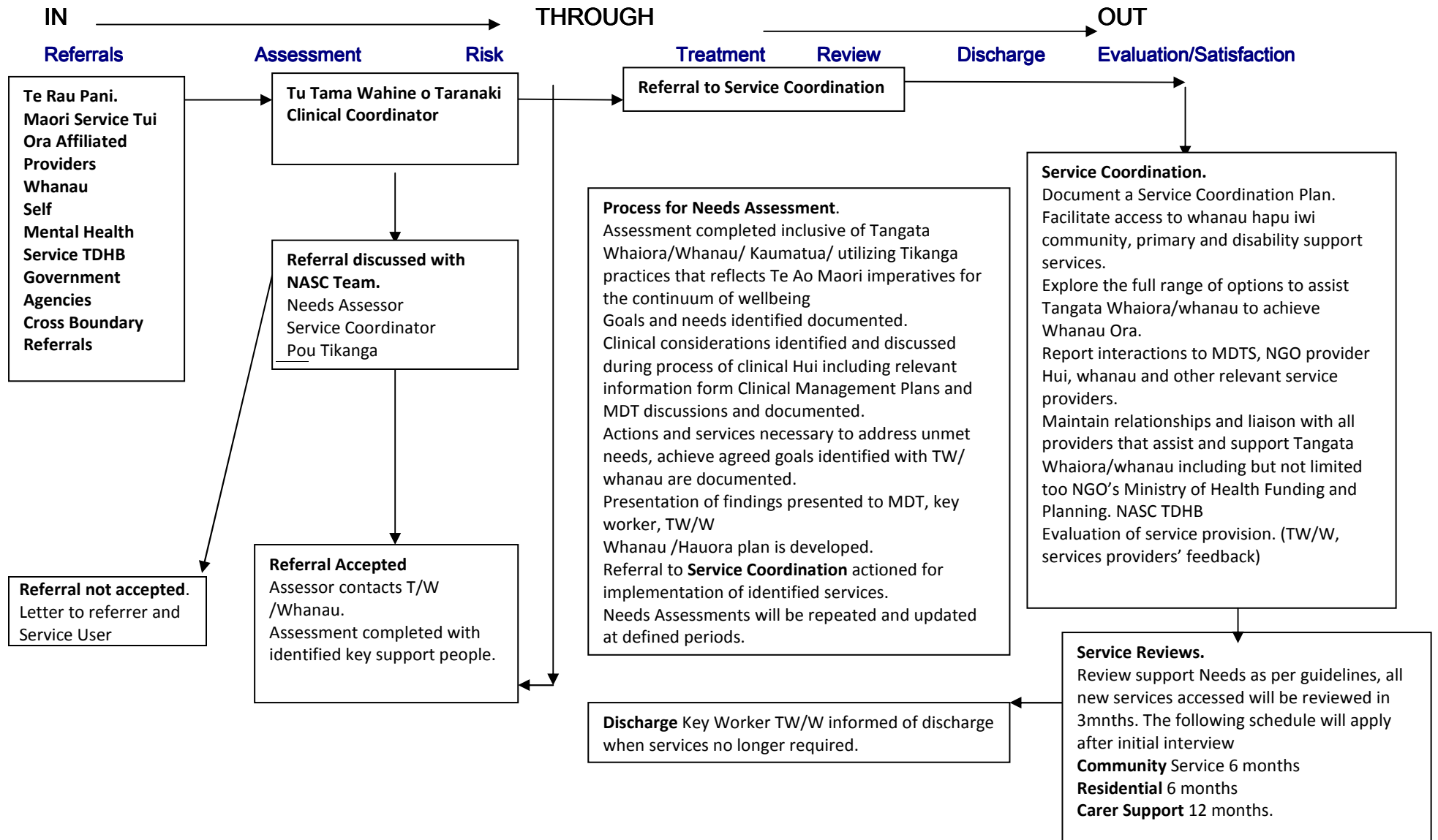


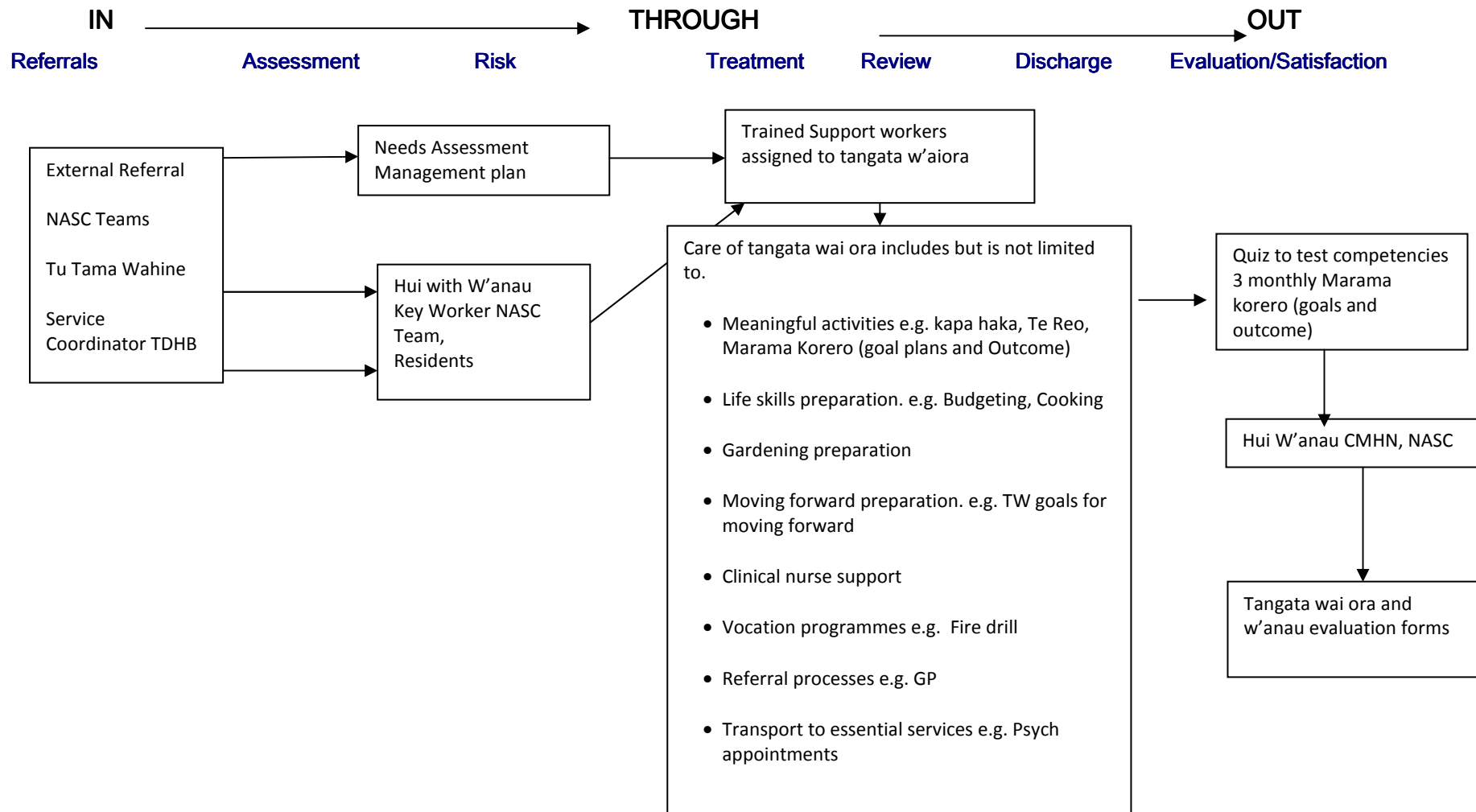




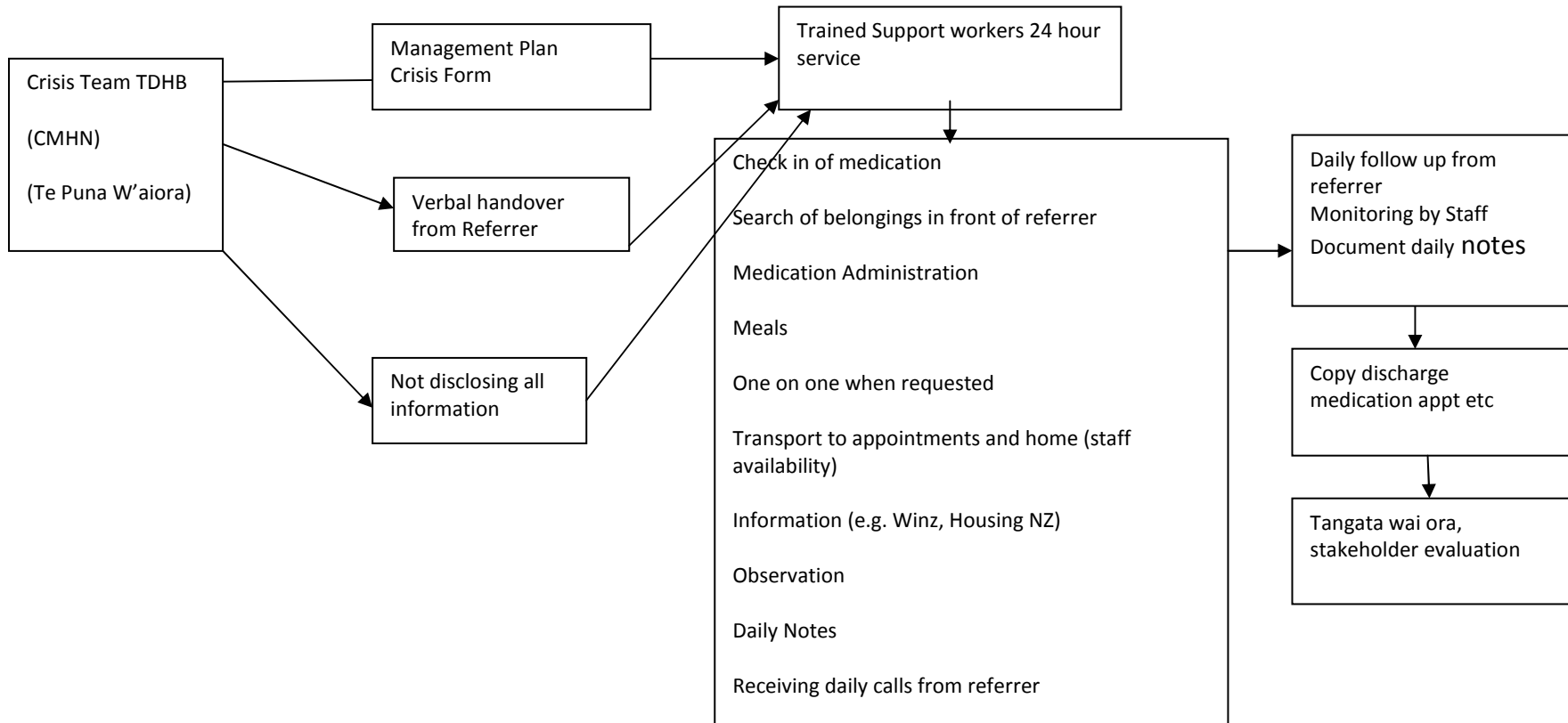
Service	F T E	Shared resource?	IN TO SERVICE	THROUGH SERVICE	OUT OF SERVICE	Barriers	Opportunity	Potential development
Early Intervention (EI) – early intervention, first psychosis	2.0	Joint service with TDHB	Referral from TDHB Intake Coord Te Rau Pani & CAMHS	Access service – home visit EI Care/Support Plan Key Workers (RNs) Liaise with TDHB MSEs Psychoeducation Whanau education Whanau support Intensive clinical support Cultural assessment	Ready for discharge Support with Mobile, Workwise, Employable, GP		EI in the time before diagnosis – community awareness Continued EI support of primary sector/GPs	
Community Assessment Treatment (CAT)	1.0		Referral from Crisis Team, Te Rau Pani, AHBT and GPs	Access service – home visit CAT Care/Support Plan Key Worker (RN) Liaise with TDHB MSEs/Risk Assessments Social & clinical support Whanau support Cultural assessment	Ready for discharge Support with Mobile, Workwise, Employable, GP		Continue to support primary sector/GPs with sub crisis work	
Meaningful Activity (MA - adult) – day programme	2.4		Referral from TPW, CMH, Te Rau Pani & GPs	Attend day programme Activity Support Plan Not Key Workers Liaise with TDHB Oversight by RN Whanau support	Ready for discharge Support with community activities, CAPS service		Extend current home based Activity Assessments	
Meaningful Activity (MA - elderly) – day programme	0.5		Referral from MHSOP	Attend day programme Activity Support Plan Not Key Workers Liaise with TDHB MHSOP Oversight by RN Whanau support	Ready for discharge Support with community activities	Limited days	Extend service to offer more days per week	
Consumer Advocacy, Peer Support (CAPS)	2.0		Referrals from TPW, CHM, Te Rau Pani & GPs	Access service – home visits Systemic Peer Support Individual Advocacy/Peer Support Plan Not Key Workers Liaise with TDHB Oversight by RN	Ready for discharge Support with community agencies, GP	No Advocacy Peer Support in some areas of sector	Peer Support in AOD & CAMHS areas	

Service	F T E	Shared resource?	IN TO SERVICE	THROUGH SERVICE	OUT OF SERVICE	Barriers	Opportunity	Potential development
				Whanau support Cultural assessment				
Oranga Ngatahi – physical health outcomes (ON)	1.0	Operational joint venture with TDHB	Referrals from TPW, CMH, Te Rau Pani, AOD & GPs	Access service – visit gym Oranga/Wellness Plan Green gym programme offered to TPW Not Key Worker Liaise with TDHB Oversight by RN	Ready for discharge Support with community activities, CAPS, MA	Unable to provide transportation to Waitara clients or provide service to South clients	Reactivate ON South Provide service to Waitara clients (transportation)	
Community Supported Living: 1. Respite	RS Ws & RNs		Referrals from Crisis Team	Respite Plan Oversight by RN RSWs	Ready for discharge Follow up by Crisis Team	Limited respite providers	Respite for Maternal & CAMHS	
2. Supported Boarding			Self-referral Private service	Supported in independence for longer term periods Oversight by RN RSWs	Ready for discharge Support with community agencies, GPs, CAPS, MA	Supports continuum without funding – limits beds available	Some funding to provide further longer term beds to free up rehab beds	
3. Level 3/3+			Referral from NASC teams	Rehab Care/Support Plan Oversight by RN RSWs MSEs/Risk Assessments Rehab skills Liaise with TDHB Key Worker Whanau support Cultural assessment	Ready for discharge Support with Mobile, Supported Accommodation, Workwise, Employable	Clients using rehab beds but actually require longer term support	Need beds for longer term (coexisting medical) presentations	
4. Level 4 - IPC			Referral from NASC teams	Rehab Care/Support Plan Oversight by RN RSWs MSEs/Risk Assessments Rehab skills Liaise with TDHB Key Worker Cultural assessment	Ready for discharge Support with Level 3/3+ options	No kaupapa Maori level 4 beds	Contracted level 4 beds for Maori – provided in kaupapa Maori	
5. High Complex Needs		Governance joint venture with TDHB	Referral from TPW	Provide RSWs Operational & rehab support Whanau support Cultural assessment	Ready for discharge Support with Mobile, Supported Accommodation, Level 3/3+ options, Workwise, Employable			



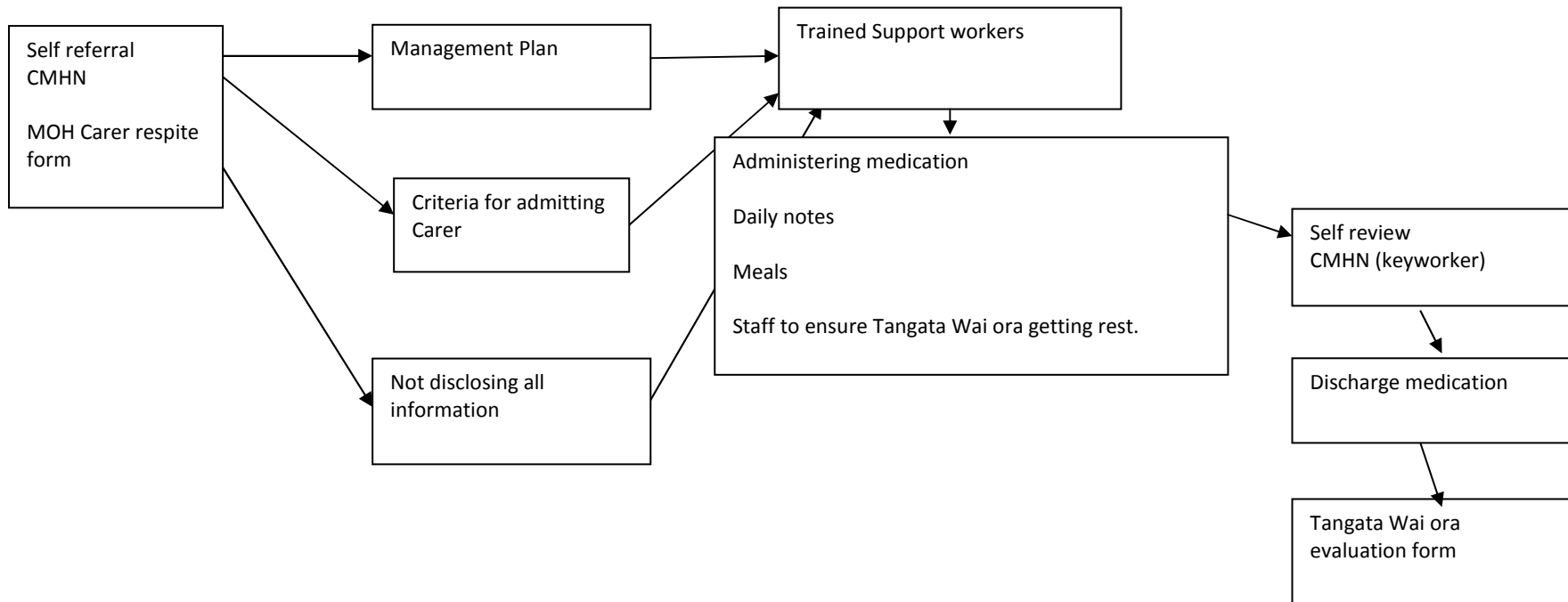


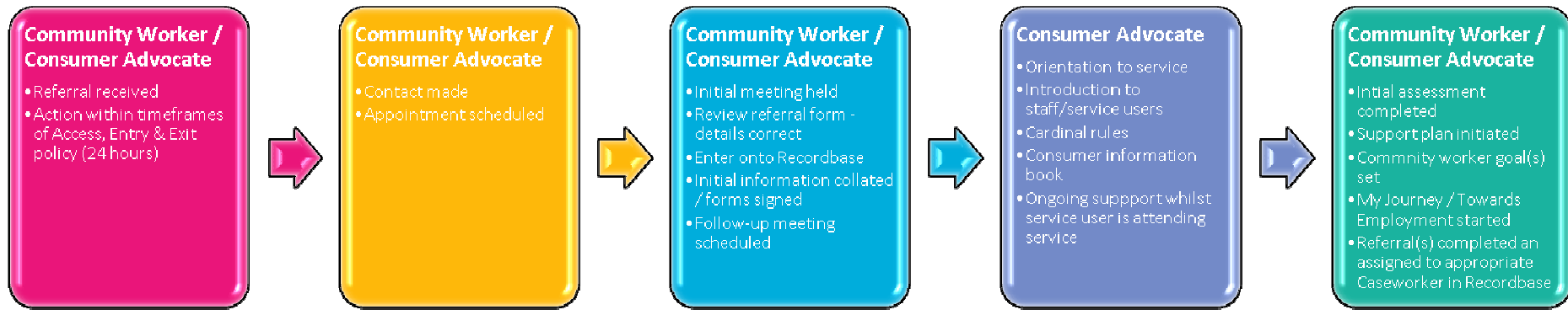
IN → THROUGH → OUT
 Referrals Assessment Risk Treatment Review Discharge Evaluation/Satisfaction

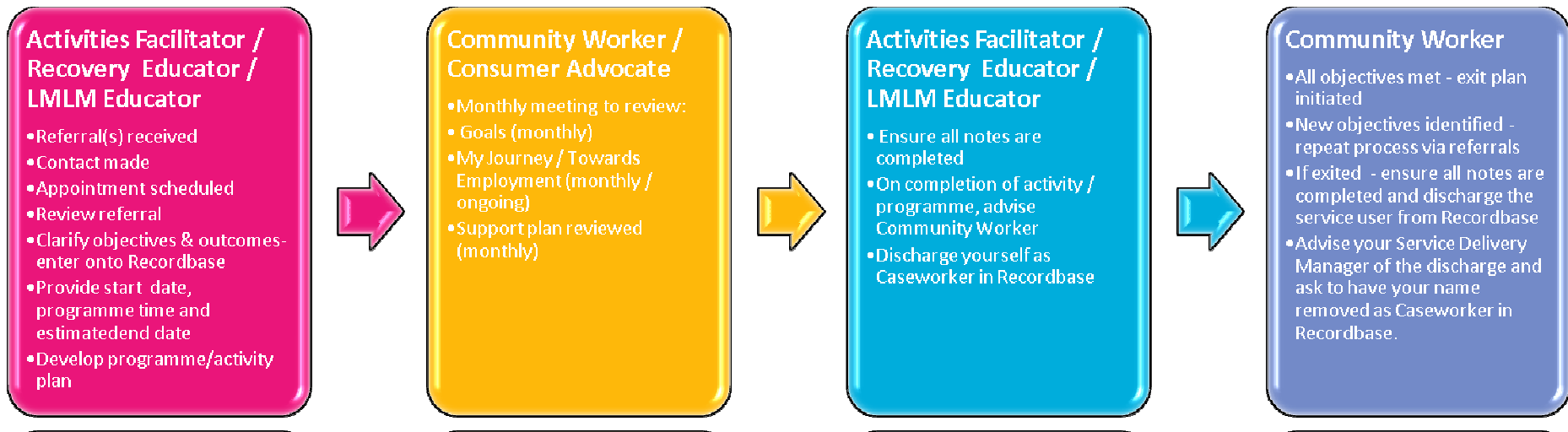


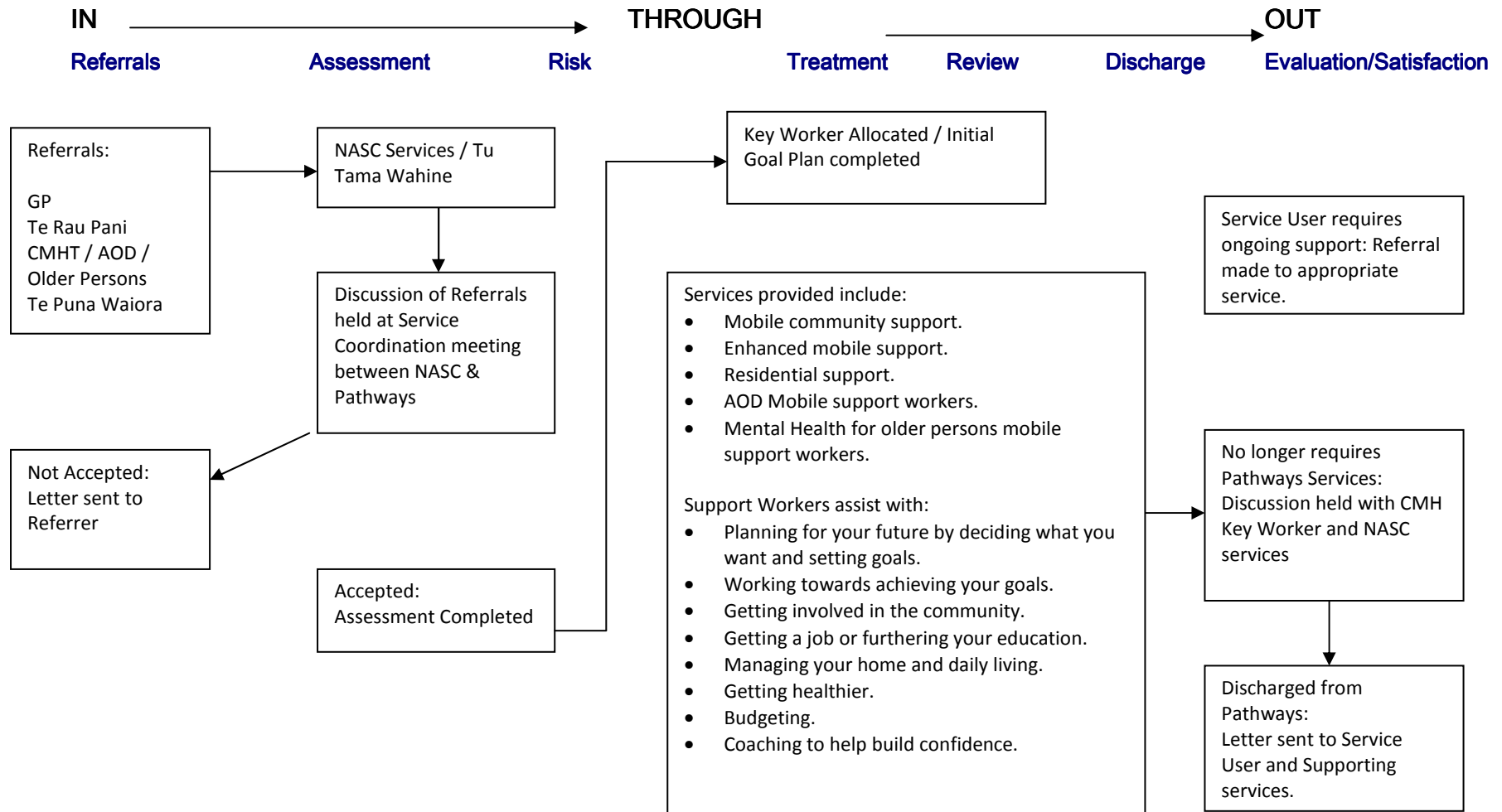
IN → THROUGH → OUT

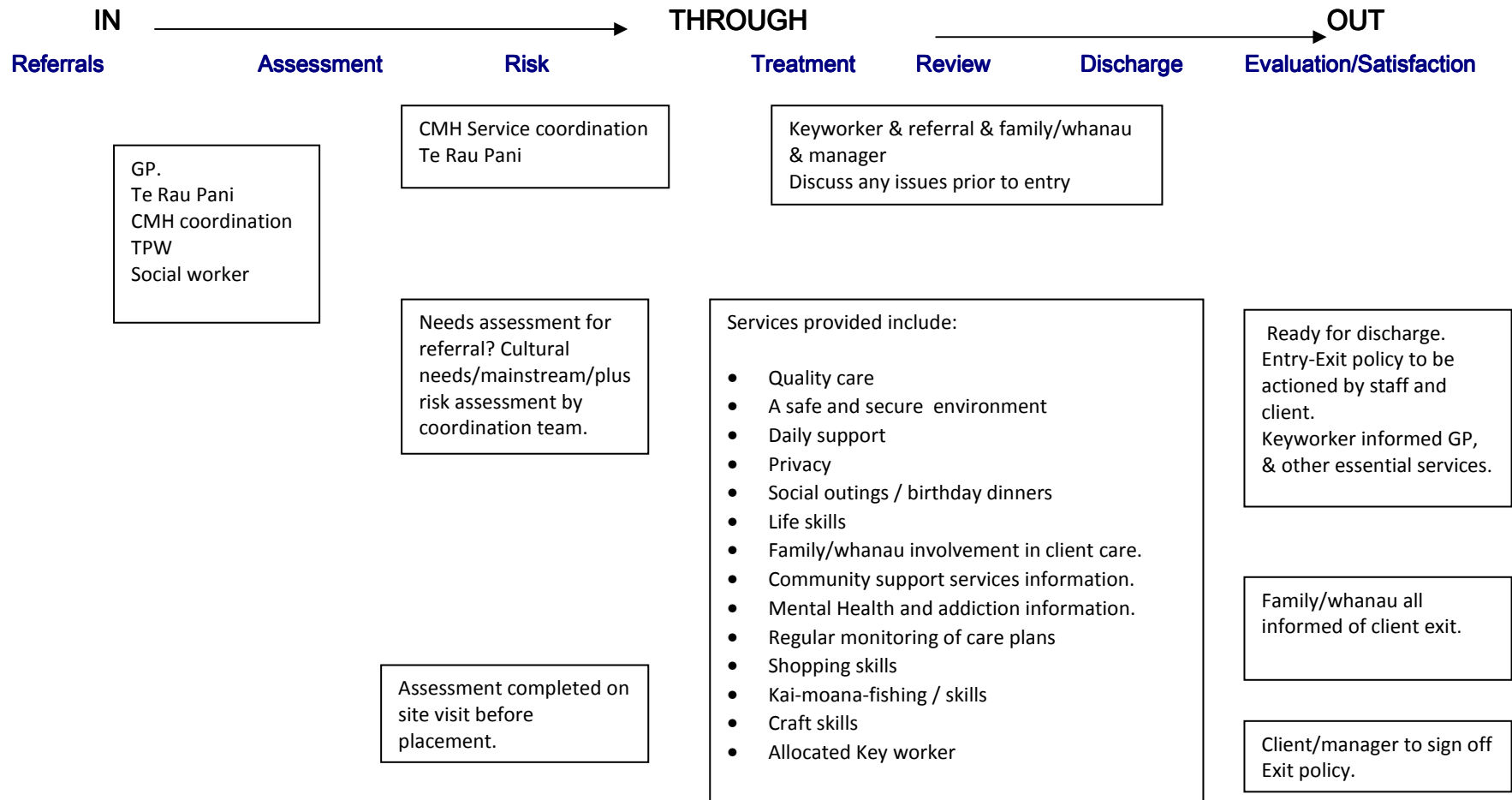
Referrals Assessment Risk Treatment Review Discharge Evaluation/Satisfaction

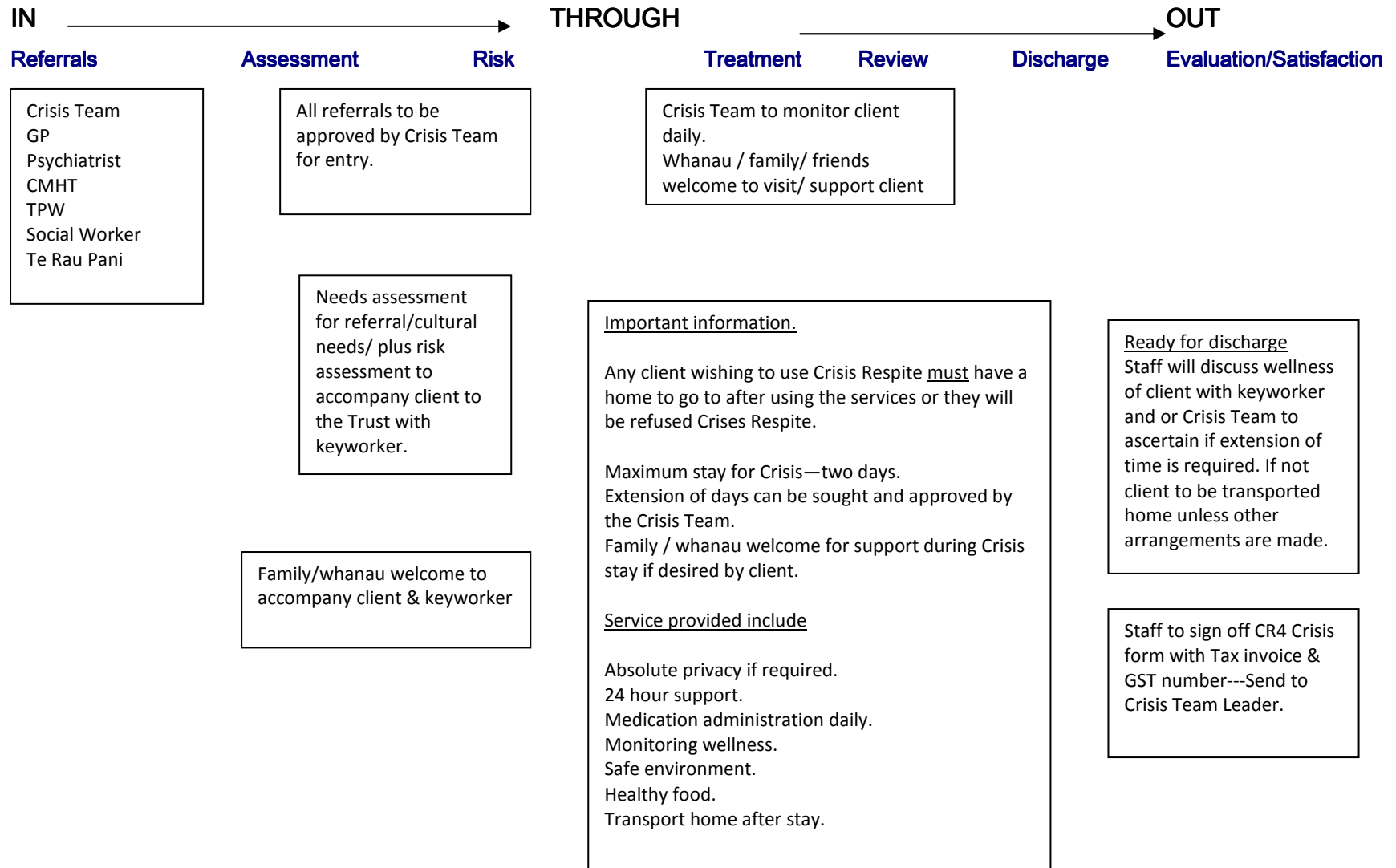














CMHT
Social worker
Te Rau Pani
Self
NASC
Key worker

Referral agency-to access Carer Support claim form from MOH for referral

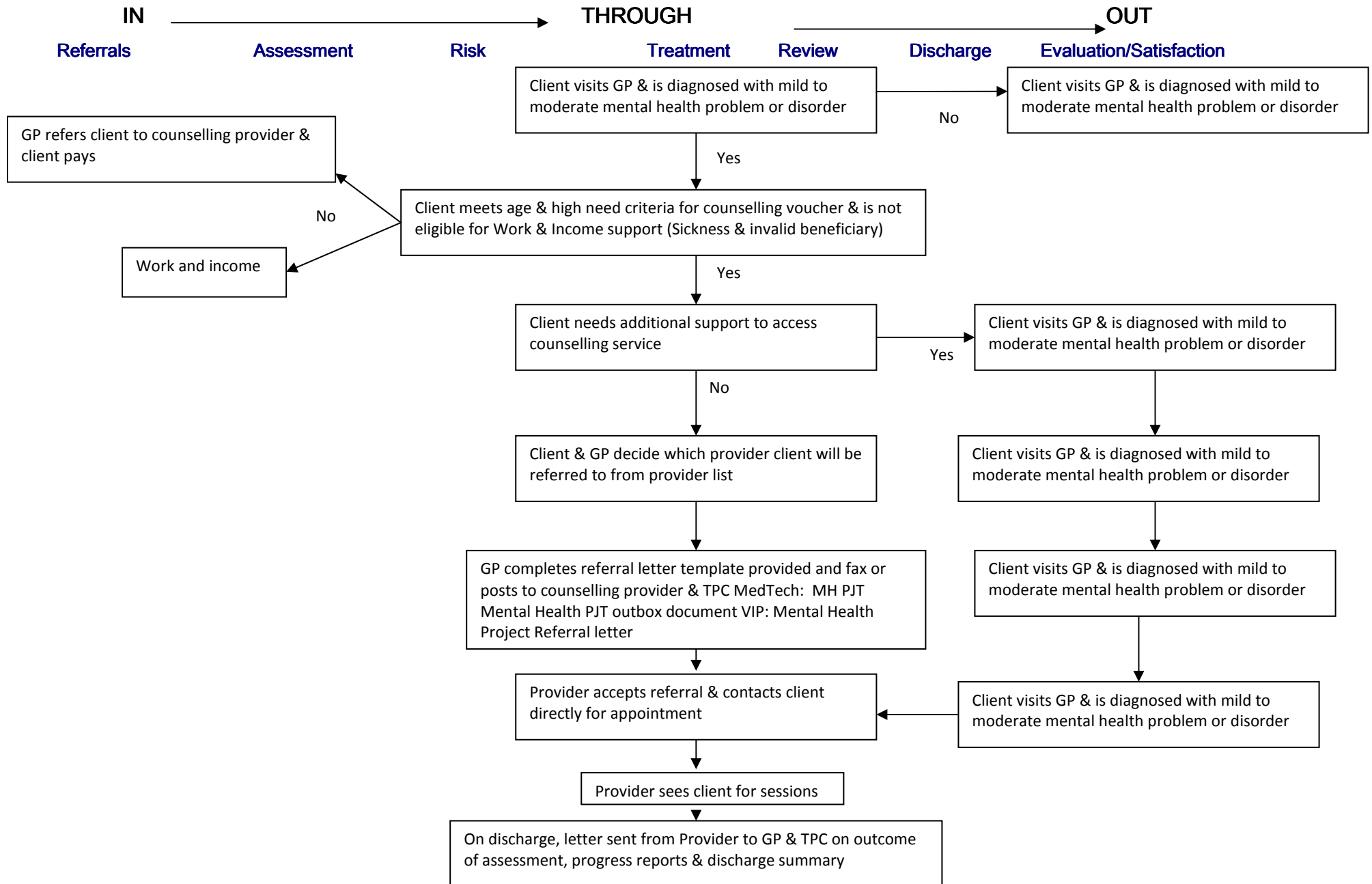
All referrals must have a Carer Support claim form when they arrive at the Trust, and it must be signed by the Full Time Caregiver but not dated.

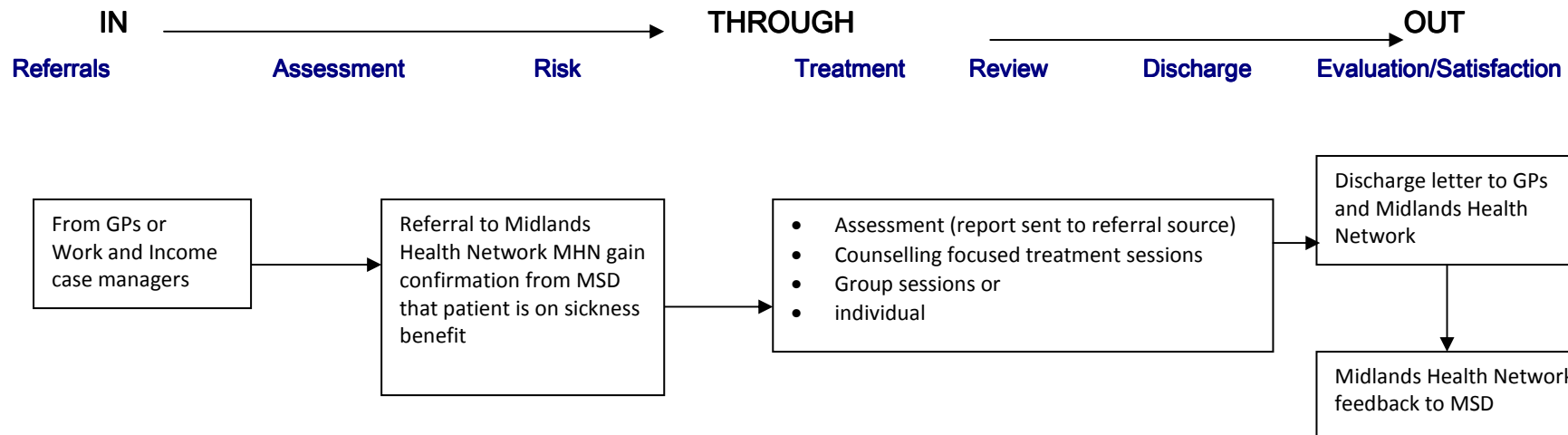
Referral to spend a designated number of days at the Trust on Carer Respite.

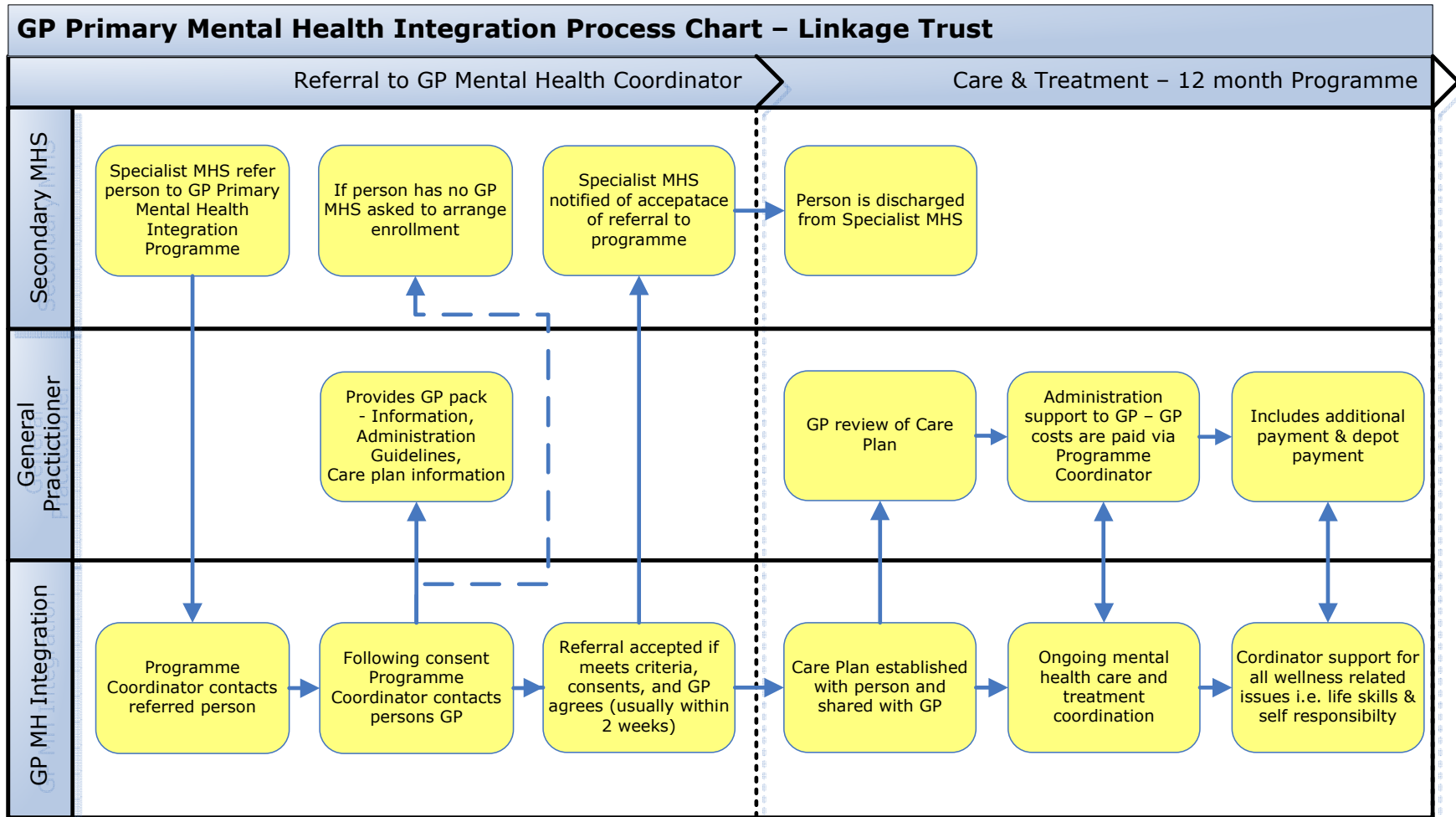
Service provided includes:
Privacy.
Rest in comfortable environment.
Med admin daily if requested.
Safe and friendly environment.
Healthy Food.
Support.

Client to exit the service after all the nominated days have been used.
Staff to sign off Carer Support Claim form for period of days used accompanied by Tax Invoice and GST Number and post to MOH Dunedin.

PROVIDER: Taranaki Primary Connections (TPC)
SERVICE TYPE (1): Primary Care Counselling Service for Enrolled Patients aged 18 years and over



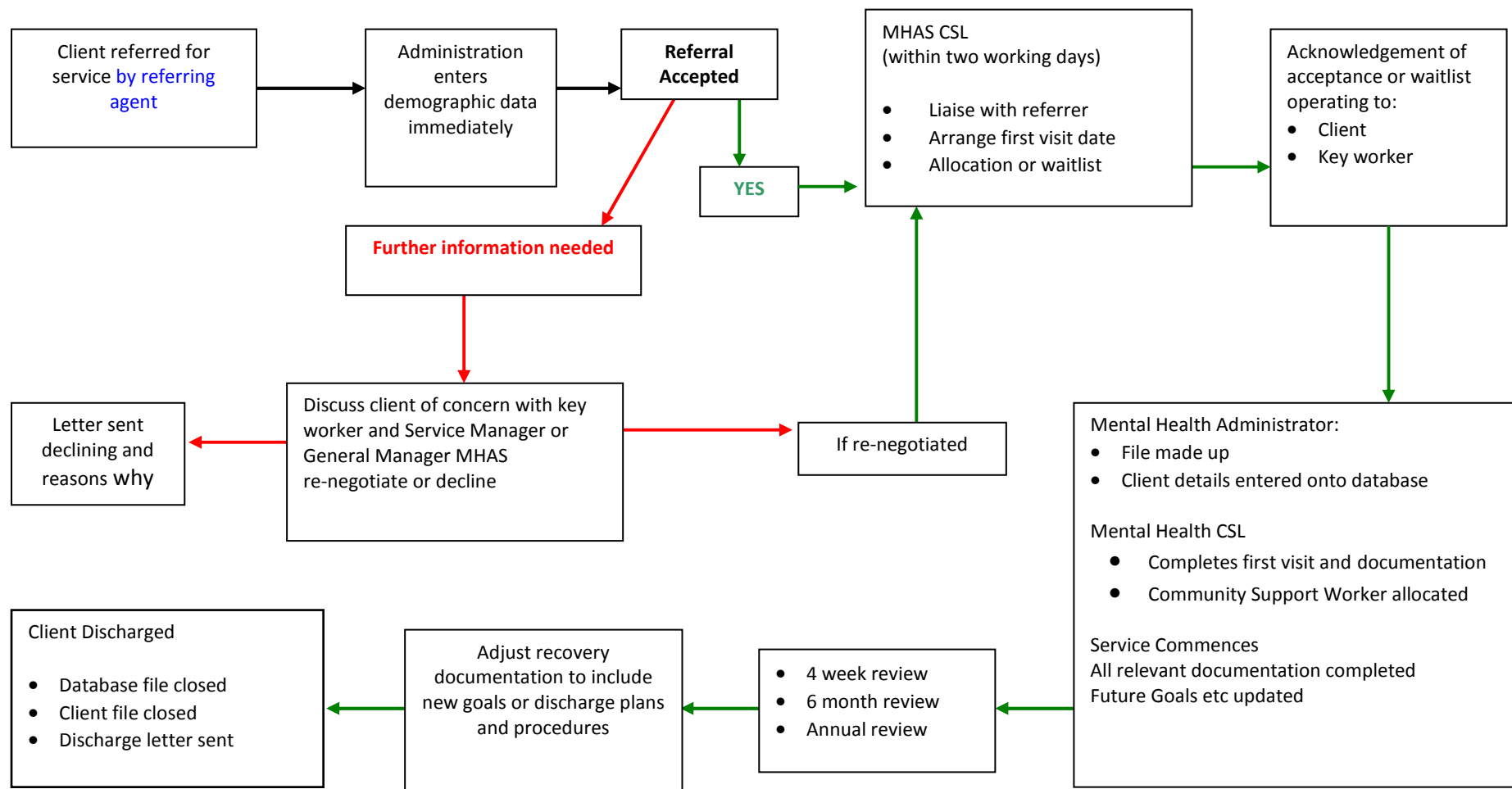


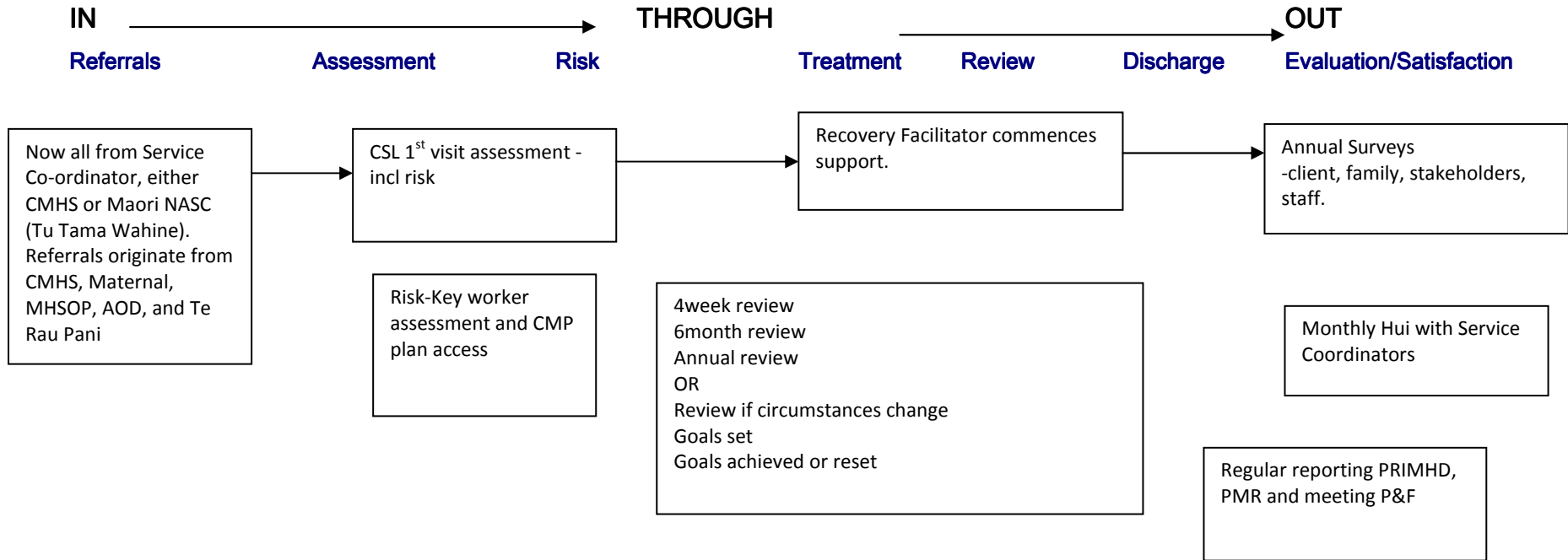


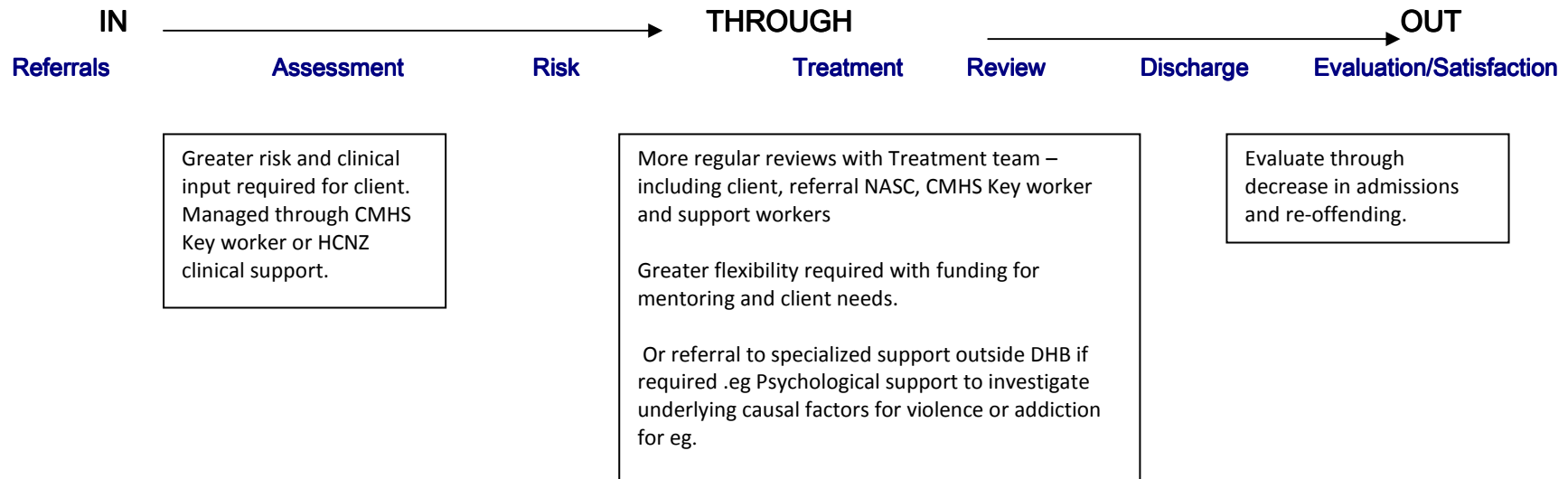
IN → THROUGH → OUT

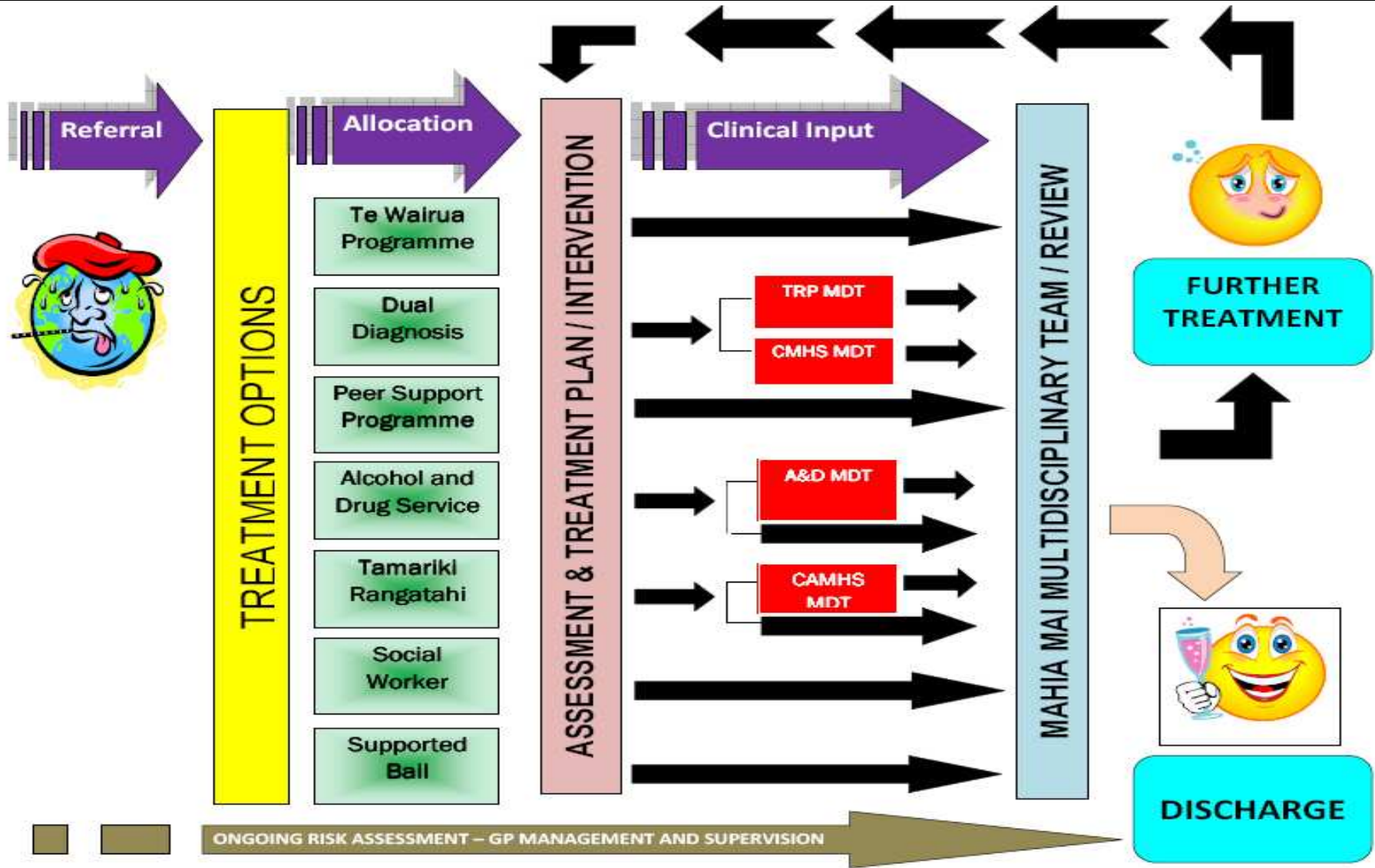
Referrals Assessment Risk Treatment Review Discharge Evaluation/Satisfaction

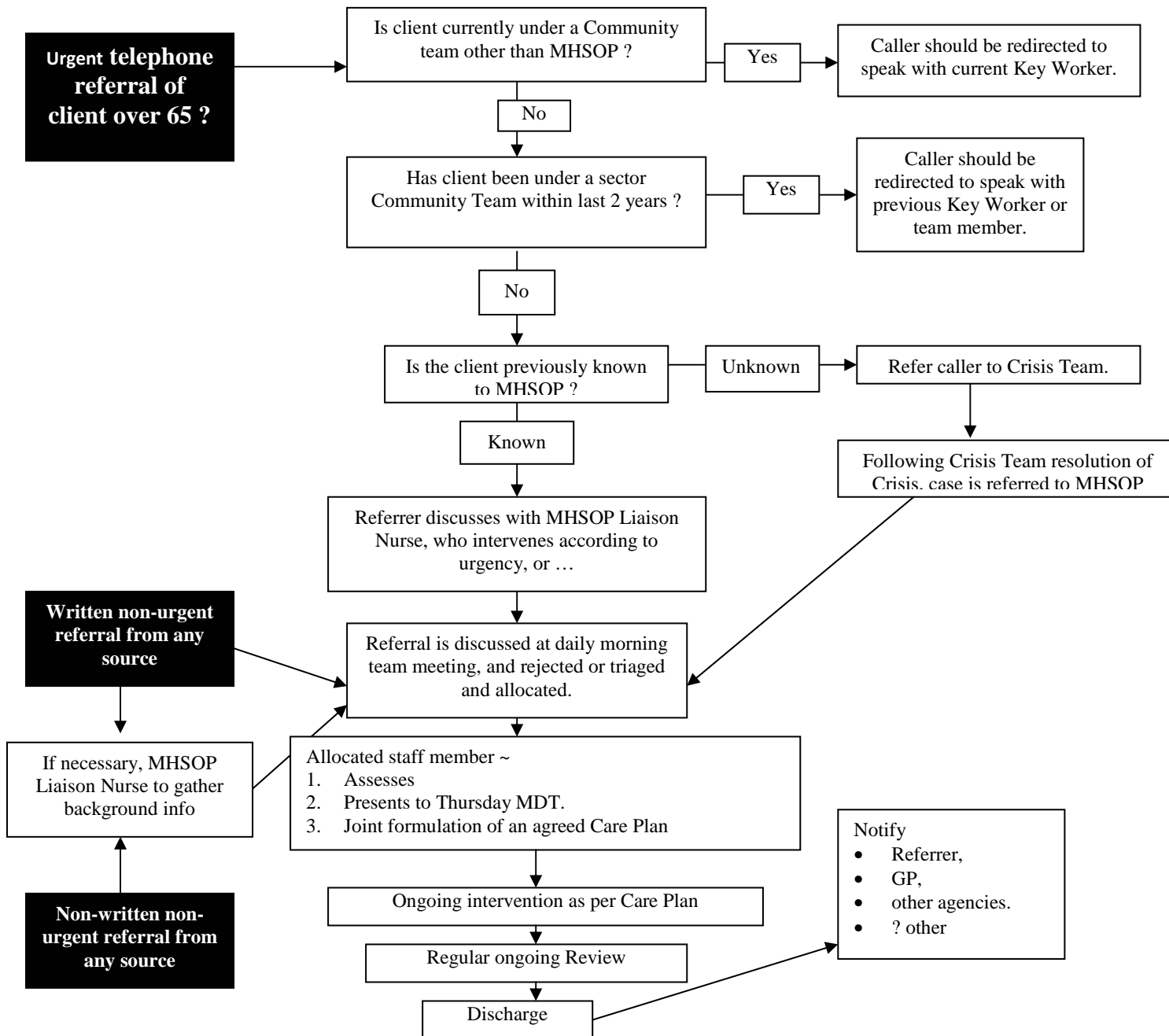
MENTAL HEALTH AND ADDICTIONS SERVICE CLIENT PATHWAY FLOWCHART

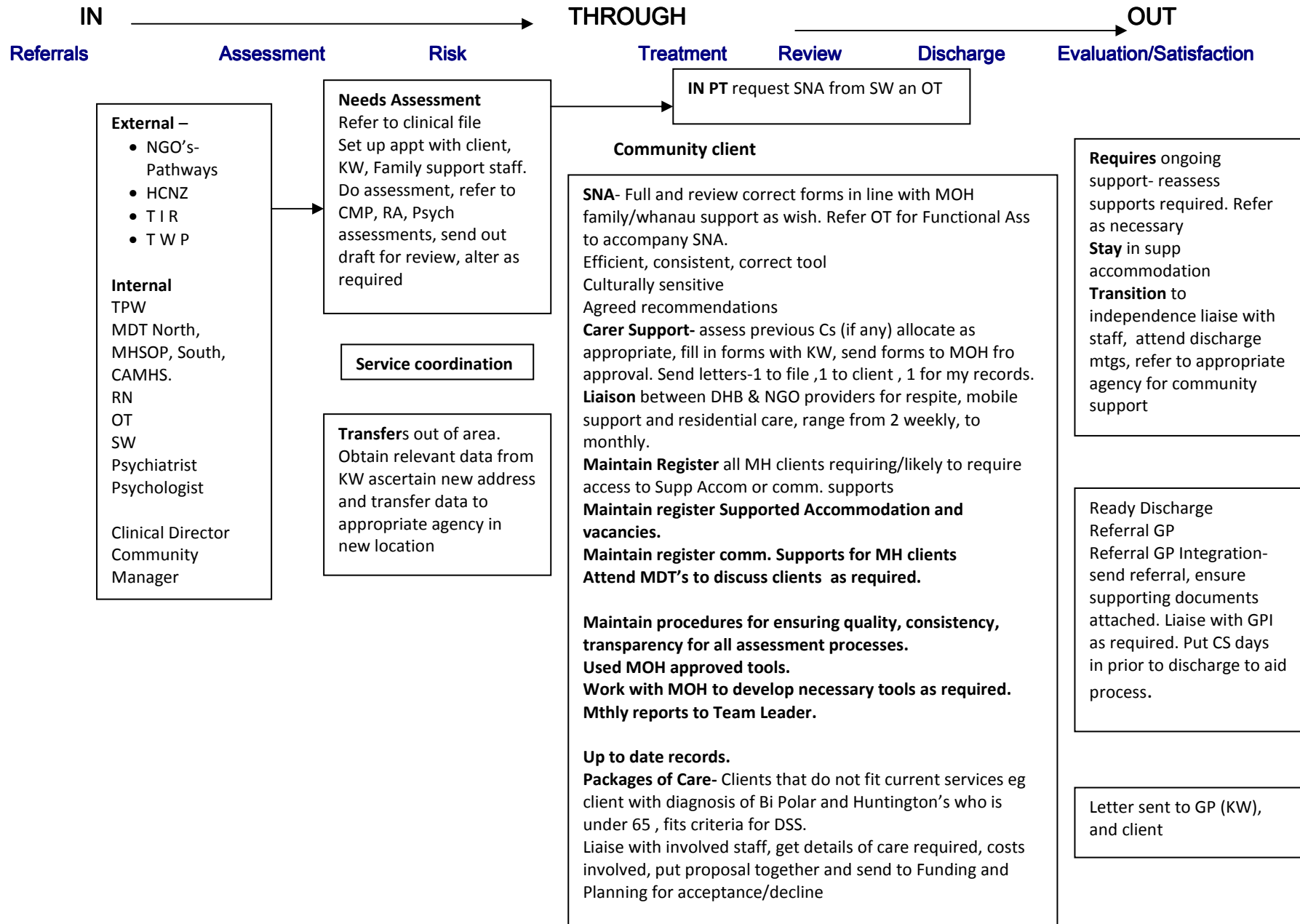


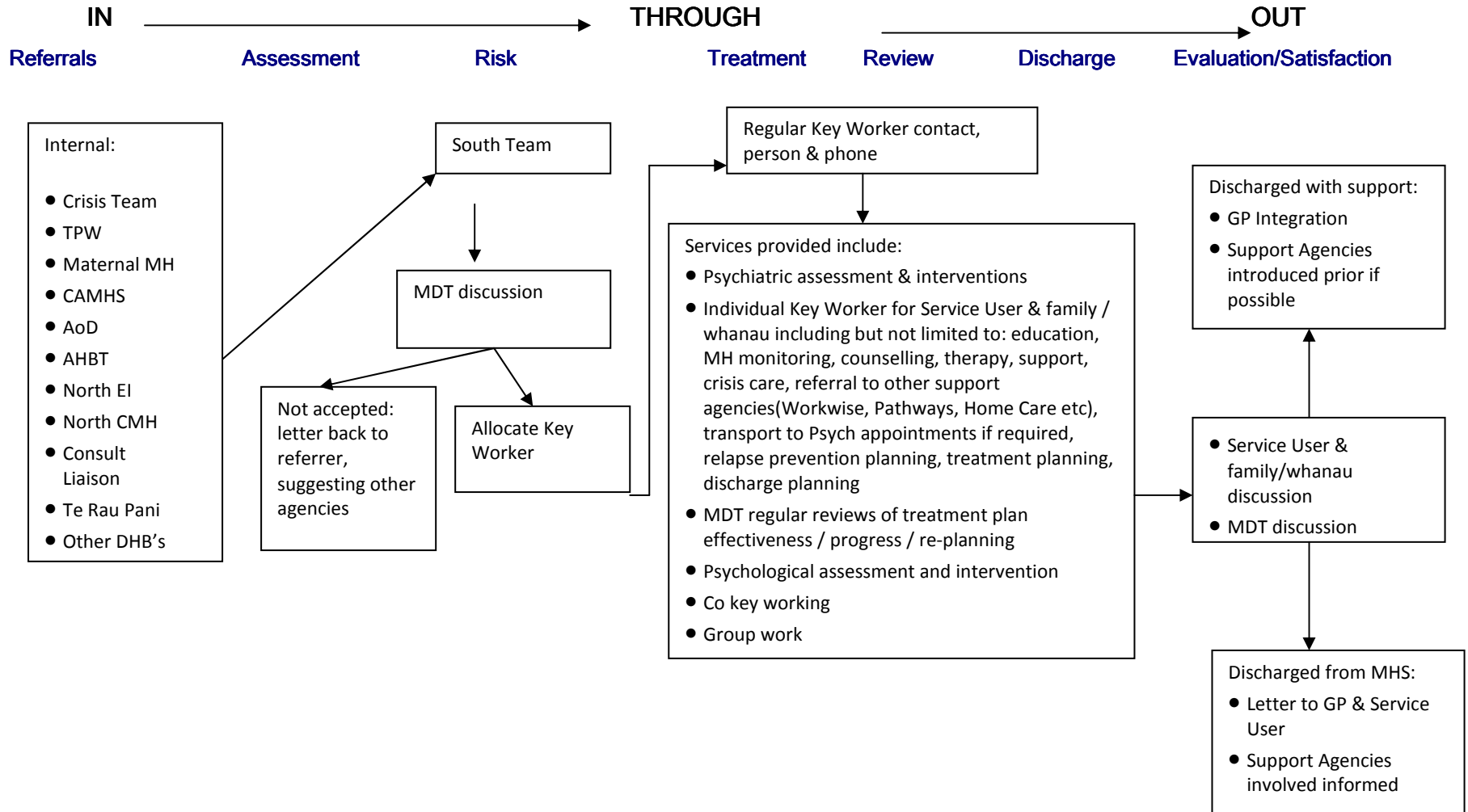


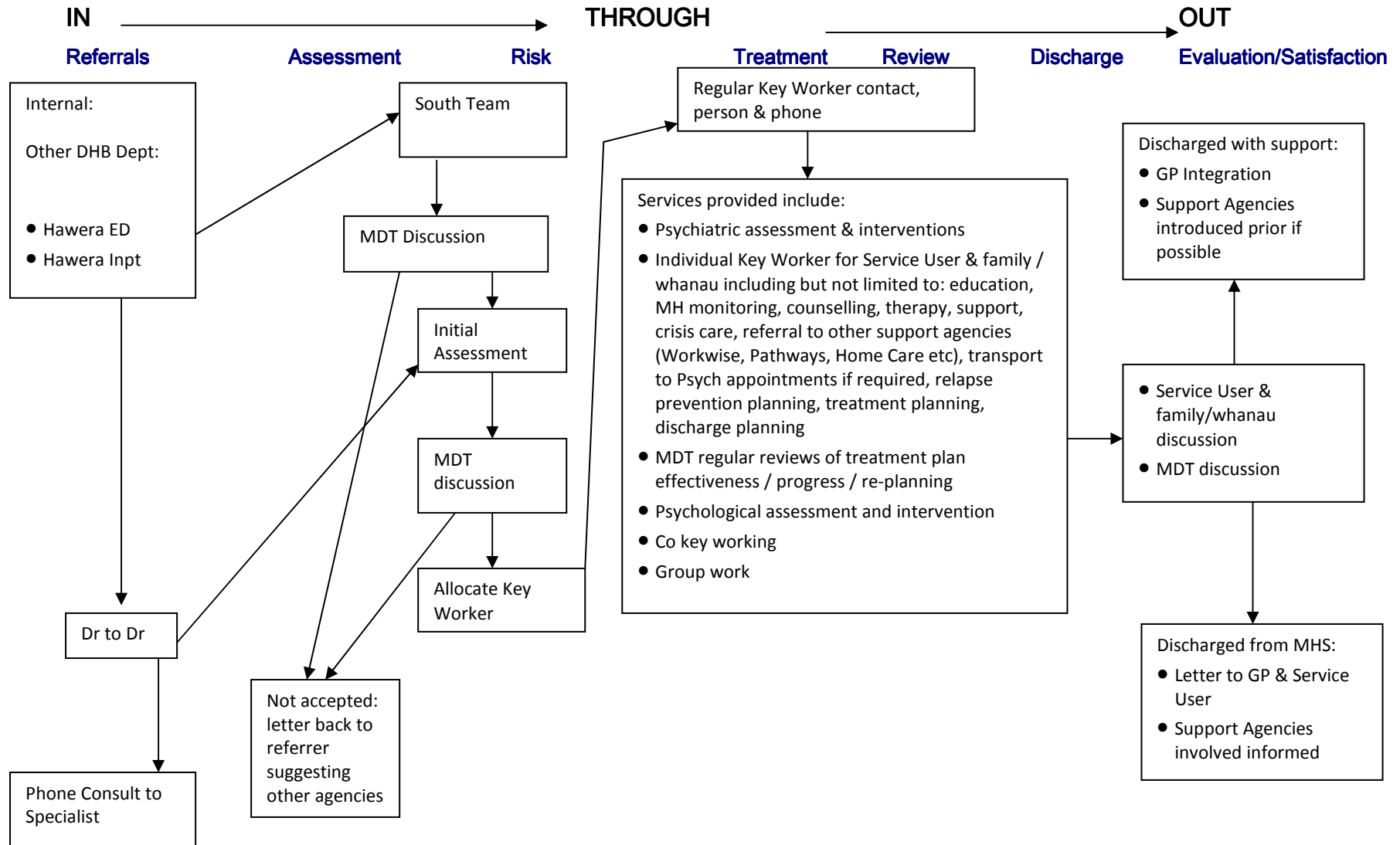






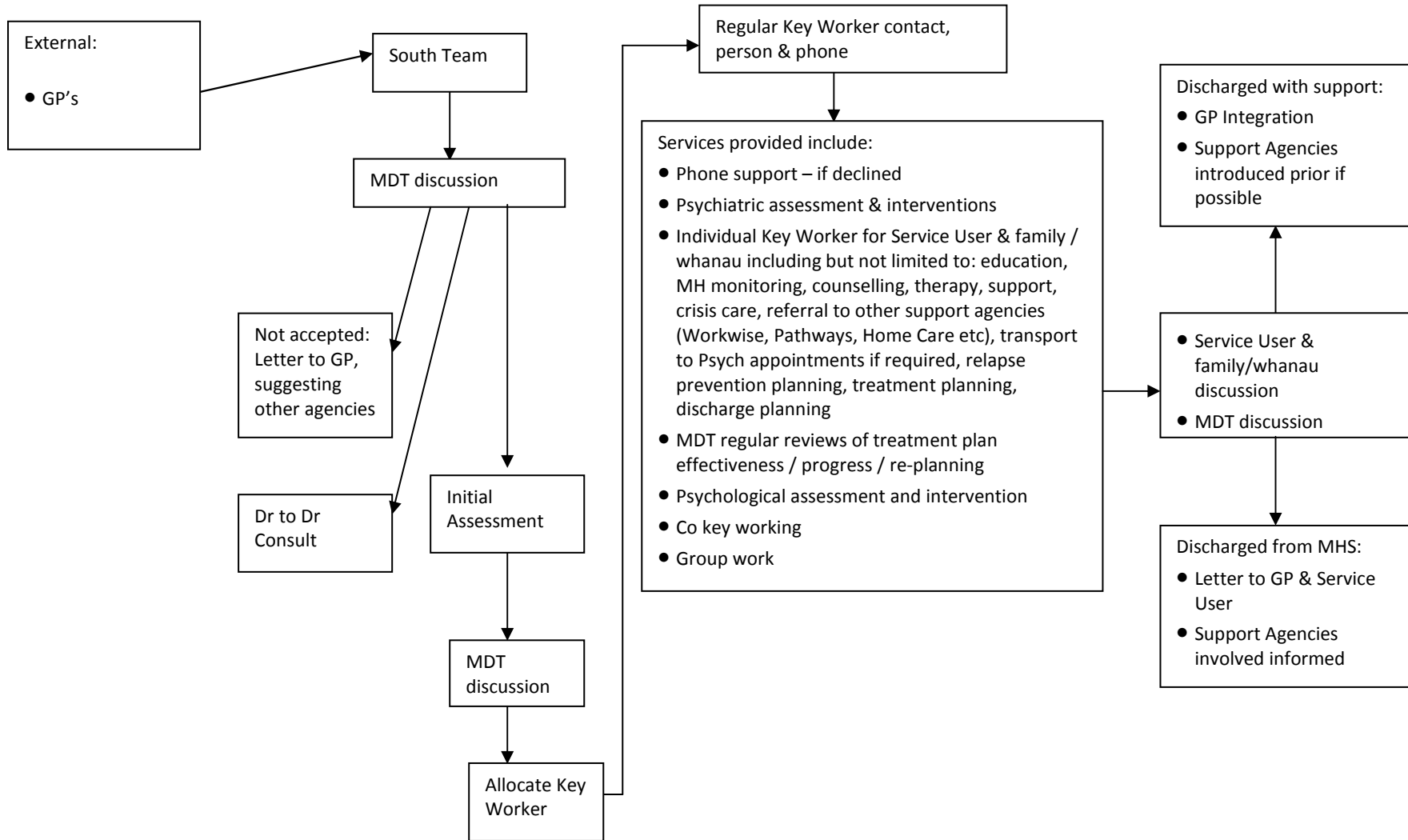






IN → THROUGH → OUT

Referrals Assessment Risk Treatment Review Discharge Evaluation/Satisfaction





Referrals into TPW
External:
 Crisis Teams /
 Police
 Psychiatry
 Liason/ED
 Intake co ordinator
 Other DHBs and
 Forensic Services
Internal referrals:
 Te Rau Pani
 MHSOP
 CAMHS
 Community Mental
 Health services.
 A&D
 AHBT

All admissions are
 accepted by relevant
 psychiatrist

Admission to
 inpatient unit for
 assessment and
 treatment, allocated
 to sector team

Further care will include MDT
 discussion with relevant sector
 team, with allocation of
 keyworker if appropriate

Asses both mental and physical health
 Care co ordination through MDT discussion and
 planning.
 Provision of education for both service user and
 family about assessment process and ongoing
 treatment planning.
 Work is done based on both medical and bio social
 models of care.
 Linkages with service providers both primary and
 secondary services.
 Work in partnership with many of these other
 services while assessment and treatment is being
 progressed.
 Focus on risk management with the least restrictive
 environment however able to utilise MH act under
 extreme circumstances.
 Work with a recovery philosophy working in
 partnership with families and service users when
 ever possible.
 Nursing lead initiatives and best practice models
 are used in all care co ordination
 Commencement of RISK, management plans and
 relapse plans, initiate referrals to other internal and
 external agencies
 Smoking cessation Drug and alcohol screening,
 metabolic monitoring commenced

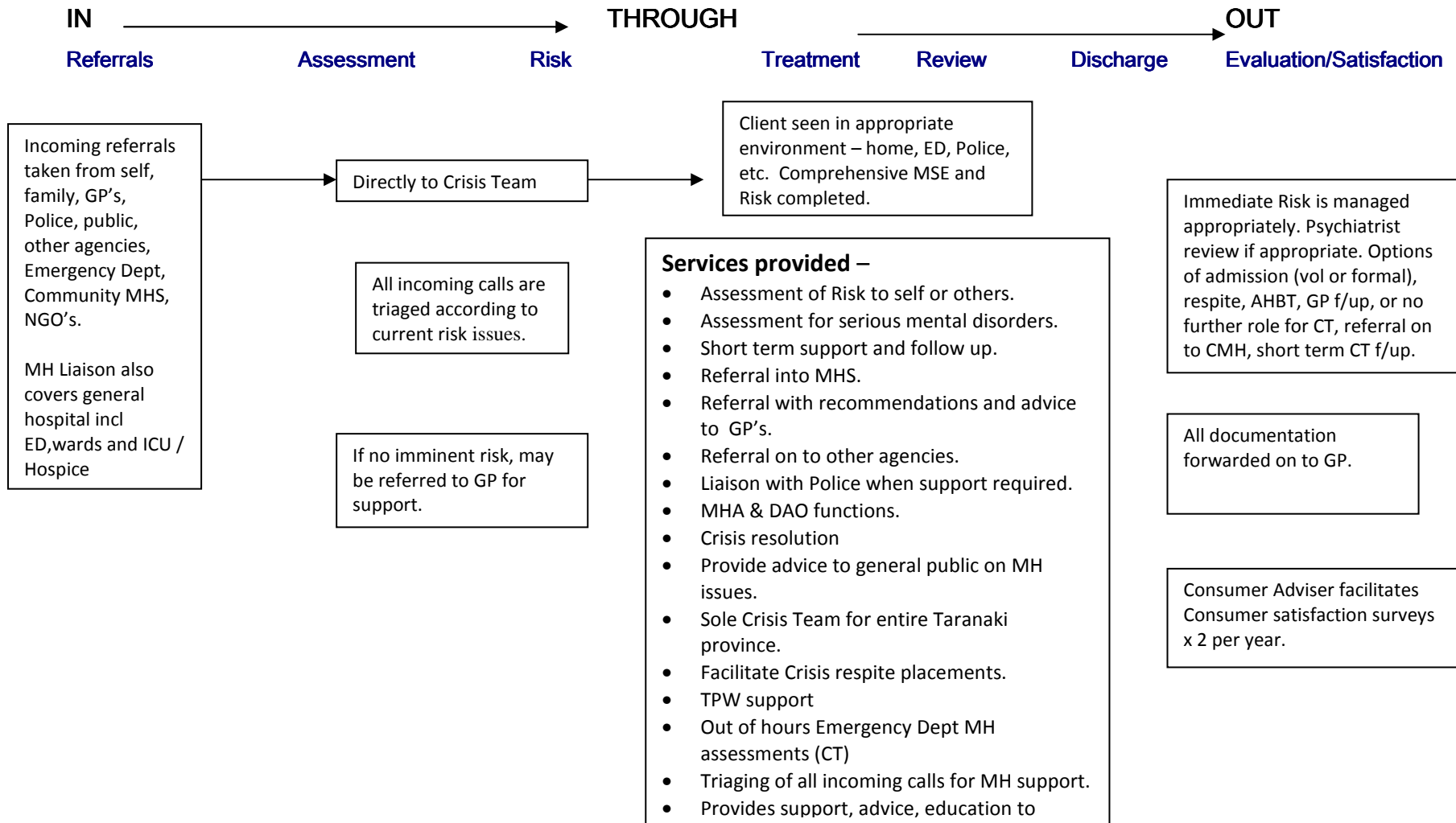
Depending on assessment
 through discharge
 planning further care in
 service or discharge to
 primary health

Requires on going mental
 health input referred onto
 appropriate Community
 MH team ; AHBT, A&D,
 STEP

Ready for discharge:
 Discussion with service
 users, family and MDT

Discharge from MH
 following discussion with
 referrer letter to GP







Allocation of key worker

Referrals from TPW. High and complex needs clients with axis I diagnosis with identified rehab needs due to extended admission to TPW

Discussion for referral from MDT. Referral or from RC

Rehab completed

- Services provided include:
- Psychiatric assessment & intervention
 - MH monitoring and support.
 - Regular reviews of Service User management plans at MDT.
 - Extensive rehabilitation plan tailored to the needs of the service user and Whanau
 - Treatment planning and options including Kaupapa cultural assessment and support.
 - Kaumatua/Kuia intervention if requested
 - Consult/liaison (co-key working if required) on discharge with existing Community Mental Health & Addiction Service
 - Assistance with finding placement for independent living or referral to supported living accommodation
 - Referral to Pathways/HCNZ for community support
 - Support with WINZ benefits
 - Consult/liaison with other healthcare providers internally and externally
 - Mental Health & Addiction information.
 - Community support services information

Discharge back to community to independent living with CMHT and key worker follow up and support

Discharged to Supported accommodation

With CMHT follow up and key worker follow

IN → THROUGH → OUT
 Referrals Assessment Risk Treatment Review Discharge Evaluation/Satisfaction

Referrals received via TPW, Crisis team, Consult Liaison nurse, Night triage CMH Teams incl of TRP, MHSOP and adult mainstream.

Go directly to AHBT RN.

Intensive goal oriented treatment occurs over 2 week time frame.

If referral not accepted, feedback given to referrer.

AHBT does not cover CAMHS or AOD clients

- Treatment/service options include:
- Early discharge from TPW
 - Alternative to admission to TPW
 - Education about Mental Illness, medication,
 - Teaching self soothing/ coping skills.
 - CBT input
 - Support with interface with various community agencies.
 - Monitoring of mental state.
 - Ongoing Risk assessment
 - Monitoring medication compliance
 - Daily medication supervision.
 - Liaison with Adult/MHSOP community MH teams.
 - Liaison with GP's
 - Short term Psychology input
 - Short term Social Worker support
 - Short term Occupational Therapy input.
 - Highly mobile intensive service
 - Support with Social systems crisis
 - Whanau support
 - Treatment in least restrictive environment
 - Integration back into community

Discussion with treating Psychiatrist re referring to CMH team or back to GP care.

Review by Psychiatrist once while with AHBT

Evaluation forms sent to every client on discharge.

