Letter re Services provided at Child and Family Unit, Starship Children's Hospital

by

AUCKLAND DISTRICT HEALTH BOARD (ADHB) CHILD AND ADOLESCENT INPATIENT MENTAL HEALTH SERVICES

for

MIDLAND DISTRICT HEALTH BOARDS

- **Waikato**
- **Bay of Plenty**
- **Lakes**
- **Taranaki**

1. BACKGROUND & CONTEXT

Midland DHBs (excluding Tairawhiti) has, since the establishment of Starship as a national children and youth hospital, accessed tertiary specialist mental health inpatient beds for children and adolescents (up to their 18th birthday) from the Child and Family Unit (CFU) at the Starship Hospital in Auckland. There is some flexibility based on the young person's developmental needs, and in some extenuating circumstances, a person may be admitted up to their 19th birthday.

In 2011, the number of beds funded by the Midland region through Inter-district Flows (IDFs) was increased from 3 to 4 per annum, in order to better meet increased demand for service by the region. Three beds are purchased under service specification – Child, Adolescent and Youth Inpatient beds (MH138)[1]. These beds are referred to as ward admissions. A further bed is purchased for intensive clinical inpatient support/high dependence under service specification - Adult Intensive Care Inpatient beds (MHA02). This is an adult service specification as there is no appropriate relevant national child and youth service specification. This bed is referred to as high dependence unit (HDU).

The other Midland bed purchased from Starship is for young people (up to their 16th birthday) with Eating disorders. This purchase line is in place until 30 June 2013 under service specification Eating Disorders Inpatient Intensive Treatment and Consultative Services.

Midland DHBs also pays through IDFs for its share of the mental health consult liaison services provided throughout the Starship hospital for inpatients from Midland DHBs.

It has been agreed that there is a need to formalise the agreements for the above services between Auckland District Health Board (ADHB) and the Midland DHBs in the form of this Letter of Services.

Given the services described above are governed by 2 separate service groups within ADHB, this document is a stand-alone agreement for **CFU Inpatient Services** between ADHB and Midland DHBs, and can be read in conjunction with the Letter of Service for the Starship Eating Disorder Inpatient Bed and Consult Liaison Service.

2. FUNCTION OF THIS DOCUMENT

This document describes the roles and responsibilities of ADHB CFU for Inpatient Child and Youth services provided for the Midland DHB Child and Adolescent Clinical teams (excluding Tairawhiti), and how these parties will work collaboratively to implement effective and responsive inpatient services for eligible children, adolescents and their families whanau.

3. CHILD AND FAMILY UNIT – INPATIENT MENTAL HEALTH SERVICES

3.1 Purpose

The Service will provide inpatient care for children, adolescents and youth with mental health disorders. The service delivers comprehensive assessment and treatment which includes consideration of physical, cultural, mental, spiritual and family aspects of health. Admission is

[1] Refer to the attachment that supports this SLA for the full Service Specifications – or http://www.nsfl.health.govt.nz/apps/nsfl.nsf/menumh/Home

indicated where assessment and treatment is unable to be provided within a community setting or in a less acute inpatient service.

3.2 Service Objectives

The Service will include acute inpatient services that are:

- provided in a general hospital setting
- specific to children, adolescents and youth
- well integrated with physical health, intensive care, day hospital and community mental health services, and form part of this continuum of services
- cognisant of the child, adolescent or youth within the context of family/whānau
- focused to ensure active intervention, crisis intervention and prevention of the escalation or development of the individual's illness, prevention of disability, and concerns associated with treatment
- conscious of the safety needs of the service users and community, including staff, reflecting that some service users may present a risk of suicide, self-harm or danger to others
- delivered in accordance with a comprehensive system of risk management within which least restrictive intervention strategies will be determined.

3.3 Model of Care

The service implements a strengths–based recovery model with a focus on the least restrictive mode of care possible. The approach is client centred with a focus on building resources within the young person and their family. A holistic, bio-psycho-social-cultural model is used with strong involvement of the family. The recovery programme offers a range of group activities.

Each young person coming into the unit has a full assessment from psychiatric, medical, social, cultural and psychological perspectives. Families are involved in this process and in all therapeutic decision making.

Each young person has a key worker who engages with the family and young person. Individual and family focussed therapeutic work is offered, usually based on a DBT or CBT approach with a focus on building skills, competence and resource.

Care is co-ordinated each week by a multidisciplinary team meeting. Notes from these are faxed to community key workers who are also invited to family meetings.

Discharge planning processes begin at the point of admission. Discharge planning involves participation of the young person, their family/whānau, the referring CAMHS team and relevant Midland DHB teams and agencies.

3.4 Service Functions

- **Acute Psychiatric Emergency Hospitalisation**

During admission to the service all young people will have access to full physical, psychological, psychiatric, social and cultural assessments, diagnostic procedures, pharmacological treatments, family and individual therapies provided by Auckland City Hospital specialist services as appropriate.

- **High Dependency/ intensive care**
  There will be an environment to enable the multi-disciplinary team to safely support young people being admitted with high acuity and complexity.

  The high dependency unit will allow for a more intensive level of monitoring, use of low stimulus or multi-sensory environments , de-escalation, containment for safety and access to seclusion if required.

- **Elective/sub acute admissions**
  The Child and Adolescent Mental Health Inpatient service may provide planned admissions for second opinions.

- **Family/Whānau involvement**
  The service will support family/whānau with psycho-education, referral to mental health services for themselves, links with other support networks as required, and will work with family members to resolve specific issues that may have an impact on the young persons' care.

3.5 Referrals and Access

Referrals usually occur with little notice, as the young person is acutely unwell and inpatient admission is indicated in response to a crisis.

Referrals and access to the service will be managed by the ADHB CFU Service Admissions Coordinator and Clinical Director (or delegate) in collaboration with Midland DHBs.

3.5.1 Consent

At all times the young person and their family/guardian has the right to refuse to enter the service or to leave the service unless subject to legal restrictions, such as the Mental Health Act.

3.5.2 Eligibility

The Service users are eligible infants, children, adolescents and youth up to their 18th birthday, with some flexibility for admission up to their 19th birthday in extenuating circumstances.

3.5.3 Access

Access to the CFU Inpatient service will be based on clinical need, occurs in a way that is inclusive and welcoming of the young person and their families/guardians, and is experienced as efficient by clinical services.

Where possible, entry will occur during usual working hours.

- Access during usual working hours will be via the CFU Admissions Coordinator and Clinical Director, in consultation with the referring DHB clinical team
- After hours access is managed by the CFU Nurse on charge and on – call Child and Adolescent Consultant
- Access by youth justice/ youth forensic clients.
    - Ideally, referrals from youth justice facilities will be initiated during business hours, but in exceptional circumstances the CFU Nurse in Charge and On-call consultant (or delegate) will reach a collaborative agreement if an afterhours admission is clinically indicated.
    - For young people who are under the custody of CYFs and require a tracker, payment of trackers will be through a national process.

3.5.4 Referral

- When a referral is indicated, the relevant Midland DHB Psychiatrist or keyworker will contact the CFU Admissions Coordinator to discuss the referral and check for eligibility and bed availability
- The referring clinician will then send referral documentation to CFU Admissions Coordinator which includes the following:
    - Relevant Assessments and Clinical Summary
    - Rationale for admission
    - Formulation of current risk
    - Other relevant assessments and documentation (e.g. MHA papers)
- The referral information will be scanned and emailed to cfureferrals@adhb.govt.nz (during business hours) or faxed to (09) 307 8994.
- The CFU Admissions Coordinator will work through the above process with the referring DHB on the basis of eligibility (as previously defined) and availability of service spaces.
- After hours admission is coordinated via the on-call consultants.

3.5.5 Prioritisation

Prioritisation for acute admission is based on clinical need. As part of prioritisation the following will be considered:

- Current level of risk to self/others
- Benefit to be gained from the inpatient admission
- Existing family and social supports/supervision in the community

The decision as to who will be prioritised will be made by the ADHB CFU Clinical staff in the first instance. If there is a disagreement, this will be raised with the CFU Service Manager and/or Consultant in collaboration with the referring Midland Consultant.

If either referrer disagrees with the decision, the ADHB CFU Consultant will reach agreement with the relevant clinical director/s of the referring teams.

3.6 Clinical Handover

A verbal handover will be provided by a referring clinician to the CFU Admissions Coordinator, or MDT member from the relevant DHB on entry, and the following will be discussed with CFU staff:

- Goals of admission
- Significant current risk
- Medical alerts
- Any infections or physical health issues
- Significant alcohol and drug issues and management plan
- Special requirements i.e. cultural or dietary food requirements
- Legal status and requirements
- Exit plan, including expected discharge address
- Arrival logistics such as
    - When the young person is expected to arrive
    - Who will be transferring the young person and how
    - What family will be present and accommodation plans

Where an after-hours admission occurs, a teleconference or videoconference will be coordinated by the CFU key worker to occur either on the next business day, or scheduled for a time that suits both CFU and the referring DHB.

3.7 Cultural Needs

Every attempt will be made to attend to the young person's cultural needs. A cultural assessment will be undertaken as part of the standard assessment process unless not appropriate. This assessment is to be included as part of the referral process and collaborative planning. CFU will ensure that the service and supports that are put in place are culturally appropriate and safe.

3.8 Progress Review

The allocated CFU clinical key worker is responsible for coordinating regular assessment and review of the young person's mental health, as well as the review of the collaborative plan, ensuring there is progress during the inpatient admission. They will monitor the well-being of the young person during the admission through regular reviews and ensure that the treatment plan is implemented.

Weekly updates will be emailed/faxed to the referring Midland DHB team providing an update on the wellbeing of the young person.

3.9 Discharge from the CFU Inpatient Service

Decisions to discharge a young person will be the responsibility of the responsible CFU clinical team in partnership with the referring DHB clinician.

Safeguards for the young person need to be in place prior to discharge and responsibilities for these will be established during the review and planning meetings, in consultation with the family/whanau. Young people will be discharged from inpatient services when:

- They no longer require the level of support provided and there is collective agreement about this; or
- Consent is withdrawn and the young person is not subject to the MH Act).

Care will be transferred to the receiving CAMHS team.

3.10 Young people leaving against advice

If a young person leaves the service against advice or without a formal exit process CFU clinicians will inform the referring DHB clinician during the day. If the young person leaves after hours, CFU clinicians will contact the ADHB Crisis team who will advise the after hours service in the referring DHB, and if appropriate, the Police or CYF. The CFU clinical team will also be responsible to notify family/whanau and emergency services as required.

3.11 Young people Absent Without leave (AWOL)

If a young person is absent without leave (AWOL), the CFU clinicians will inform the referring DHB clinician during the day. If the young person is AWOL after hours, CFU clinicians will contact the ADHB Crisis team who will advise the after hours service in the referring DHB, and if appropriate, the Police or CYF.

The CFU clinical team will be responsible to notify family/whanau and emergency services as required

4. OUTCOME FOCUS

Outcome measures based on wellness and recovery using a range of established outcome measurement tools will be used to track health and wellbeing over time. Measures include quality of life across a range of life domains (e.g. social, educational vocational, training, recreational, living circumstances, and accommodation), attainment of personal goals, and successful movement through services towards achieving independence and involvement with the community in general.

Specifically outcome measures will include:

- HoNOSca on entry and exit, to be forwarded to the referring DHB upon discharge
- Progress against established goals set out in the young person's care/ recovery plan should also be recorded.

5. COMMUNICATION AND INFORMATION SHARING

Information sharing will occur between the Starship and CFU clinicians and referring DHB key workers that will be open, transparent and intended to increase the quality of care that both parties deliver.

Young people and their families will be advised that services will share information with other service partners involved in their care. Information sharing between services will occur with the person's knowledge, and it is recognised that family/whanau are key members of the recovery team.

Information needs to be shared concerning:

- The context of the young person's support needs
- The responsibilities of the different parties in relation to ongoing treatment and care
- Monitoring of progress
- Any changes to level of risk and/or safety concerns
- Notification of serious incidents of:
    - Aggression
    - Violence
    - Restraint and/or seclusion
    - Attempted self harm
- For all Leave Arrangements, the key worker will be notified in advance.

6. DISPUTE RESOLUTION

If any disagreements arise between the CFU Clinical Staff and Midland DHB clinicians, both parties will act in good faith to settle the dispute or difference by agreement.

Any unresolved disputes and differences between the parties will be directed in the first instance to the relevant DHB Clinical Directors or DAMHS within each organisation who will then enter into discussion to seek resolution.

7. REPORTING REQUIREMENTS

7.1 CFU Reporting

As part of this agreement, the CFU will provide a monthly report (via email) to the Midland Regional Director Midland Mental Health and Addictions Network on the following areas:

- By Midland DHB, by individual admission to ward and/or HDU
    - NHI
    - Gender
    - Date of Birth
    - Admission age

- Ethnicity
- Inpatient stay start date
- Inpatient stay end date
- Number ward days
- Number of days in HDU
- Number of leave days
- Total stay days

- Summary of bednights by DHBs including the following:
  - Overall occupancy level (number and percentage of bed days available and actual occupancy) for ward
  - Overall occupancy level (number and percentage of bed days available and actual occupancy) for HDU

- Counts of clients with one or more bednights during month by DHB & demographics

8. REVIEW OF THIS LETTER OF SERVICES

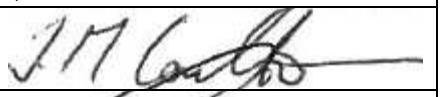
This document will be reviewed annually (or sooner as required by either party) by those with delegated authority, or their delegates from ADHB and Midland DHBs.

- Service Managers
- Clinical Directors
- Funding and Planning
- Midland Regional Clinical Director

Next review date: 30th June 2013.

9. SIGN OFF

This Document has been agreed and signed off by:

Name	Position/DHB	Signed
Helen Wood	General Manager MH&A Waitemata & Auckland DHBs	
Fionnagh Dougan	CFU General Manager	
Richard Aicken	CFU – Clinical Director	
Jeff Bennett	Waikato DHB – Group Manager	
Rees Tapsell	Waikato DHB – Director Clinical Services	
Ian Goulton	BOP DHB – Business Manager	
Sue Mackersey	BOP DHB – Clinical Director	
Maureen Emery	Lakes DHB – Group Manager	
Richard Thompson	Lakes DHB – Acting Clinical Director	
Wendy Langlands	Taranaki DHB – Group Manager	
Hester Swart	Taranaki DHB – Clinical Director