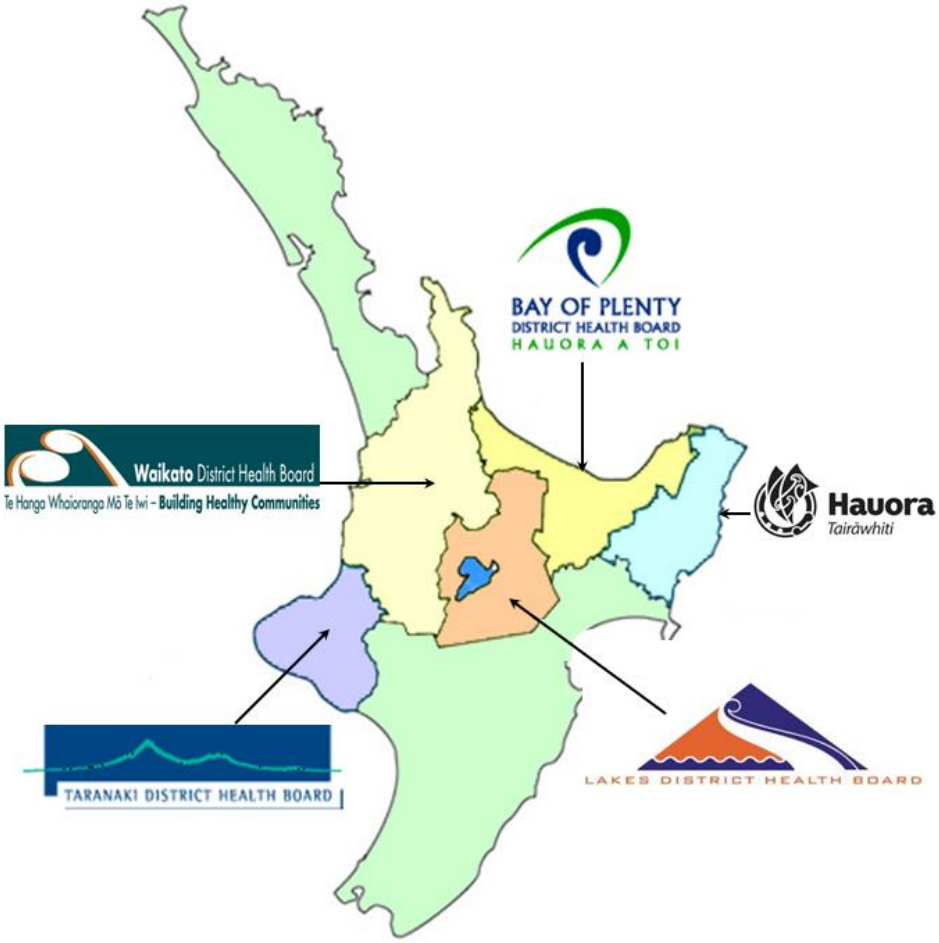
Midland District Health Boards

# Eating Disorders Services for the Midland Region




## Service Change Proposal

**September 2017**

# Contents

# Recommendation

That Midland DHB GMs P&F:

1. Accept the Midland Eating Disorders (ED) Model of Care (MoC) for implementation in the 2018-2019 financial year

2. Approve the Midland ED MoC for release to the Ministry of Heatlh

3. It is proposed that the funding returned from the Northern region be fully applied to further develop the Midland DHBs MoC. No additional funding is being sought, although more cost-effective adult residential bed(s) may assist. The key components that the returned funding will cover are:
    - Expert clinical support to the five Midland DHBs
    - Clinical supervision to the EDS Eating Disorder Liaisons
    - Additional FTE in each DHB to build sustainability

4. It is proposed that a hybrid model of specialist clinical expertise and support is implemented :
    - Regional Support – provided by the Waikato for the smaller DHBs and formalised by Service Level Agreements to be developed with the Midland DHBs. This will include but not limited to complex case review, advice, standardising of processes and procedures and training as required.
    - External Expert Support – for the provision of Family Based Therapy (FBT) supervision for all of the Midland DHBs by the New Zealand Eating Disorders Clinic. Although Midland has a number of staff trained in the Maudsley FBT, we do not have anyone specifically trained in FBT supervision.
    - Bay of Plenty – will continue to get its clinical expertise through the New Zealand Eating Disorders Clinic

# Executive Summary

The Midland DHBs are seeking formal agreement for the implementation of a new model of care for Eating Disorders Services (EDS) delivered closer to home from a continuum of integrated partnerships that encompass primary, secondary and tertiary level care. This regionally coordinated model of care is similar to the acclaimed South Island DHBs EDS and will be fully implemented in the 2018-2019 year.

Over the past nine years the Midland region has continued to develop its EDS capacity and capability at individual DHB and regional levels, and consistent with Ministry of Health directions. It has been reliant on the tertiary service component being provided by the Northern region, Auckland DHB (ADHB). A recent review showed that the provision of the tertiary component was problematic and recommended that Midland DHBs withdraw from the ADHB arrangements with the exception of access to a Tupu Ora bed, and that other options be explored.

A gap analysis of the Midland DHBs' EDS confirmed their strengths and areas for development. Local accessible service user-centric services are in place and are well developed in most DHBs but access to tertiary level consultation, liaison and supervision for more complex cases will be needed when the arrangement with ADHB ceases. Options with Southern, Central regions and Waikato DHB have been explored. Further to this is the need for a centrally coordinated training and development programme for EDS workforce. Established networks are to be further strengthened to connect the workforce regionally and nationally enhancing collegial relationships and learning. EDS Family support groups are to be developed to foster peer support.

Overall the new Midland EDS model will provide opportunities for quality improvement with the development of evidence-informed consistent guidelines, standards, policies and procedures to support its implementation, consistent with the New Zealand Health Strategy's five strategic themes.

# 1. Background

In 2008 The Ministry of Health (MoH) reviewed EDS provision nationwide and developed the document ***Future Directions for Eating Disorders Services in New Zealand.*** At that time the Midland region did not have a robust system for delivering eating disorders services. Additional MoH funding allowed the Midland region to develop and strengthen its Eating Disorder continuum of care recruiting Midland Eating Disorders Liaison roles within each of the Midland DHBs. Options were explored for managing the more complex cases, and collaborating with the Northern region in a supra-regional arrangement seemed a practical solution in the immediate term. However over the past years Midland has invested in their own service development including local workforce (in addition to funding the ADHB delivered EDS) to support a more comprehensive continuum of care closer to home for a wider range of Eating Disorders, consistent with the Midland Mental Health and Addiction strategic plan.

# 2. Current Situation

The Midland Region DHBs provide primary and secondary EDS locally and access supra-regional EDS provided by Auckland District Health Board (ADHB) for the tertiary or more complex cases. A recent review of EDS provision confirmed that less than expected was being provided by the Supra- regional service for the Midland populations and that service provision had been problematic.

Current access to the Starship EDS bed is limited and thought primarily due to the increased need to treat young people who are medically compromised closer to their homes. Relationships with Midland DHB

Paediatric and Medical wards have been established, with the DHB Eating Disorder Liaison (EDL) roles providing support and advice as required.

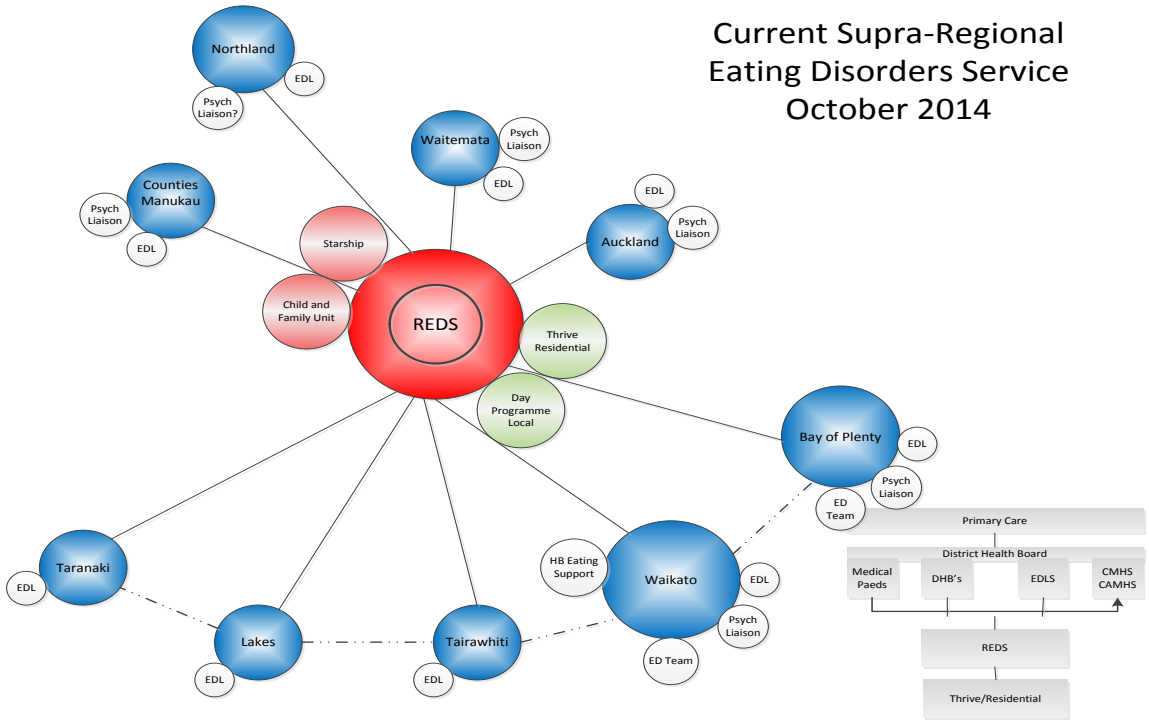
Access to the Tupu Ora residential service (15 years plus) has remained consistent. In the past year the Tupu Ora service has improved and consequently the waiting time for the Midland bed has increased as it's perceived to have greater value and benefit. However Midland DHBs have experienced significant delays in referrals being processed by Regional Eating Disorders Service REDS administration. Access to REDS Liaison (2 FTEs) funded by Midland has been variable. Based on the quarterly reporting and confirmed by stakeholders there has been less than 0.25 FTE provided.

Other factors have also contributed to the current EDS model not working well for the Midland region include:

- Lack of clarity between the primary, secondary and tertiary functions of REDS, REDS liaison and local and supra-regional roles.
- Limited access into the adult residential service (Tupu Ora) with REDS acting as a gatekeeper. This has caused delays in gaining entry and hampered direct communication with Tupu Ora during treatment and discharge. Furthermore, the Tupu Ora assessment processes have been lengthy and time consuming.

Overall, the current EDS model is unsatisfactory, and it would seem that this model for care is no longer fit for purpose with the model of care the Midland DHBs wish to deliver.

**Figure 1: Current EDS**




Following formal notification to the Northern region of the Midland DHBs' intention to exit[1] by the Midland regional CE Lead for Mental Health and Addictions (Ron Dunham), three stakeholder workshops were held in November 2016. These workshops confirmed a stock take and gap analysis, and agreed a way forward.

[1] (This exit is with the exception of access to one available adult residential bed (24/7 for 365 days of the year at Tupu Ora).

# 3. Gap Analysis

Midland DHBs report approximately 160 active EDS clients that they are currently providing services for. EDLs are in place in four of the five Midland DHBs providing liaison, coordination, education and training. In Waikato DHB the EDL is part of an EDS Multidisciplinary team.

Midland DHBs confirmed that EDS service requirements can be met by providers in the Midland region with the exception of access to EDS specialist expertise for consultation, liaison and supervision and expertise. This is required to support the more complex cases. Further to this is the ongoing requirement for EDLs' education, supervision, training and development as described in Table 1.

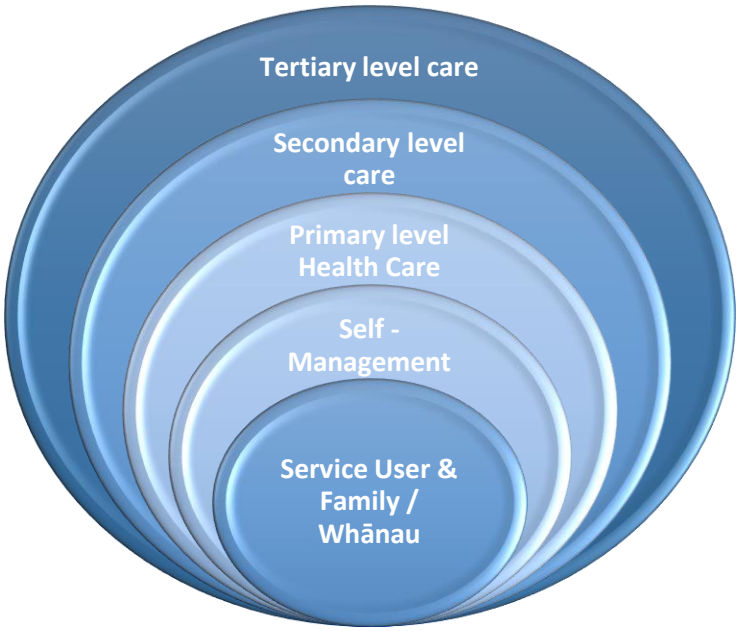
**Table 1: Gap Analysis**

| DHB | Current Strengths | Areas for Input or Development |
|---|---|---|
| Bay of Plenty<br>( 50 clients) | EDL (.80) serving locations and age groups<br>Pathways developed connecting community with specialist services work force training accessible<br>Family based therapy active<br>Specialist expertise for consultancy and supervision accessed | Day programme<br>Specialist role in meal support<br><br><br><br>EDS education, training and development for clinicians & EDL |
| Lakes<br>(14+ clients) | EDL (0.2)<br>Trained clinicians competent working at secondary level | Pathways to be formalised<br>Access to EDS specialist expertise-consultation, liaison, supervision<br>EDS Psychiatry input<br>EDS education, training and development for clinicians & EDLs |
| Hauora Tairāwhiti<br>(6 clients) | Interim EDS taskforce<br>GPs active in medical management | EDL 0.2 FTE function for the role shared between clinicians<br>Access to specialist EDS expertise-consultation, liaison, supervision<br>Dietician expertise<br>EDS education, training and development for clinicians & EDLs |
| Taranaki<br>(20 clients) | EDL (0.4)<br>Staff participating in training as offered | Access to specialist EDS expertise-consultation, liaison, supervision<br>Dietician expertise<br>EDS education, training and development for clinicians & EDLs |
| Waikato<br>(70 clients) | EDS Specialist Team includes EDL (3.4fte)<br>Pathway development<br>Expertise in talking therapies<br>Training/education provided to community and other providers | Access to specialist EDS expertise-consultation, liaison, supervision<br>EDS Networking opportunities<br>EDS education, training and development for clinicians & EDLs |

# 4. Midland Region EDS Model of Care

The proposed new Midland region EDS model of care is consistent with a stepped care or tiered approach ensuring that the right level of care is available and accessible to meet the level of need and complexity of the individual at that time in the right location and where possible closer to home. Levels of care as described in Figure 2.

**Figure 2: EDS Levels of Care**




This proposed EDS model of care is similar to the acclaimed South Island DHBs EDS. Canterbury DHB offers regular support to the EDLs at each DHB and coordinates the regional EDS. At the Clinical Steering Group meeting held in February 2017, the Midland DHBs propose to deliver a wide range of EDS that is evidence-informed to meet identified needs across the full spectrum of clinical complexity.

The Midland Regional EDLs will connect each DHB's local EDS, building on current resource capacity and capability, to provide treatment and care as close to home as is clinically appropriate and practicable.

It is proposed that a hybrid model of clinical expertise and support be offered to the five Midland DHBs:

1. External Expert Support – for the provision of Family Based Therapy (FBT) supervision for all of the Midland DHBs through the New Zealand Eating Disorders Clinic. Although Midland has a number of staff trained in the Maudsley FBT, we do not have anyone specifically trained in the formal FBT supervision.

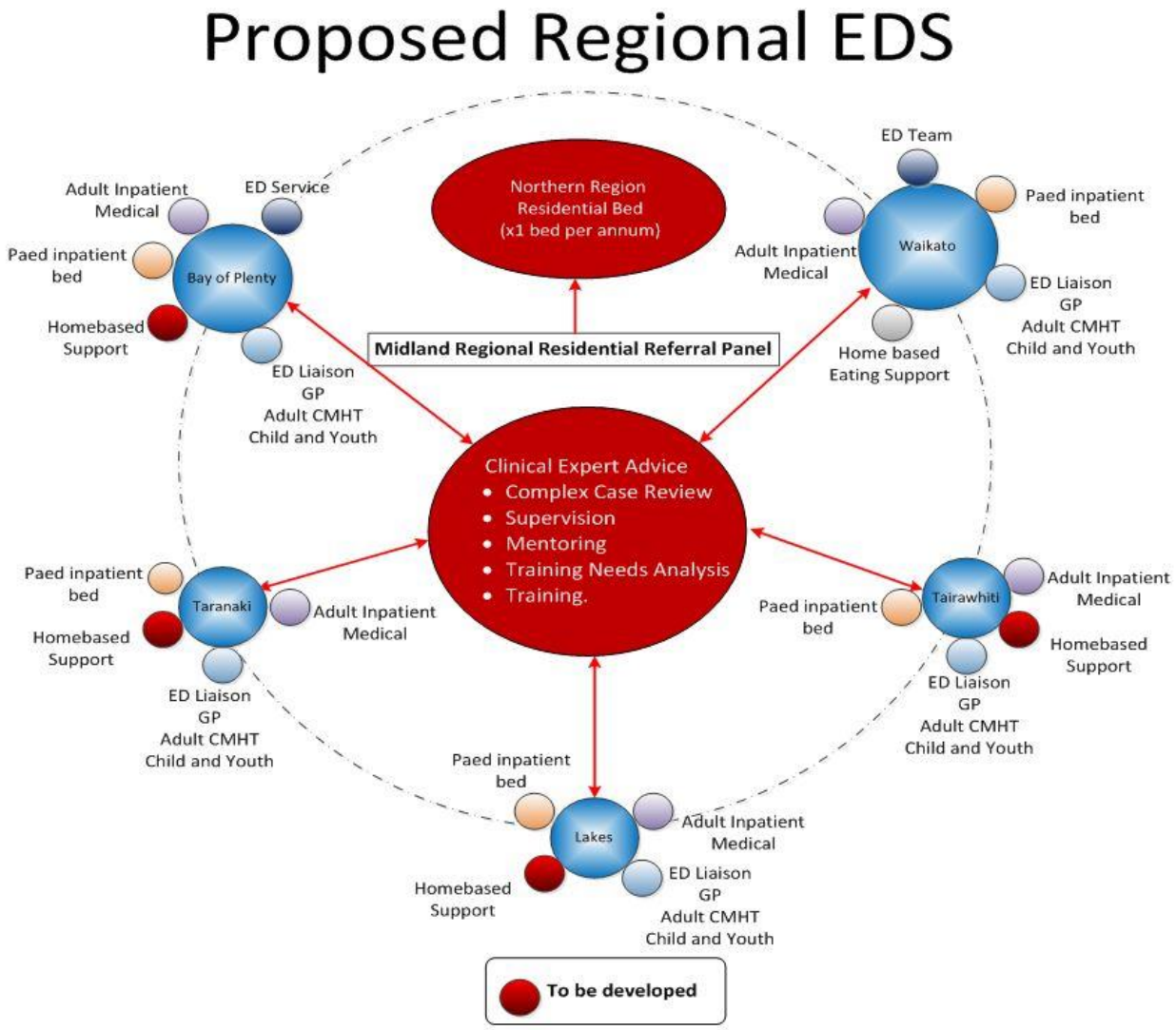
2. Regional Support – provided by the Waikato for the smaller DHBs and formalised by Service Level Agreements to be developed with the Midland DHBs. This will include but not limited to complex case review, advice, standardising of processes and procedures and training as required.

3. Bay of Plenty – will continue to get its clinical expertise through the New Zealand Eating Disorders Clinic

Consistent agreed documentation such as guidelines, standards, policies, and procedures will be applied across the region. Figure 3 shows the Midland DHBs connected, networked and supported in the delivery of Midland Regional EDS.

Engaging the service user and their family efficiently and effectively as care partners will be central to the Midland Regional EDS.

**Figure 3: Midland Regional EDS Connected, Networked & Supported**




## 5. Principles of the New EDS Model (as described in Figure 3)

This new EDS model will be service user and family–centric and constructed using integrated partnerships to provide an integrated continuum of care including medical and mental health expertise. This will be consistent with the New Zealand Health strategy's five strategic themes: People Powered, Closer to Home, Value and High Performance, One Team, and Smart System.

The skills and expertise in EDS of the five Midland DHBs, will be developed and strengthened to ensure sustainability locally and regionally.

Services will be:

- Accessible, timely and responsive
- Age, gender and culturally appropriate
- Safe with a focus on quality improvement
- Evidence informed

# 6. Values and Behaviours

The Midland EDS will uphold the following values:

- Respectful
- Confidential
- With empathy
- Service user centric
- Promotes self- determination and autonomy
- Values Family/Whanau participation and partnership
- Sensitive and responsive to other cultures
- Collaborative and consultative

# 7. Service Components of the New EDS Model

There are a number of components that make up the new EDS model.

## 7.1 Self –Management

Raising awareness of Eating Disorders in the community through health promotion and health education will promote self- management of symptoms and earlier access to professional advice and support.

An accessible repository for information on Eating Disorders and services available in the Midland region will be developed. Access to a specialist response to media concerns will also be facilitated.

## 7.2 Primary health care

The development of regional Eating Disorders guidelines, pathways and support for Primary practitioners will strengthen their practice, for example utilising the Map of Medicine that identifies clear pathways of care, and improve access and earlier intervention for service users. Liaison with specific Mental Health roles in Primary Health care and the opportunity for "shared care" will be identified and strengthened.

Existing Primary Care training packages will be consolidated into one regional package that is reviewed and updated annually by the Regional EDS Liaison Group.

## 7.3 Secondary care

Within secondary care, there is the initial acute EDS medical stabilisation stage. This requires effective liaison and agreed ways of working with Emergency departments, Medical and Paediatric services. Following medical stabilisation there is engagement of mental health expertise to provide mental health assessments, treatment planning, talking therapies, access to nutritional advice, meal support and to aid transitions to other services and self- care as needed. Attention is also required to:

- Post discharge care to provide home and school meal support
- Step up and down facility to prepare people for residential care and to transition people back to home post residential care
- Therapeutic programmes that are closer to home
- Post discharge intensive support by NGOs
- Access to expert clinical multi-disciplinary advice
- Clinical supervision

Not all the Midland DHBs have established formalised processes with their NGO partners and the Bay of Plenty is in the process of determining what will work best for their district. Standardised protocols and

procedures will be developed and implemented for NGO partnerships region wide. The possibility to develop a regionalised e-Learning package for support workers working alongside clients and whanau with clinical expert advice will be considered as this has worked well with Infant Perinatal NGO partnerships.

### 7.4 Tertiary care

Some Eating Disorders may present severe and life threatening concerns. At these times a high level of specialist expertise required to advise and deliver complex medical and mental health treatment requirements in community outpatient, hospital inpatient or residential settings. Needs of individuals' may fluctuate necessitating flexible treatment responses.

At the workshop held in February 2017, The EDS Steering Group affirmed that acute hospital inpatient treatment is best delivered closer to home as per the best practice guidelines. A letter was received from the Northern region in January 2017 stating that on top of the enhanced bed day price for Tupu Ora a further $104K was required to purchase Liaison Consult. The Midland region believes that the premium bed day price should include Consult Liason. This makes the Tupu Ora option expensive even though the service has improved in the last six months. To that end, discussions were commenced with the Central region to ascertain their capacity to offer Midland a bed(s). Unfortunately, due to the Central region reviewing its current facility stock this option is no longer viable.

The Midland EDS Steering Group agreed that whatever option for residential treatment is selected that it is viewed as temporary. This is because the five DHBs are committed to a sustainable future with Waikato DHB including the EDS beds as part of their mental health services building development.

A Regional Referral Panel comprising the Midland DHB EDS Liaisons will be responsible for ensuring that all referrals to the residential beds are prioritised. A regionally agreed process and protocol will be similar to the Ashburn Hall process which is very effective and efficient.

Standardised regional policies, procedure, protocols and service level agreements will be developed aross the Midland region to ensure consistency and reviewed annually by the EDS Liaison Group.

### 7.5 Midland Regional Network Coordination

As agreed by the stakeholders the Midland Mental Health and Addictions Regional Network is identified as being the best fit to provide:

- Regional coordination of the EDS Clinical Network meeting (4 per year)
- Regional coordination of the EDS workforce development needs
- Regional coordination of the Community Support Work eLearning tool
- Regional coordination of the National EDS meeting (1 per year)
- Regional coordination of quarterly reporting

Consistent reporting and data collection is essential to ensure that the proposed model is making a difference. Regional agreed measures for success and throughput are to be developed. All work undertaken by the Regional Network will be following consultation with the regional EDS Liaison Group and with Clinical Governance approval.

## 8. Collaboration and Partnerships

Integrated partnerships delivering a continuum of care will require collaboration across traditional boundaries and engage providers and other agencies. Service level agreements will formalise these partnerships, where required.

# 9. Options Appraisal for Tertiary Care Provider / Access to Specialist EDS Expertise

An options appraisal was conducted by the Midland Region EDS Steering Group regarding the tertiary or very complex care component. Four options were appraised:

a) Status quo
b) Private provider
c) Overseas provider
d) Central or Southern region provider

The status quo option could not be maintained. As demonstrated in the gap analysis, specialist expertise was wanted by DHBs across the region.

The Private Provider option was initially discounted for a number of reasons. However, given the limited number of Family Based Therapy clinicans gazetted to undertake supervision in New Zealand, this option was explored further.

The option of an Overseas Provider was considered not financially viable given current situation in Midland and preference for services closer to home.

It was agreed that support from the Central and or Southern regions should be explored further. Unfortunately the Central region withdrew their initial offer of assistance and the Southern region were unable to meet the timeframes for response. This has resulted in a hybrid response with Waikato DHB providing a regional leadership model as per the South Island model, in conjunction with a Private Provider.

# 10. Quality, Monitoring and Reporting

The Midland Region EDS will be supported by the Midland Clinical Governance and Quality Improvement framework. The service, its performance, its outcomes with agreed KPIs, will be actively managed, and potential risks will be mitigated with appropriate strategies. There will be opportunities to capture consumer/service user and family stories of experience to aid ongoing service improvement.

Data capture and reporting is an essential component going forward. The Midland Decision Support will work alongside Clinical Governance and the Regional EDS Liaison Group to ensure that the data collected in meaningful and recognisable not only to the staff but to the clients and their whānau.

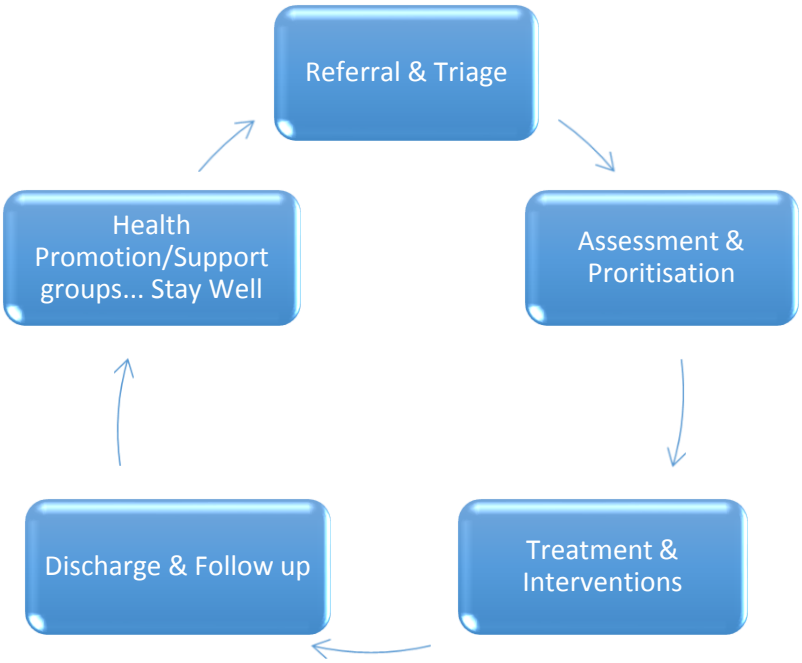
Some of the Midland DHBs have invested in Real Time Feedback. This tool can be utilised as an opportunity for whānau and the client to give feedback in real time for service improvement purposes.

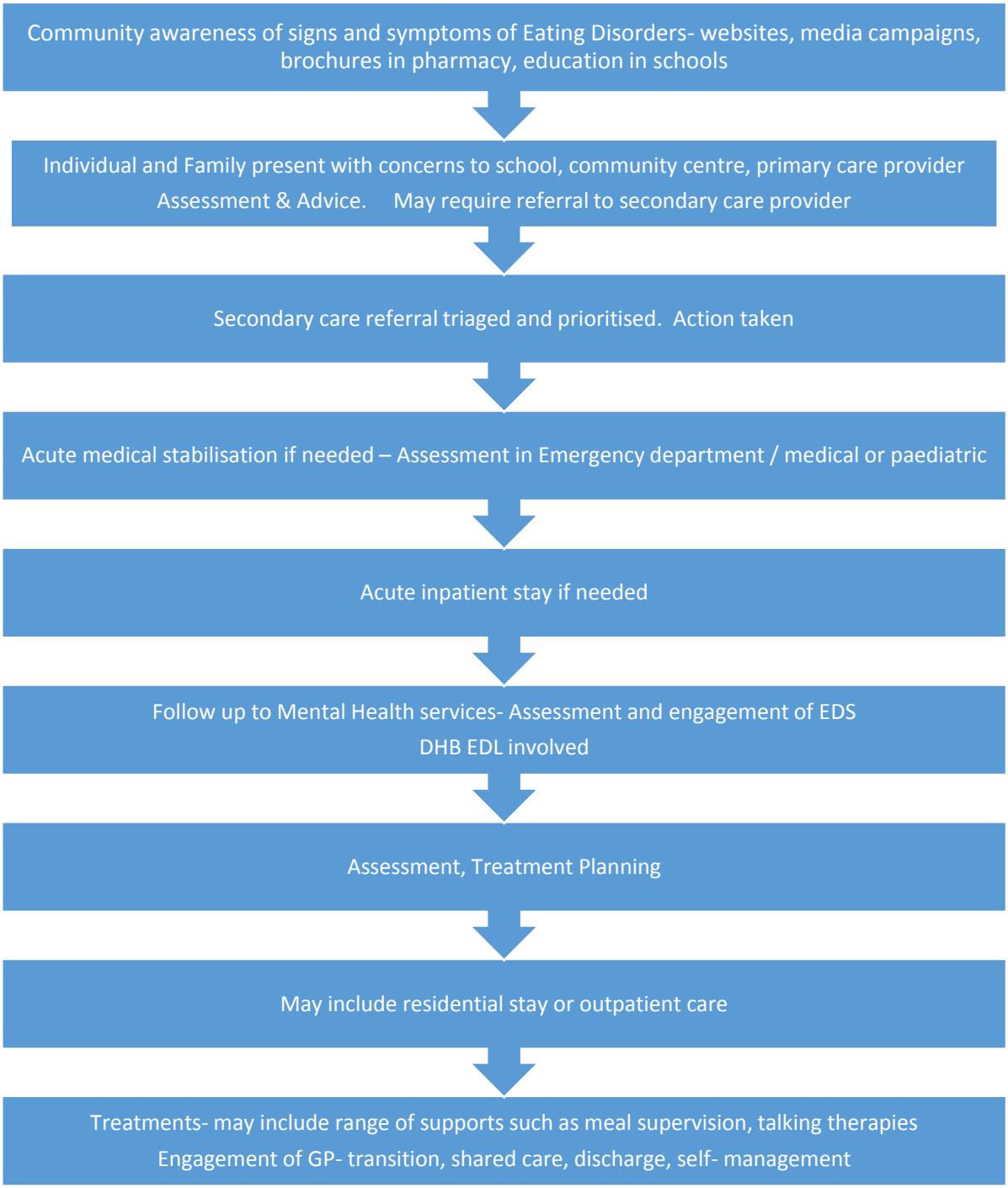
# 11. Service User Journey

The service user and family journey as depicted on the next page (page 12) commences with an awareness of how to prevent eating disorders and the recognition of the earliest signs and symptoms in order to access early intervention. Mixed methods of communication including using social media, community campaigns, online tools, and approaches with schools and other agencies may feature.

Supporting the service user journey is a number of processes that the service user and their family will participate in. These processes are outlined in Figure 4 and will be conducted aligned to the MoH national service specifications and service coverage document.

**Figure 4: EDS Pathway**






# 12. Enablers

## 12.1 Workforce

The workforce is a critical component to the delivery of EDS. The EDS Workforce is made up of EDS specialists such as psychologists, psychiatrists, nurses, dieticians; support workers for meal support, family/whānau groups, and peer support groups. Additionally there are clinicians involved in medical stabilisation in emergency department, medical and paediatric wards.

What is required is the development and implementation of an EDS workforce strategy for the Midland Region, a strategy that is coordinated regionally. This will include the development of e-learning tools,

particularly to support the non-regulated workforce. Additionally, standardised training packages for specific groups based on their assessed learning needs.

Midland DHBs have identified EDS training, education and development as a gap in service and are keen for it to be coordinated and delivered centrally and in a sustainable way.

### 12.2 Establishment and Development of Groups & Networks

There is a need for the development of EDS family support groups and networks with a strong education and evidence informed focus to improve peer support.

The Midland Regional Eating Disorders network will be maintained, strengthened and linked to the National Eating Disorders network. The Network activity will support further development of the Midland EDS expertise.

## 13. Cost Analysis

The 2016 – 2017 Midland Eating Disorders Inter-district Flows (IDFs) idenfity that currently Midland is purchasing:

- REDS Tertiary Options – for exit
- Starship Hospital Acute Medical – for exit
- Access to the Tupu Ora Day Programme – for exit
- Tupu Ora Residential Treatment – retain

See Appendix 15.1 – Midland Eating Disorders IDFs 2018-2019 Funding to be Returned.

A letter sent by the Northern DHBs in response to our letter of intent to exit identified that Midland will need to continue funding the Tupu Ora Residential Treatment and Access to the Day Programme as they are fixed costs. In the letter they requested an addition $104K for Consult Liaison and a five year commitment.

If Midland remains with the Northern region the amount of funds that will be returned into the region is $198,432.00 which is insufficient to build a sustainable future within the Midland continuum of services.

It is proposed that the funding returned from the Northern region be fully applied to further develop the Midland model of care. No additional funding is being sought, although more cost-effective adult residential bed(s) may assist. The key components that the returned funding will cover are:

1. Expert clinical support to the five Midland DHBs
2. Clinical supervision to the EDS EDLs
3. Additional FTE in each DHB to build sustainability

A project will be undertaken to ensure that all of the regional SLA's, policies, procedures and protocols (client pathways) are developed with all external and internal stakeholders prior to the 1st July 2019. This will be funded through the existing Midland MH&A Regional Network budgets.

# 14. Conclusion

This proposal presents new opportunities for the Midland DHBs to make significant gains in the provision of EDS to improve health outcomes for the Midland populations. The status quo is not a viable option. With targeted development activities and investment in the Midland region, EDS will become stronger, more connected and networked, and more sustainable over-time.

The Midland Mental Health and Addictions Clinical Governance Network and the regional Portfolio Managers group will contribute to the prioritisation and final clinical approval of the model of care.

# 15. Appendices

## 15.1 Midland Eating Disorders IDFs 2018-2019 Funding to be Returned

| DHB | MHE28C | MHE27 | MHE32C | TOTAL to be Returned |
|---|---|---|---|---|
| **BOP** | 16,936.09 | 58,459.60 | 11,271.81 | **$86,667.50** |
| **Lakes** | 8,704.23 | 30,482.00 | 5,801.15 | **$44,987.38** |
| **Taranaki** | 4,667.95 | 15,479.86 | 3,156.65 | **$23,304.46** |
| **Tairawhiti** | 8,685.96 | 28,532.40 | 5,818.70 | **$43,037.06** |
| **Waikato** | 30,091.12 | 100,332.55 | 20,461.12 | **$150,884.79** |
| **TOTAL** | **$69,085.35** | **$233,286.41** | **$46,509.43** | **$348,881.19** |

## 15.2 Midland EDS Implementation Plan for March 2017-July 2019

| Task | Actions | By Whom | Completion Date |
|---|---|---|---|
| Final MoC to GMs P&F meeting | Review content of draft | EDS Steering Group<br>Andrew Campbell-Stokes | September 2017 |
| Develop Project Scope | Incorporate all aspects of the clinical pathway<br>Ensure that policies proceedures and protocols are identified<br>Ensure that linkages with external regional and local services are clearled defined<br>Identify preferences for regional support with each DHB | EDL Group and Regional Director | March 2018 |
| Develop and implement measurement tools and reporting templates | Ensure consistent application across the region | EDL Group and Regional Director | November 2017 |
| Develop and complete the EDS Map of Medicine | Involve Primary Health in project group | EDL Group and Decision Support | May 2018 |
| Ensure a regional solution for the residential rehabilitation programme | Ensure the EDS beds are built into the Waikato rebuild plan | Waikato CD and GM MH&A | Jan 2018 |

## 15.3 Monitoring and reporting, KPIs, Outcome measures

The Midland Region Network will require regular quarterly reporting in order to monitor the performance of EDS in the Midland region. This will be a combination of data and narrative reporting.

A range of key performance indicators (KPIs) and Outcome measures across domains will be agreed. They are likely to include the following:

| | |
|---|---|
| Service performance | Numbers of referrals received to the different EDS components eg DHB Community Mental Health, NGO Meal Support |
| | Numbers of referrals accepted |
| | Numbers of contacts by service type |
| | Numbers of discharges by service type |
| | Total number of people supported by service type |
| | Average length of stay of inpatient/residential services |
| | Readmission rate of inpatient/residential services |
| | Numbers of suicides known to service |

| | |
|---|---|
| Service workforce | Numbers of staff (funded and actual) to provide the service by professional group by service type |
| | Numbers of staff by ethnicity |

## 15.4 Definitions / Glossary

**Addiction:** relates to alcohol and other substance misuse and or problem gambling

**Eating Disorder (ED):** psychological disorder with both psychiatric and medical symptoms with high levels of co-morbidity. It may be acute and life-threatening, and it may be long term and life- long.

**Eating Disorder Services (EDS):** services provided for people experiencing eating disorders. They may be delivered by DHB, NGO or Primary Health Care and in a range of community and hospital settings.

**Eating Disorder Liaison (EDL):** a health professional with responsibilities to support staff working with Eating Disorders within a DHB locality, and for the liaison with other Eating Disorder Services as required.

**Family / whānau:** the service user's family, extended family, partner, friends or other people that the service user has nominated as family.

**Mental Illness:** any clinically significant psychological or behavioural state with distressing symptoms and or functional impairment

**Mental Health Outcome**: a change in the person's mental health status which is attributable to an intervention or service

**Mental Health Service User:** a person who accesses mental health services. They may also be known as a consumer, patient or client.

## 15.5 National EDS Service Specifications

**EATING DISORDERS SERVICES - MENTAL HEALTH AND ADDICTION SERVICES**

**TIER TWO SERVICE SPECIFICATION**

This tier two service specification for Eating Disorders Services (the Service) must be used in conjunction with the tier one Mental Health and Addiction Services service specification as well as the tier three Eating Disorders Services listed below.

- Eating Disorders Inpatient, Intensive Treatment And Consultative Service
- Consultative Service Within A Specialist Eating Disorder Service
- Clinical Outpatient Services For Eating Disorders
- Community Service For Eating Disorders
- Eating Disorders DHB Liaison Service
- Specialist Eating Disorders Service (With Accommodation).

This tier two service specification is the overarching document for the Eating Disorders Services specifications. The service specification defines the services and their objectives in the delivery of a range of eating disorders services.

### 1. Service Definition

The term 'eating disorders' encompasses a range of conditions that have overlapping psychiatric and medical symptoms. These conditions are considered to have multi-factorial aetiology with strong genetic as well as environmental factors. They present with complex psychological, psychiatric and medical symptoms that may involve acute and chronic complications that can be life-threatening and/or life-long. Eating disorder diagnoses include Anorexia Nervosa, Bulimia Nervosa and Eating Disorders Not Otherwise Specified (EDNOS).

### 2. Service Objectives

#### 2.1 General

As outlined in *Future Directions for Eating Disorders Services in New Zealand* (Ministry of Health 2008), eating disorders services will:

- provide seamless service delivery across primary, secondary and tertiary settings, straight-forward transitions between services, continuity of care and appropriate discharge planning
- provide effective early identification and treatment
- provide a range of services and a multi-disciplinary approach to care
- enable Service Users to actively participate in the planning of their own recovery
- support Service Users as close to their home as possible.

Service Users have indicated the factors they value from an eating disorder service, in order of priority, are:

- maintaining a sense of autonomy over their lives
- respect
- confidentiality
- anonymity

- the need for a supportive and empathetic atmosphere
- being recognised and treated as an individual.

Eating disorders services should actively support and promote these service values.

The full continuum of care for eating disorders has been well recognised in best practice guidelines. It is expected that this continuum will be available in line with current best practice. Family and whānau often play a vital role in seeking treatment for and supporting the Service User. Therefore it is important they are involved in the whole process from assessment and treatment to transition between and out of services.

It is likely that the range of eating disorders services will be delivered by different providers, often in different areas. Clear communication and referral processes will help to ensure that services work collaboratively to provide seamless services. Long duration of treatment and relapse is common in eating disorders and services need to appropriately transition Service Users, while still retaining flexibility to re-engage with them if and when necessary.

### 2.2 Māori Health

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

## 3. Service Users

The Service Users are those eligible people of any age. Eating disorders in children and young adolescents differ from older age groups because of differences in physiology, development and cognition. Early intervention along with involving and supporting families/whānau in treatment is crucial.

## 4. Access

### 4.1 Entry and Exit Criteria

Referral criteria and processes to access Eating Disorders services are specific to the Service provided and are documented in tier three service specifications.

## 5. Service Components

### 5.1 Processes

The following processes apply but are not limited to: assessment; treatment, intervention and support; review; and support.

### 5.2 Settings

The treatment environment may be different for children and adolescents and, wherever possible, children and adolescents should be separated from adult Service Users.

Typically, children (under 15 years old) need to be treated in a paediatric/child and adolescent mental health service (CAMHS) environment with specialist eating disorders liaison/consultation/support. Older adolescents (15 to 19 years old) should be treated in a child, adolescence and youth and/or eating disorders environment, and adults should be treated by the eating disorders and community mental health team. There needs to be flexibility based on developmental need rather than age.

### 5.3 Key Inputs

Staff as specified in the tier three service specifications.

## 6. Service Linkages

Linkages include, but are not limited to the following:

| Service Provider | Nature of Linkage | Accountabilities |
|---|---|---|
| Primary Health Care | Referrer<br>Care Provider at Primary Level | Early identification of an Eating Disorder and referral to secondary service<br>Management of care at a primary level |
| Personal Health/General Hospital | Provide care for Service Users physical/ medical needs | Work with Eating Disorder Services to meet the needs of the Service User holistically |

## 7. Exclusions

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

## 8. 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.

## 9. Purchase Units and Reporting Requirements

Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The specific Purchase Unit codes are applied to the tier three service specifications.

The Eating Disorder services must comply with the requirements of the national data collection PRIMHD. There are no specific reporting requirements for tier two service specifications. Reporting requirements are applied at both tier one and tier three service specification levels.

## 10. Tier Three Service Specifications

This range of tier three service specifications for Eating Disorders Mental Health and Addiction services has been developed to meet varied service needs.

The following tier three service specifications for Eating Disorders include:

| Title | PU Code |
|---|---|
| Eating Disorders Inpatient, Intensive Treatment And Consultative Service | MHE27 |
| Consultative Service Within A Specialist Eating Disorder Service | MHE 28A, MHE28B, MHE28C, |
| Clinical Outpatient Services For Eating Disorders | MHE 29A, MHE29B, MHE29C, MHE29D, MHE29E |
| Community Service For Eating Disorders | MHE30A, MHE30B, MHE30C, MHE30D, MHE30E |
| Eating Disorders DHB Liaison Service | MHE31A, MHE31B, MHE31C |
| Specialist Eating Disorders Service (With Accommodation) | MHE32A, MHE32B, MHE32C, MHE32D, MHE32E |

**EATING DISORDER SERVICES - DHB LIAISON SERVICE**

**MENTAL HEALTH AND ADDICTION SERVICES**

**TIER LEVEL THREE MHE31A, MHE31B, MHE31C**

This tier three service specification for Eating Disorders DHB Liaison Service (the Service) is linked to tier one Mental Health and Addiction service specification and tier two Eating Disorders service specification.

## 1. Service Definition

The Service supports staff working to treat eating disorders in their DHB area, including staff in primary services. The Service also acts as a liaison on behalf of the local DHB Community Mental Health Team with the lead DHB specialist eating disorder provider.

This Service is only for DHBs when there is no specialist clinical eating disorder service (ie, this is for spoke DHBs in the hub and spoke model).

## 2. Service Objectives

### 2.1 General

The Service is likely to be based in the Community Mental Health Team of a DHB, and will include responsibility for eating disorders services within that DHB. The DHB liaison service will:

- facilitate clear communication between the DHB and eating disorders services, and between DHBs
- be the key DHB linkage between primary and secondary services, particularly in providing general practitioners and other primary care practitioners with advice, support and assistance with referrals and with supporting family/whānau
- advise, guide and support staff in primary care services
- assist with the supervision and professional development of staff involved in providing eating disorders services in their DHB
- be involved in referrals and transitions of Service Users to and from medical and psychiatric settings
- provide liaison/advice/input to medical and psychiatric services treating those with eating disorders
- receive support and education from tertiary eating disorders services.

### 2.2 Māori Health

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

## 3. Service Users

The Service Users will be others within the district, both DHB and Primary Care Providers requiring advice and support with the management of Eating disorders Service Users.

## 4. Access

### 4.1 Entry and Exit Criteria

This Service will be accessible to primary care and DHB workers, supporting those Service Users who experience anorexia, bulimia and EDNOS, and their family/whānau and carers.

## 5. Service Components

### 5.1 Processes

The processes include but are not limited to consultation and liaison.

### 5.2 Settings

The Service is usually community based but maybe in a hospital setting.

### 5.3 Key Inputs

The Service is provided by Health professionals appropriately trained in the field of eating disorders regulated by the Health Practitioners Competence Assurance Act 2003.

## 6. Service Linkages

Linkages include, but are not limited to the following:

| Service Provider | Nature of Linkage | Accountabilities |
|---|---|---|
| Primary and Secondary Services | Consultation/liaison | Providing General Practitioners, other primary health care practitioners and DHB staff with advice, support and assistance with referrals and with supporting Service Users, family/whānau. |

## 7. Exclusions

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

## 8. 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.

## 9. Purchase Units and Reporting Requirements

**9.1** 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 | PU Definition | PU Measure | PU Measure Definition | Payment System |
|---|---|---|---|---|---|
| MHE31A | Eating disorders DHB liaison - Senior medical staff | A liaison role based in the Community Mental Health Team of a DHB, provided by senior medical staff to support primary care workers working to treat eating disorders (Anorexia, Bulimia and EDNOS). The service is only for DHB's when there is no specialist clinical eating disorder service. | FTE | Full-time equivalent staff member (clinical or non-clinical) involved in direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions e.g. half-time coordination of a community team. | Sector Services |
| MHE31B | Eating disorders DHB liaison - Junior medical staff | A liaison role based in the Community Mental Health Team of a DHB, provided by junior medical staff to support primary care workers working to treat eating disorders (Anorexia, Bulimia and EDNOS). The service is only for DHB's when there is no specialist clinical eating disorder service. | FTE | As above | Sector Services |
| MHE31C | Eating disorders DHB liaison – Nursing and/or allied health staff | A liaison role based in the Community Mental Health Team of a DHB, provided by nurses and/or allied health staff to support primary care workers working to treat eating disorders (Anorexia, Bulimia and EDNOS). The service is only for DHB's when there is no specialist clinical eating disorder service. | FTE | As above | Sector Services |

### 9.2 Reporting

Details of any additional information to be collected and the frequency of reporting to Sector Services Contract Management System are as specified and documented by the Funder in the Provider Specific Schedule of the contract.

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

When the Service is satisfactorily reporting to PRIMHD, and agreement is reached with the DHB, only the following information needs to be reported to:

The Performance Reporting Team, Sector Services

Ministry of Health

Private Bag 1942 Dunedin 9054.

Email performance_reporting@moh.govt.nz.

**After PRIMHD Reporting to Sector Services, Ministry of Health:**

| Frequency | Data |
|---|---|
| Monthly | Group sessions delivered |
| Monthly | Consultation/liaison training sessions |
| Quarterly | Senior medical FTEs |
| Quarterly | Junior medical FTE |
| Quarterly | Nursing and allied FTE |
| Quarterly | Non clinical FTE |
| Quarterly | Cultural FTE |
| Quarterly | Peer support FTE |
| Quarterly | Staff turnover ratio |
| Quarterly | Number of suicides of current clients |
| 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:<br>• Medical<br>• Nursing<br>• Psychology<br>• Occupational Therapy<br>• Social Work<br>• Maori Mental Health<br>• Other |

**EATING DISORDER SERVICES – COMMUNITY SERVICE FOR EATING DISORDERS**

**MENTAL HEALTH AND ADDICTION SERVICES**

**TIER THREE SERVICE SPECIFICATION**

**MHE30A, MHE30B, MHE30C, MHE30D, MHE30E**

This tier three service specification for Community Service for Eating Disorders (the Service) is linked to tier one Mental Health and Addiction and tier two Eating Disorders and other tier three Eating Disorders service specifications.

## 1. Service Definition

The Service provides early identification, treatment and recovery-oriented community services for people requiring support for eating disorder issues. It is recommended this Service has clear referral pathways with a clinical outpatient, inpatient and, where available, residential eating disorders service and links with primary care.

This is a community-based service for those at risk of relapse or developing more severe eating disorders, or those who are transitioning into or out of clinical eating disorders services. The Service may also provide support and resources to family and whānau, health workers and members of the community.

## 2. Service Objectives

### 2.1 General

The Service may include, but will not be limited to:

- counselling and support and regularly monitoring of progress and wellbeing
- advice around the criteria and process for referral into clinical services
- support to Service Users, including their family and whānau, who are on waiting lists for speciality services
- culturally responsive services and linkages with other health services
- attention to matters in relation to early identification and treatment, maintenance of health, relapse prevention, problem prevention and promotion of good mental health
- information about, and access to, services within the community
- liaison with other health professionals involved in the care of the individual/family
- education, support and advocacy services for family and whānau
- education, training and information to health workers, schools and others in the community about early identification and intervention, referral processes, prevention initiatives
- act as an eating disorder resource for the members of the public.

Where appropriate, care will be provided in conjunction with primary health services. There will be clear communication with any primary health providers regarding the support/therapeutic plan and progress.

For all people under the care of other services for their eating problems, there will be clear communication regarding the role of the community eating disorders service.

### 2.2 Māori Health

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

## 3. Service Users

The Service Users will be eligible people of all ages.

## 4. Access

### 4.1 Entry and Exit Criteria

Referrals with be received from any source, including primary health services, clinical outpatient eating disorder services, community and inpatient mental health services and self-referral.

The Service will have clear referral processes/guidelines to support seamless transitions into clinical eating disorders services where appropriate.

## 5. Service Components

### 5.1 Processes

The processes include but are not limited to: assessment; treatment, intervention and support; review; discharge; consultation and liaison.

### 5.2 Settings

The Service is provided in community based settings.

### 5.3 Key Inputs

The Service is provided by people with skills and experience in eating disorder intervention, treatment and support, and who belong in one of the following categories:

- health professionals regulated by the Health Practitioners Competence Assurance Act 2003
- people regulated by a health or social service professional body
- people who interact with Service Users and who are not subjected to regulatory requirements under legislation or by any other means.

## 6. Service Linkages

Linkages include, but are not limited to the following:

| Service Provider | Nature of Linkage | Accountabilities |
|---|---|---|
| Clinical outpatient, inpatient and, residential eating disorders service and primary care. | Referral pathways for referring on and receiving Service Users | Service Users will be transitioned in to other services within the continuum to support their needs appropriately |

## 7. Exclusions

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

## 8. 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.

## 9. Purchase Units and Reporting Requirements

**9.1** 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 | PU Definition | PU Measure | PU Measure Definition | Payment System |
|---|---|---|---|---|---|
| MHE30A | Community service for eating disorders - Senior medical staff | A community-based service for those at risk of relapse or developing more severe eating disorders, or those who are transitioning into or out of clinical eating disorders services. The service may also provide support and resources to family and whānau, health workers and members of the community. The service is provided by senior medical staff with experience in eating disorder intervention, treatment and support. | FTE | Full-time equivalent staff member (clinical or non-clinical) involved in direct delivery of services to consumers. Excludes time formally devoted to administrative or management functions e.g. half-time coordination of a community team. | Sector Services |
| MHE30B | Community service for eating disorders - Junior medical staff | A community-based service for those at risk of relapse or developing more severe eating disorders, or those who are transitioning into or out of clinical eating disorders services. The service may also provide support and resources to family and whānau, health workers and members of the community. The service is provided by junior medical staff with experience in eating disorder intervention, treatment and support. | FTE | As above | Sector Services |

| PU Code | PU Description | PU Definition | PU Measure | PU Measure Definition | Payment System |
|---|---|---|---|---|---|
| MHE30C | Community service for eating disorders – Nursing and/or allied health staff | A community-based service for those at risk of relapse or developing more severe eating disorders, or those who are transitioning into or out of clinical eating disorders services. The service may also provide support and resources to family and whānau, health workers and members of the community. The service is provided by nurses and/or allied health staff with experience in eating disorder intervention, treatment and support. | FTE | As above | Sector Services |
| MHE30D | Community service for eating disorders - Non-clinical staff | A community-based service for those at risk of relapse or developing more severe eating disorders, or those who are transitioning into or out of clinical eating disorders services. The service may also provide support and resources to family and whānau, health workers and members of the community. The service is provided by non-clinical support staff with experience in eating disorder intervention, treatment and support. | FTE | As above | Sector Services |
| MHE30E | Community service for eating disorders - Cultural staff | A community-based service for those at risk of relapse or developing more severe eating disorders, or those who are transitioning into or out of clinical eating disorders services. The service may also provide support and resources to family and whānau, health workers and members of the community. The service is provided by staff trained in culturally responsive services | FTE | As above | Sector Services |

### 9.2 Reporting

Details of any additional information to be collected and the frequency of reporting to Sector Services Contract Management System are as specified and documented by the Funder in the Provider Specific Schedule of the contract.

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

Prior to the Services satisfactorily reporting to PRIMHD, the following information will be reported to:

The Performance Reporting Team, Sector Services

Ministry of Health

Private Bag 1942 Dunedin 9054.

Email performance_reporting@moh.govt.nz.

**Prior to PRIMHD Reporting to Sector Services, Ministry of Health:**

| Frequency | Data |
|---|---|
| Monthly | First face-to-face contact with individual/family |
| Monthly | Follow up face-to-face contact with individual/family |
| Monthly | Group sessions delivered |
| Monthly | Face-to-face contact group |
| Monthly | Consultation/liaison contact |
| Monthly | Consultation/liaison training sessions |
| Monthly | Number completed support needs assessments |
| Monthly | Number of people supported by services at end of period (by NZ Maori, Pacific Island, Other) |
| Monthly | Number of people supported by services during month (by NZ Maori, Pacific Island, Other) |
| Quarterly | Senior medical FTE |
| Quarterly | Junior medical FTE |
| Quarterly | Nursing and allied FTE |
| Quarterly | Non clinical FTE |
| Quarterly | Cultural FTE |
| Quarterly | Peer support FTE |
| Quarterly | Staff turnover ratio |
| Quarterly | Average length of stay |
| Quarterly | Number of suicides of current clients |
| 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:<br>• Medical |

| | |
|---|---|
| | • Nursing<br>• Psychology<br>• Occupational Therapy<br>• Social Work<br>• Maori Mental Health<br>• Other |

When the Service is satisfactorily reporting to PRIMHD, and agreement is reached with the DHB, only the following information needs to be reported to:

The Performance Reporting Team, Sector Services

Ministry of Health

Private Bag 1942 Dunedin 9054.

Email performance_reporting@moh.govt.nz.

**After PRIMHD Reporting to Sector Services, Ministry of Health:**

| Frequency | Data |
|---|---|
| Monthly | Group sessions delivered |
| Monthly | Consultation/liaison training sessions |
| Quarterly | Senior medical FTEs |
| Quarterly | Junior medical FTE |
| Quarterly | Nursing and allied FTE |
| Quarterly | Non clinical FTE |
| Quarterly | Cultural FTE |
| Quarterly | Peer support FTE |
| Quarterly | Staff turnover ratio |
| Quarterly | Number of suicides of current clients |
| 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:<br>• Medical<br>• Nursing<br>• Psychology<br>• Occupational Therapy<br>• Social Work<br>• Maori Mental Health<br>• Other |