



# **Mental Health and Addiction services Service Specification Tier 1**

**September 2024**

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## 1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY  RECOMMENDED

## 2. Review History

Review History	Date
First Published on NSF Library	June 2009
<b>Amended:</b> Section 9.1 National collections workforce reporting and 9.1.2 Additional Reporting Items for NGO Providers <u>only</u> : Organisational Governance.	April 2011
<b>Amended:</b> Section 9. Added purchase unit codes MHFF, MHSD, MHQU and MHWF that do not have nationwide service specifications but are covered under this Tier One specification.	July 2012
<b>Amended:</b> Background content to reflect current policy requirements	October 2013
<b>Amended:</b> Updated link to Health and Disability Services Standards	June 2014
<b>Amended:</b> Added new purchase unit code MHFF0001	August 2015
<b>Amended:</b> referenced the refreshed NZ Health Strategy 2016, added explanation about primary mental health, moved wording from Background to service definition and service user sections, removed reporting requirements section, and referenced Mental Health and Addiction services data definitions.	April 2017
Moved to Health NZ template. Updated links for PUDD and NSFL only. Amended DHB to become District/Region where appropriate. No other changes to content made.	September 2024
Consideration for next Service Specification Review	Within five years

**Note:** In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-

2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

### 3. Introduction

The full continuum of publicly funded mental health and addiction care includes health promotion, prevention, primary, secondary and tertiary services.

Mental Health and Addiction service specifications cover specialist mental health and addiction services targeted at those most severely affected by mental illness or addiction. However, it is recognised that a focus on early intervention and integration between specialist, primary and community services will lead to increased access for those who may be more at risk of developing mental health or addiction issues.

Primary mental health services provide a general primary care response to the needs of people of any age with mild or moderate illness. The national expectations are outlined in the primary health strategy and are excluded from this suite of service specifications.

This tier one service specification provides the overarching specification for all publicly funded specialist mental health and addiction services (the Service). The tier two and tier three service specifications are used with this service specification to provide additional service-specific detail. Refer to the accompanying glossary for definitions of terms used within the tier one, two and three service specifications.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017 sets the direction for service delivery across the health sector over the next five years. The primary focus of Rising to the Challenge is to assist health services to collectively take action to achieve four overarching goals in the table below.

#### The ABCD overarching goals and desired results

Overarching goal	Results we wish to see
A Actively using our current resources more effectively	Increased value for money
B Building infrastructure for integration between primary and specialist services	Enhanced integration
C Cementing and building on gains in resilience and recovery for: <ul style="list-style-type: none"> <li>i. people with low-prevalence conditions and/or high needs (psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions)</li> <li>ii. a) Māori b) Pacific peoples, refugees, people with disabilities and other groups</li> </ul>	Improved mental health and wellbeing, physical health and social inclusion Disparities in health outcomes addressed
D Delivering increased access for: <ul style="list-style-type: none"> <li>i. infants, children and youth</li> <li>ii. adults with high-prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms)</li> </ul>	Expanded access and decreased waiting times in order to: <ul style="list-style-type: none"> <li>• avert future adverse outcomes</li> <li>• improve outcomes</li> </ul>

Overarching goal	Results we wish to see
iii. our growing older population	<ul style="list-style-type: none"> <li>• support their positive contribution in the home and community of their choice</li> </ul>

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017<sup>1</sup> seeks to improve outcomes for all people with mental health and addiction issues. It also seeks to improve the integration of and quality of services to reduce disparities. A key step in achieving these goals is through developing a culture of responsiveness where Service Users, families, whānau and significant others are actively supported and involved in treatment and recovery.

The refreshed New Zealand Health Strategy outlines the high level direction for New Zealand's health system to improve the health of people and communities. It has been developed to guide change in the system and has two parts, the Future Direction and the Roadmap of actions 2016. The strategy describes new ways of working so that all New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system (Ministry of Health 2016, p 13).

Social and economic inequalities are associated with poor health outcomes. Section four of the Mental Health and Addiction Service Development Plan has a focus on building on gains in resilience and recovery for Māori and Pacific peoples, refugees, people with disabilities and other groups. The expected result is consistent mental health and addiction outcomes for all.

It is unlikely that any single provider will deliver the full range of services, therefore all services in the mental health and addiction sector must work collaboratively and co-operatively to provide a well-integrated and seamless continuum of care. Effective, robust planning and partnerships within and across health service providers, other government-funded services and private sector service providers are critical in enabling better recovery outcomes for Service Users, their family, whānau and communities.

## 4. Service Definition

Specialist mental health and addiction services are delivered to those eligible people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. However, it is recognised that a focus on early intervention strategies will mean services may be delivered to people who are at greater risk of developing more severe mental illness or addiction.

To the extent that funding for specialist mental health and addiction services does not support coverage for all target populations, it is expected that District Health Boards (DHBs) will have criteria in place for prioritising the provision of services, to people with the highest level of need.

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<sup>1</sup> <http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017>

## 5. Service objectives

These following objectives have been developed in collaboration with, and should apply to all specialist mental health and addiction services:

### 5.1 Services will be responsive

Responsive services adapt to meet the unique needs of specific population groups and individuals. This is achieved through being flexible around service delivery settings in both urban and rural areas and adaptable to the Service Users' individual circumstances and needs, including cultural and spiritual needs. Services should be age and gender appropriate.

Responsive services focus on recovery, reflect relevant cultural models of health and take into account the clinical and cultural needs of people affected by mental illness and addiction. Services working together will also ensure adequate referrals between mainstream services and those developed to meet the unique needs of specific population groups.

Service delivery should be flexible and responsive to the local situation, national direction and future innovation and evidence.

Where services have smoke-free policies, Service Users should be routinely offered advice on how to quit smoking and should have access to appropriate cessation supports, including nicotine replacement therapy (NRT) products.

### 5.2 Māori Health

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to, matters such as referrals and discharge planning, ensuring that the services are culturally competent and that services are provided that meet the health needs of Māori. Actively involve tangata whenua in planning for mental health and addiction services.

### 5.3 Responsive to Māori

The overall aim of *Te Puāwaiwhero*, is whānau ora, that is Māori families achieving their maximum health and wellbeing. Kaupapa Māori services working together with Whānau Ora providers will support positive outcomes for those using infant and child services.

### 5.4 Responsive to Family and Whānau

Family and whānau are critical to successful recovery. Services will acknowledge the particular role the Service User plays in their family and whānau. This may include their role as parents or carers. For most Service Users, family and whānau plays a key role in the road to recovery. There are significant clinical, social and economic advantages to providing mental health and addiction services in a family inclusive way. Services need to listen to

family and whānau and respond to their specific needs, including providing education on recovery and referral of family and whānau to appropriate support services.

## **5.5 Recovery Focused**

Recovery is defined as the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential. Recovery is different for everyone; therefore there should be a range of service models and flexibility of services. For those with addiction problems, recovery is a process whereby Service Users are assisted to minimise harms and to maximise wellbeing. Recovery may or may not involve abstinence.

## **5.6 Foster Resilience**

Resilience can be encouraged through a continuous process where individual and family whānau capacities are recognised along with protective factors in the community. Building upon and fostering these factors can help people counter life challenges such as mental illness and/or an addiction. Strength-based approaches help to promote engagement and build resilience.

## **5.7 Encourage Natural Supports**

Supports may include family whānau, partners, friends, neighbours, colleagues or those from an identified group. Mental health and addiction workers will foster relationships with natural supports, as defined and chosen by the Service User, as supports play an important role in building resilience and recovery.

## **5.8 Promote Independence**

Services should support individuals to live as independently as possible within the context of their treatment and support needs, and in an environment that is consistent with these goals.

## **5.9 Support Service Users to Make Informed Choices**

All providers need to ensure information about services is available and easily accessible to Service Users and their family and whānau. Service Users should be informed of their choices and options for care.

## **5.10 Reduce Inequalities**

A desired result of Rising to the Challenge is to see disparities in health outcomes addressed. Social and economic factors, such as income, poverty, employment, education and housing, have been cited as contributing significantly to mental health and addiction status. It is acknowledged that socioeconomically disadvantaged groups bear a disproportionate burden of risk for mental ill health. This highlights the importance of mental health and addiction services, to co-ordinate and co-operate with other government agencies, such as, housing, employment and education. Responsiveness to infants, children, adolescents and youth is critical to interrupt cycles of mental illness and addiction within families, whānau and communities.



## 5.11 Promote Seamless and Integrated Services

An overarching goal for Rising to the Challenge is building infrastructure for integration between primary and specialist services. Service Users may be receiving care/treatment for both addiction and mental health issues. Both types of services need to be provided in a seamless way. It is vital that 'any door is the right door' and the mental health and addiction sector must build capacity and capability to respond to co-existing disorders.

Mental health and addiction Service Users may also access other services. Services should work together to determine shared care arrangements that best meet the Service User's needs. It is important that those with a mental illness and/or addiction also have their physical health needs met.

Increasing recognition by the Justice system of the need for health interventions for offenders requires mental health and addiction services to interface well with the Justice system. This population is particularly high risk, with a high incidence of co-existing disorders.

## 5.12 Develop Organisational Governance

Organisational governance structures contribute to the stability and viability of organisations. A strong and active engaged board that is structured to provide fiscal oversight, has the skills and experience to work alongside other mental health and addiction organisations to deliver seamless, well-integrated services and meet the organisation's governance needs is promoted.

## 5.13 Develop Workforce

Workforce development needs to be part of the focus for every service. This development involves building the capacity and capability of the Service providers to work in partnership with the Service Users. Investment in the development of the mental health and addiction workforce is key to ensuring the delivery of effective services. Integrated care and treatment can be achieved through the establishment of a competent workforce appropriately trained to recognise and respond to mental health and addiction issues.

*Let's get real: Real Skills for people working in Mental Health and Addiction* (Ministry of Health 2008) is a framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services.

Rising to the Challenge will deliver a national workforce development plan which considers:

- new ways of working
- new roles to complement existing staff groups
- future services, changing demography and future demand for services.

## 5.14 Value Lived Experience

People with a lived experience of mental illness and addiction offer a unique contribution to services. The important perspective of those with a lived experience should be utilised in the planning and implementation of services. Services should foster a culture that promotes Service Users participation and recovery. Real life examples of recovery can offer hope to Service Users. Service Users should be encouraged into a range of roles, both within consumer-led services and across the continuum of services.

The valuable perspective and experience of family and whānau supporting a loved one with a mental illness and / or addiction should also be seen as an asset within the mental health and addiction workforce.

## 6. Service Users

A Service User is an eligible person/people<sup>2</sup> deemed to receive or be receiving publicly funded specialist mental health and/or addiction services for those who are most severely affected by mental illness or addiction.

Specialist mental health and/or addiction services includes healthcare, health information, or support services resulting from direct contact with a healthcare provider where the healthcare results in use of resources associated with observation, assessment, diagnosis, consultation, rehabilitation or treatment. This includes ongoing support, education, training, or ensuring or monitoring compliance with relevant legislation.

## 7. Access

### 7.1 Entry and Exit Criteria

Referrals to the Service may be made from any source, including self-referral. Some speciality services have specific requirements before accepting a referral. In these circumstances, services need to have clear documented access criteria and protocols, and ensure these are communicated with family, whānau and others making contact with the Service.

On referral (including self-referral), the criteria for assessment is based on the person having a suspected, developing or identifiable mental illness, and/or an addiction problem.

Services may prioritise referrals based on:

- clinical assessment about need and the severity of the mental illness and/or addiction
- the likely impact the mental illness and / or addiction will have on the person's ability to participate in activities of daily living, work, education and community life, and their role as a family and whānau member
- relevant legal requirements including the Mental Health Compulsory Assessment and Treatment (CAT) Act 1992 and Alcoholism and Drug Addiction Act 1966
- the safety of the individual and/or of others such as family members
- patients may exit the Service by transfer, discharge from the Service or death
- the Child Health Strategy (1998), defines a child as being aged from before birth to 14 years, and further identifies that young people up to the age of 18 years should be given care within the most developmentally appropriate services, as young people have specific developmental needs which require that they are cared for in youth

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<sup>2</sup> Not all patients who are referred or present to the Service are eligible for publicly funded services. Refer to [www.moh.govt.nz/eligibility](http://www.moh.govt.nz/eligibility) for more eligibility information.

appropriate settings. It is also necessary to recognise that the transition to adult services must occur at the appropriate time

on entry to the Service, the most appropriate course of action will be discussed in consultation with the Service User and their family and whanau. This will be based on needs, strengths, mental health and /or status and supports. Service Users must be informed of their choices and options for care in line with consent protocols.

## 7.2 Distance

Services will be delivered locally where possible. DHBs are also expected to have in place arrangements that ensure the people of their DHB area have access to regionally and nationally provided mental health and addiction services.

## 7.3 Timeliness of Service

When assistance is required under the Mental Health (CAT) Act 1992, 90% of people presenting should be assessed within four hours. DHBs with isolated rural communities will ensure that effective arrangements are in place.

If a person is assessed as needing hospital care under the Mental Health (CAT) Act 1992, 90% should be admitted to a hospital within six hours of being assessed by a doctor or health professional.

The DHB will ensure that crisis services to deal with a critical or urgent mental health and/ or addiction needs will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act) as follows:

- telephone or other remote assistance will be available at all times with minimal delay
- where telephone assistance is insufficient to meet the person's needs, direct contact with a clinician will be provided within four hours; DHBs with isolated rural communities will ensure that effective arrangements are in place
- other services will be arranged when required, including acute inpatient admission and crisis respite.

People are seen and assessed as needing services will receive those services as soon as possible. For some services, there may be a wait before treatment can begin (eg, opioid substitution programmes.)

Note: until a person is assessed, it will not be known whether they fall under the Mental Health (CAT) Act 1992.

# 8. Service Components

## 8.1 Processes

Processes occur as part of a Service User pathway. Processes that include: health education, health promotion, engagement, assessment, diagnosis, treatment, rehabilitation,

onward referral, family support, case management, liaison and consultation and ongoing support.

At all stages of this pathway, skilful engagement, consultation and, where appropriate joint care planning between services will be used to ensure the needs of the Service User are identified and responded to. Service Users and their family and whānau should be encouraged to participate in evaluation/review at each step. Appropriate risk management procedures should also be put in place for the safety of the Service Users, staff and others.

## **8.2 Assessment**

Assessment will be appropriate and sufficiently comprehensive for the purpose of the particular service. It forms the basis of the recommended treatment, intervention or support and must be completed by staff with the required competency, knowledge and skills.

The assessment process will vary and take into account individual circumstances and, as well as the Service User, will include agreed family, whānau and support people where practicable. The assessment will take into consideration cultural needs. A full explanation of the process must be provided and reiterated to the Service User and those accompanying them.

The assessment will help develop an initial recovery plan, which will include treatment, intervention or support options, appropriate risk assessment/management and the plan for discharge. Recovery plans will be developed in a collaborative process with Service Users, their family and whānau and support networks and will address their broader physical, spiritual, social and psychological needs and aspirations. The recovery plan will be discussed with the Service User, and informed consent must be sought. There will be a process in place for reassessment. The assessment process should take into account identification of parental roles and responsibilities. Because the Service Users may be linked into several different services, all will contribute to the overall recovery plan.

## **8.3 Treatment, Intervention and Support**

Treatment, intervention and/or support are the key focuses for the Service delivery. The models for treatment, intervention and/or support will vary, and are described in further detail in tier two and three specifications.

After the initial assessment, treatment, intervention and/or support options will be recommended specific to the Service Users' individual needs and circumstances. The recovery plan will be developed collaboratively with the Service User and, if appropriate, their family and whānau that will identify goals towards discharge and outline supports to assist the person to achieve those goals. It will include early warning signs, wellness maintenance, relapse prevention information and may include advance directives. Recovery plans will address the Service User's broader physical, spiritual, social and psychological needs and aspirations. Recovery plans will be kept current by regular review. Evidence-based, best practice education and information will be proactively provided to Service Users and their family and whānau. The Service User will give written informed consent for treatment, intervention and/or support and will receive a copy of their recovery plan.

More positive outcomes occur when people are able to easily access services, and when services show flexibility and encourage Service User participation within clearly communicated and coherent treatment programmes. Information should also be provided about the role of family and whānau and the supports available to them, and other social networks.

## 8.4 Review Process

This is the process of formally reviewing recovery plans, goals and outcomes both with the Service User and in a multi-disciplinary setting. Reviews must occur at a minimum of every six months but the frequency will be determined by the Service User's individual circumstances, for example, their specific goals and the specific role of the service involved. In the addiction sector it is recommended that a review of progress is more frequent, occurring at a minimum of once every four months.

The review will include the Service User and with their consent, their family and whānau. Reviewed outcomes and new treatment goals will be reflected in ongoing recovery plans.

## 8.5 Discharge

Discharge is a planned process that is part of the recovery plan. It should begin from when the service is accessed. Discharge planning must involve Service Users and, with their consent, be communicated to all relevant support people. It will include reassessment of risk, the relapse prevention plan and follow-up arrangements. Discharge planning may also include advance directives and will identify medication on discharge and education about this. The Service Users, family, whānau and other services and agencies involved should be informed of how to re-engage with the service if required.

A discharge summary will be given to the Service User and, where relevant, the general practitioner/primary care provider and support people.

## 8.6 Settings

The Service will be provided in the appropriate setting to provide the desired health outcomes. A consideration in determining the settings for the service should include (but not be limited to) issues such as cultural appropriateness, accessibility, gender, age and developmental stage, and the most effective and efficient use of resources. Services may be provided using hospital settings such as inpatient and day hospital, and outpatient settings such as those community based and mobile services. Some services may be electronic, such as e-therapies.

## 8.7 Support Services

The following support services, if required, are to be provided as an integral part of the Service.

- clinical support services such as: laboratory, pharmaceutical, pathology
- allied health support services such as: dietetic, physiotherapy, social work and counselling service
- ancillary services such as: sterile supplies, laundry and cleaning, occupational health, infection control
- interpreting services (including sign language)
- chaplaincy services
- corporate services such as: human resource department, legal, finance.

Additional support services if any are listed in the appropriate tier two and three service specifications.

## 8.8 Key Inputs

The key input for mental health and addiction services is the workforce and national electronically delivered programmes such as the National Depression Initiative<sup>3</sup> and Like Minds, Like Mine<sup>4</sup>.

## 8.9 Pacific Health

Mental Health and Addiction Services for Pacific are underpinned by the Ministry of Health strategic document *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018*. Pacific peoples share similar risk factors to Māori in terms of health and social inequalities. *Te Rau Hinengaro*. The New Zealand Mental Health Survey (Ministry of Health 2006) confirms that Pacific peoples experience mental illness at higher levels than the general population. Pacific people are also less likely to access treatment than the total New Zealand population. The service must take account of key strategic frameworks, principles and be relevant to Pacific health needs and identified concerns.

For regions that have significant Pacific populations, the service must link service delivery to the improvement of Pacific health outcomes. Health service providers should also ensure that their service provides a holistic approach to health and wellbeing, assessment and treatment for Pacific peoples. This approach should include focusing on family, relationships, spiritual, physical, language, cultural, emotional and mental dimensions.

## 8.10 Health for other Ethnic Groups

Mental health and addiction services will be relevant and responsive to the diversity of cultures within local communities. Services will recognise resources, relationships and other protective factors in the community that will empower and promote wellbeing. Services will deliver culturally appropriate care, considering the individual ethnic, spiritual and cultural beliefs of those served.

Service planning, development and delivery will ensure that people are not discriminated against or disadvantaged. Mental health and addiction services will acknowledge that different cultures come with varying perspectives. Mental health and addiction services shall demonstrate effort to recruit staff from different cultures to reflect and match the cultural needs of people from Asian, migrant and refugee backgrounds in the community. Services will take steps to ensure that the mental health and addiction workforce is culturally competent and that qualified interpreters are available to provide maximum access for ethnic/cultural communities.

## 9. Service Linkages

Service linkages are requirements regarding linkages to other related services and provide a description of such links. The costs of such services are not included in the price of the

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<sup>3</sup> [www.ndi.org.nz/index.php?q=content/welcome](http://www.ndi.org.nz/index.php?q=content/welcome)

<sup>4</sup> [www.likeminds.org.nz/](http://www.likeminds.org.nz/)

Service, however, the costs of liaison and linkages with these services are included within the Service Purchase Unit price.

Service Provider	Nature of Linkage	Accountability
Other primary, secondary and tertiary services that the service refers Service Users to	Refer and access to skills, expertise and resources within other disciplines ie medical services, surgical services	Referral processes and protocols are in place include mechanisms for shared working where appropriate. Services assist the Service User to access the other services that are required
Supporting services not purchased within this service specification	Provide continuity of care and facilitate access to services that best meet the needs of the Service User	Knowledge of other services within a district maintained Relationship with other providers through stakeholder networks
<p>Publicly funded disability or long term support services for the Service Users with co-existing disabilities/ conditions who meet other funding streams eligibility criteria such as:</p> <p>Needs assessment and service co-ordination (eg, NASC)</p> <p>Specific support services such as: home and community support; carer support and respite; residential services; supported independent living; habilitation/rehabilitation; other specialist support services, as appropriate</p> <p>Environmental support services (eg, long-term equipment, including specialist assessment services, home modifications) to assist with essential daily activities</p> <p>Information and advisory services (eg, on available services and how to access these)</p>	<ul style="list-style-type: none"> <li>• Referral and liaison</li> <li>• Consultation</li> </ul>	<ul style="list-style-type: none"> <li>• Effective local and regional linkages are in place to facilitate appropriate referrals</li> <li>• Service Users needing long-term support services: have: <ul style="list-style-type: none"> <li>– timely access to individual needs assessment and service coordination services</li> <li>– receive appropriate services across the continuum of care and support to meet their individual needs, within available resources</li> </ul> </li> <li>• Service Users needing environmental support services receive appropriate equipment and environmental modifications</li> <li>• Service Users have timely access to appropriately presented information and relevant advice</li> </ul>

Service Provider	Nature of Linkage	Accountability
Local Māori health providers, Māori agencies and community groups	To improve mental health and addiction outcomes and reduce health inequalities for Māori	Local Kaupapa Māori services are strengthened by relationships, networks and cross agency working.
Local Pacific health providers, Pacific agencies and community groups	To improve mental health and addiction outcomes and reduce health inequalities for Pacific people.	Local Pacific services are strengthened by relationships, networks and cross agency working.
Other Government funded social services such as Education, Justice, Police, Social Development eg Work and Income and Child Youth and Family	<p>Alignment of delivery of health services and delivery of other government funded social services to better meet the goals of government strategies and policies from health and related sectors (eg Social Development , Education, Justice, etc)</p> <p>Where children/young people are receiving services from other agencies, the service provider will participate in inter-sectoral collaboration and co-ordination initiatives such as 'Strengthening Families'.</p>	Agreements and protocols regarding obligations of lead providers and collaborative working.
Consumer support groups	Share information with other providers about how to better meet the needs of Service Users.	<p>Maintain communication with consumer groups.</p> <p>Support the consumer voice at planning and delivery of services.</p>
Between DHB providers, non-governmental organisations and Primary Health Organisations	<p>Share innovative ideas, solve problems and improve access to services</p> <p>Provide co-ordinated support to people affected by mental illness and/or addiction.</p>	Document agreements in memorandum of understanding (MOU) and protocols.

There will be:



- clear arrangements/protocols/statements describing the accountabilities for access, entry, treatment, care management, exit processes, follow up and information sharing between linked providers.
- definitive statements on the boundaries between services and whether these are a matter of clinical judgement or prescribed by regulation/other mechanism.
- clear arrangements/protocols/statements describing how the provider will ensure treatment is delegated to the most appropriate person or agency, and which provider is primarily responsible for the care on each occasion.
- the requirement for providers to establish dispute resolution processes (depending on the linkage/relationship).

## 10. Exclusions

Mental illness or addictions often co-exist with other health or social service needs that impact on intervention outcomes. The presence of such needs shall not reduce a Service User's access to mental health and addiction services to which they would otherwise be eligible, but should be a signal that collaboration with another agency or health provider and joint intervention planning/provision is likely to be required.

DHBs do not fund services for mental health and addiction when the service or support needs are solely orientated to:

- sexual abuse
- violence and anger
- intellectual disability (including post-head injury), with or without behavioural problems
- learning difficulties
- criminal activities (anti-social behaviours)
- conduct disorder
- parenting difficulties
- relationship issues
- nicotine addiction.

Where people are eligible for services funded under the Injury Prevention, Rehabilitation, and Compensation Act 2001, they are excluded from receiving these services through public funding under Vote: Health.

The following services are not funded mental health and addiction treatment services where they are the sole focus of the intervention. They may be funded through other health funding or, in some cases, by other agencies:

- relationship services
- sexual abuse counselling services
- any counselling interventions not related to mental health and addiction
- psychological testing for educational requirements

- preparation of court reports ordered by the Ministry of Justice, except for those under the Criminal Procedure (Mentally Impaired Persons) Act 2003
- preparation of court-ordered reports or parole board reports
- assessments under section 65 of the Land Transport Act 1998
- assessments and reports under section 333 of the Children, Young Persons, and Their Families Act 1989.

## 11. Quality Requirements

### 11.1 General

The Health and Disability Sector Standards (HDSS) applies to this Service. Where available, the Service should use accepted clinical guidelines and standards.

Refer to the Operational Policy Framework<sup>5</sup> for a comprehensive and updated list of standards and legislation that require provider compliance.

### 11.2 Monitoring Quality

It is important that at each stage of the pathway Service Users and their family and whānau are able to give feedback on the Service. Regular contract monitoring and auditing will occur and contribute to a continuous quality improvement cycle for all services.

When assessing the quality of the Service to the extent to which the Service has met the following priorities will be considered:

The process of service delivery should ensure:

- the Service User's needs are central
- Service User and wherever possible family / whānau participation
- recognition that many Service Users will have parental roles and this will impact on their needs and those of their children
- high-quality mental health and/or addiction care is supported
- compliance with the Health and Disability Services Standards<sup>6</sup>
- Mental Health and Addiction key performance indicators and PRIMHD data are reported
- evidence-based best practice is followed.

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<sup>5</sup> [www.nsfl.health.govt.nz/accountability/operational-policy-framework-0](http://www.nsfl.health.govt.nz/accountability/operational-policy-framework-0)

<sup>6</sup> Health and Disability Services Standards: [www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards)

## 11.3 Mental Health and Addiction Service specifications

When selecting the appropriate service specifications required for a Mental Health and/or Addiction service to be purchased, the following steps are to be taken:

- select tier one Mental Health and Addiction service specification
- consider the most appropriate service type and select one or more tier two service specifications
- consider the Service User needs to be met and the preferred service delivery mode
- select the tier three service specification that best meets these requirements.

(A minimum of three Mental Health and Addiction service specifications are required for each contract- a tier one, at least one tier two and a tier three service specification).

## 12. Purchase Units and Reporting Requirements

### 12.1 Purchase units

The Mental Health Purchase Unit (PU) codes are published in the joint DHB Ministry Nationwide Service Framework Purchase Unit Data Dictionary on [www.nsfl.health.govt.nz](http://www.nsfl.health.govt.nz).

The following PU codes do not have specific nationwide mental health and addiction services service specifications, but may be included under this Tier One service specification.

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definition	National Collections or Payment Systems
MHFF	Mental Health - flexifund	Service to cover the costs for flexible funding for mental health services in addition to specific services with a unit of measure client, available bed day, occupied bed day or FTE.	Programme	MHFF	Mental Health - flexifund
MHFF0001	Individual Treatment bed (Mental Health & AOD)	Bed for a client of mental health and/or alcohol and other drugs (AOD) services, of any age, who requires individualised care	Occupied bed day	MHFF0001	Individual Treatment bed (Mental Health & AOD)

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definition	National Collections or Payment Systems
MHQU	Mental Health - quality and audit	Service to cover the costs for quality and auditing of mental health services	Programme	MHQU	Mental Health - quality and audit
MHWF	Mental Health - workforce	Service to cover the costs for mental health workforce development.	Programme	MHWF	Mental Health - workforce
MHSD	Mental Health - service development	Costs to cover service development projects.	Project	MHSD	Mental Health - service development

PU codes for mental health and addiction services are included at tier three service specification level and reflect the tier one and tier two service specification components.

Unit of measure	Definition
Occupied bed day	Total number of beds that are occupied each day over a designated period. For reporting purposes, count beds occupied as at 12 midnight of each day. Leave days, when the bed is not occupied at midnight are not counted. Counting formula is discharge date less admission date less leave days.
Programme	A set of related measures or activities that is purchased in a block arrangement and is uniquely agreed at a local level
Project	Agreed lump sum amount. Service purchased in a block arrangement

## 12.2 Reporting Requirements

### 12.2.1 Programme for the Integration of Mental Health Data

Mental Health and Addiction providers will provide the required data electronically to Ministry of Health Information Services via the Programme for the Integration of Mental Health Data (PRIMHD).

There will be participation in KPI Benchmarking project as this work is implemented in the sector. Refer to Mental Health Data Definitions and Descriptions document<sup>7</sup>.

## 13. Glossary

The definitions in this glossary are consistent with the definitions used in other national documents.

Term	Meaning
Addiction	Addiction in the context of the mental health and addiction services relates only to alcohol and other drug use and/or problem gambling. It refers to a maladaptive pattern of substance abuse, or problem gambling leading to significant impairment or distress.
Advocacy	Actively advancing or protecting the rights and interests of people with mental illness and/or addiction.
AOD	Alcohol and other drugs.
Assessment	A service provider's systematic and ongoing collection of information about a consumer to form an understanding of consumer needs.
Clinical Assessment	Forms the basis for developing a diagnosis and an individualized treatment and support plan with the Service User, their family, whanau and significant others.

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<sup>7</sup> [www.nsfh.health.govt.nz/service-specifications/current-service-specifications/mental-health-and-addiction-services](http://www.nsfh.health.govt.nz/service-specifications/current-service-specifications/mental-health-and-addiction-services)

Community Service	A service based within the community that maybe delivered in hospital outpatient and/or community settings.
Consultation	Obtaining opinions and views of people affected by potential or proposed changes or developments, in order to consider those views in the decision making process.
Culture	The beliefs, customs, practices, and social behaviour of a particular nation or people, a group of people whose shared beliefs and practices identify the particular place, class, or time to which they belong.
Family Inclusiveness	Families and whānau have a fundamental role in supporting recovery and wellness and their participation in service planning and delivery will be critical.
Harm Reduction	Harm reduction focuses on reducing harms associated with addiction, including health, social economic and other harms experienced by individuals, families, communities and society.
Lived Experience	The term refers to having experience of mental illness or addiction.
Natural Supports	Natural supports include family whānau, partners, friends, neighbours, colleagues or those from an identified group who help the Service User in his/her recovery.
PRIMHD	Programme for the Integration of Mental Health Data; a common code set for the health sector.
Protective Factors	Supports, strengths and activities that help build resilience.
Recovery	Recovery is defined as the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential. Recovery in the addiction sector includes a view of both

	<p>abstinence and harm minimization perspectives that have evolved over time to represent the individual's view. There is a long and generally held view that in the addiction field recovery involves an expectation/ hope that people can and will recover from their addiction / unwellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the word's widest sense) providing help. Health and Social Services will need to expect recovery and work in a way that will support it and will build future resilience.</p>
Relapse Prevention Plan	<p>Relapse prevention plans identify early relapse warning signs of clients. The plan identifies what the client can do for themselves and what the service will do to support the client.</p> <p>Ideally, each plan will be developed with involvement of clinicians, clients and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the individual. Each client will know of (and ideally have a copy of) their plan.</p>
Residential	<p>The term residential has been replaced by the terms "housing" or "accommodation" dependant on the type of service.</p>
Resilience	<p>Personal and community strengths or skills that enable people to rebound from adversity, trauma, tragedy, loss or other factors, and go on with life with a sense of control, competence, and hope.</p>
Service User	<p>A person who uses specialist mental health or addiction services regardless of level of need. This term is often used interchangeably with consumer and/or tāngata whaiora</p>
Strength based	<p>A treatment approach, that focuses on and helps develop the Service User's strengths. This approach combines both provision of direct services and treatment, along with helping people define or priorities their needs, navigate the system and link into community resources.</p>

Talking Therapies	Talking therapies involve people talking about their problems or issues with trained therapists. They encompass a wide range of psychological and behavioural therapies, including behavioural therapy, cognitive therapy and other types of counselling.
Whanāu	Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term in this document is not limited to traditional definitions, but recognises the wide diversity of families represented within Māori communities.
Whanāu Ora	Māori families achieving their maximum health and wellbeing, and provides an overarching principle for recovery and maintaining wellness.