

CANTERBURY DISTRICT HEALTH BOARD

INPATIENT SERVICES REVIEW

Child, Adolescent and Family Services

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Child, Adolescent and Family Services

Inpatient Services Review

Context of review

The decision to undertake a general review of inpatient services delivered by the Canterbury District Health Board (CDHB) for children and youth with mental health problems arose in the context of a decision by the Ministry of Health to cease the use of Locked Door Time Out (LDTO) in the Child and Family Inpatient Unit (CFIU). The full scope and purpose of the review are set out in Appendix 1 however, the specific terms of reference of the review are to:

- 1. Delineate a standardised and appropriate philosophy for Service Delivery and Clinical Practice across the Inpatient spectrum of the CAF Service.*
- 2. Draw up a model for the delivery of age appropriate and evidence based Inpatient Services taking into account their relevance to the wider CAF Service.*
- 3. Make recommendations regarding any necessary service changes required to operationalise that model of service delivery.*

Prior to visiting Christchurch between 11-13 February 2008 I was provided with a wide range of materials relating to Child, Adolescent and Family Mental Health Services (CAFMS) in New Zealand, in particular in relation to the CFIU and the Youth Inpatient Unit (YIU). I also had the opportunity of visiting the units and talking to members of staff, as set out in Appendix 2.

During the course of the review I spoke to staff of the CFIU and Day Programme, the YIU and Day Programme, Child and Family Specialty Services (CFSS), Family Mental Health Service (FMHS), Youth Specialty Services (YSS), Maori Cultural Workers (Pukenga Atawhai), Consumer and Family Representatives, some parents of children admitted to the CFIU and staff of the Starship Child and Family Unit in Auckland. I have also spoken to key personnel at similar facilities in Australia to compare services provided by YIU and CFIU with their Australian counterparts. I must also note an oversight on my part, as I did not look at the record keeping system in either unit nor did I look at the clinical records of any past or current patients. This clearly limits my ability to comment on these aspects of the two units.

I would like to record my thanks to all of those I met for the frank and open way in which they were prepared to discuss important and at times sensitive issues relating to the review. It is also important to acknowledge the conscientious, dedicated team of professionals from many disciplines who provide mental health services to this severely troubled group of children, adolescents and their families. They are the most important resource available to the service.

Introduction

As an external reviewer, from Australia, it is impossible to develop a comprehensive understanding of the history of CAFMHS within the Canterbury/ South Island region in the time available. However, I have tried to understand the two units that are the subject of the review in the context of CAFMHS in the Canterbury District and the South Island. The inpatient services for children and youth in Christchurch are only a small but nevertheless important and resource intensive part of CAFMHS in the South Island. As the only specialist inpatient psychiatric services for young people they have a regional responsibility as well as their responsibility to the population of the Canterbury District.

In the context of the current review it is important to acknowledge the substantial growth in funding and services for CAFMHS in the Canterbury region over the past 20 years, to the point that they would now be considered well resourced in terms of funding, facilities and personnel compared to other parts of New Zealand and Australia. This has been accompanied by a commensurate increase in the knowledge, training and skills of these personnel. Regardless of facilities and funding, the quality of CAFMHS depend to a very large degree on the expertise of its staff. This is arguably even more the case in CAFMHS than in many other areas of health. It is fair to say that CAFMHS in Christchurch are the envy of services elsewhere in New Zealand, as is the ability of the CDHB to recruit and retain skilled and experienced staff to its CAFMHS. A recent positive development has been the centralisation of referrals to CAFMHS with the establishment of CAFLink.

The challenge for all CAFMHS is to ensure that experienced staff are retained, remain abreast of recent developments in CAFMH, particularly with regard to evidence-based interventions, and are willing to embrace change as new knowledge emerges. Services should be evidence rather than ideology driven without pursuing every new fad with quixotic enthusiasm. It is also important to recognise that CAFMHS exist in a social and political context and that not all change is based on evidence-based practice.

The Youth Inpatient Unit (YIU)

The YIU was established in 2001 as

*an eight bed facility for the assessment and treatment of youth aged 16 up to the 18th birthday, or older if they are still at school, who have a psychiatric disorder (including but not limited to depressive, psychotic, anxiety disorders, substance abuse with co-morbidity etc.), and who cannot be effectively treated or managed in other mental health or youth services.*¹

The Unit's 'Philosophy and Principles' explicitly state that youth with conduct disorder (where the primary reason for requesting admission is behavioural problems), or anti-social personality disorder with a history of interpersonal violence will not be admitted because they could jeopardise the safety of others.

The age range of patients is somewhat unusual (16 – 17 year olds) although occasionally younger and older patients are admitted. This age range was selected because of the problems associated with admitting acutely mentally ill young people to adult mental health services and the gap in services between those accepted in the CFIU and adult services. Another important consideration

¹ Youth Inpatient Unit: Mission statement

was the fact that in NZ young people 16 years and older are not required to attend school and are able to consent to, and therefore by implication also refuse, treatment. The latter means that parents have less say in their child's treatment and use of the Mental Health Act is sometimes necessary and appropriate to ensure that a young person with a 'mental disorder' is appropriately assessed and receives necessary treatment. While accepting the legal issues related to consent, the important role of families in the care and protection of young people with a mental illness needs to be recognised.

The Unit was established as an 'acute psychiatric unit'. Accordingly the emphasis is on acute admission, treatment and early discharge. The Clinical Director of CAFMHS, who was instrumental in establishing the Unit, has clearly stated his view that "*young people who are well enough to be in school do not need to be in hospital and those who are sick enough to be in hospital are not well enough to be at school.*" This is reflected in the fact that there is no school programme attached to the YIU.

Despite having a mandate to admit young people requiring acute psychiatric admission from the whole of the South Island, in excess of 90% of young people admitted to the YIU were from the Canterbury area². Comparable information was not provided for CFIU however, anecdotal information suggests that a higher proportion of admissions come from outside the CDHB catchment area. Some staff of community based services commented on the problem for young people outside the Canterbury region in accessing the YIU. This was particularly a problem on the West Coast where there are few specialist CAFMHS. They acknowledged that if they are really worried about an acutely ill young person the YIU almost always responded positively unless there were no beds.

The Unit accepts admissions under the Mental Health Act (MHA) but does not provide secure facilities. Discussion with staff indicate that principles of 'least restrictive care' are applied wherever possible and the compulsory assessment and treatment provisions of the Act are mainly used during the initial assessment period or if there are concerns for the safety and well-being of the young person or others. The unit has a High Dependency Unit (HDU) including a seclusion room that can be used as a low stimulus area for one young person, however only 35/600 patients were placed in seclusion during their admission. It should be noted that there is no direct viewing facility from the nurses' station into the seclusion room.

Data from the '600 Inpatient Study'³ indicate that 18% of admissions were under the MHA and a further 7% of young people were made involuntary at some point during their admission. Of all 'involuntary patients' (n=152) almost 40% (58/152) were 'assessment orders' for five days or less, almost 35% (52/152) were on 'further assessment orders' for up to 14 days and less than 30% (42/152) on Compulsory Treatment Orders. The primary discharge Axis I DSM-IV diagnoses of the 600 patients were Mood and Anxiety Disorder 71% and Psychosis 12%. Almost 50% of patients had a comorbid Axis I diagnosis, less than 1% had no Axis I disorder and almost 70% had no Axis II disorder. These data suggest that the Unit is meeting its charter as an acute adolescent psychiatric unit.

The Unit is sometimes locked for short periods for safety reasons, to deter a young person from absconding, but the facilities, staffing levels and staff gender mix means that at times a seriously

² Bobier, C and Mernick, J (2007) *The first 600 Youth Inpatient Unit Admissions*

³ *ibid*

threatening young person is allowed to leave and the Police informed rather than allowing a dangerous situation to arise. Since its commencement there have been two suicides, one occurring on the Unit and the other off site. The suicide on the Unit had a particularly significant impact, as one might expect, resulting in an overly cautious or conservative approach to 'risk management' for a time, with some adverse effects on the treatment programme. This has subsequently been rectified with a standardised approach to risk assessment that is reviewed for each young person at the twice weekly clinical meetings. This meeting is held twice weekly to monitor the progress and safety of young people, given the acuity of their illness. However, the format, involving a reasonably detailed synopsis of each patient at each meeting, has been questioned by some as unnecessary and time consuming given the stability of staff and the small numbers of patients.

The '600 Inpatient Study' indicates that the number of admissions per annum ranged from 71 (2005) to 135 (2002). For the last four years admissions have remained fairly stable at 70-80 per year. The mean length of stay (LOS) was 23 days with a median of 11 days (Range 1-373). More than 50% of young people spent less than one week in hospital, almost 40% 1-6 weeks and only 2% more than three months, confirming that the Unit is functioning primarily as an acute unit, as proposed. The acute focus has meant that the YIU is seen as reluctant to admit young people for 'elective admissions' for a more intensive assessment or treatment stabilisation.

Data for the period July 2004 – December 2007⁴ (inclusive) show that the average length of stay for the 231 young people discharged during that period was 30 days (compared to 40 days for 245 children admitted to CFIU during that period) with an occupancy of 56% (62% for CFIU). Comparison with data from the '600 Inpatient Study' suggests that more admissions in the early days of the Unit were very brief crisis admissions or that the '600 Inpatient Study' excluded leave days from the LOS. Leave days need to be taken into account when considering occupancy and comparing it to acute adult psychiatric units as the use of weekend and extended leave as part of the therapeutic and assessment programme is commonplace in child and adolescent units. On the day I visited the YIU there were only three inpatients with one likely to be discharged the following week. I was informed that there was recently a period when there were no patients in the Unit.

One concern that was repeatedly expressed is the lack of general medical cover for the YIU. Apparently Princess Margaret Hospital provides medical cover for the other units on campus, including the CFIU, but this does not extend to the YIU. This leaves the responsibility for providing medical cover to the half-time medical officer or psychiatric registrars during normal working hours. After hours patients requiring urgent medical care must be transported to the Christchurch Hospital Emergency Department. This seems an unsatisfactory situation in a hospital setting.

Another concern has been the difficulty filling staff vacancies, particularly in the area of psychology. It is interesting to note in this regard that although many patients had 'psychometric testing' during their admission, none had any cognitive testing. Psychometric data in the descriptive data base for the 600 Inpatient Study confirm that the young people admitted are severely disturbed, that they improve while they are in the Unit, may deteriorate somewhat three months after discharge but not to pre-admission levels. This is consistent with other reports of the effectiveness of inpatient services as the gains made can only be maintained by active involvement of family/whanau, school

⁴ Child and Youth Inpatient Units Activity Data: July 2004 – December 2007

and community agencies. The descriptive data do not include statistical analyses that provide information about the significance of improvement or subsequent relapse.

Staffing issues were also raised in relation to psychiatry registrars. It is not clear why the YIU has not been included in the rotations for general psychiatry trainees. There are often insufficient advanced trainees in the child and adolescent training programme to ensure that there is always at least one trainee attached to the YIU and CFIU. This has meant that the Units have learned to function without registrars, leaving the psychiatrists to carry out duties that are usually the responsibility of registrars as well as their own responsibilities as consultant psychiatrists. Despite these difficulties registrars and consultants who recently completed their training in Christchurch spoke very warmly of their experiences in both units and expressed concern if the CFIU were to close. The only concern voiced by registrars related to the small number of patients to be shared between themselves and consultants. The advanced trainee spoke very positively of her experience in YIU and the responsibility she was allowed to carry for her patients given her experience and seniority.

The Unit has developed a strong database and standardised system of recording. This is a real strength, particularly if it is put to good use in the form of publications about the Unit's work and as the basis for successful research grant applications. The research and publication record of the Unit is disappointing however it should be acknowledged that it is no worse in this regard than many CAMHS in Australia. A culture of clinical research and inquiry should be encouraged, particularly if staff can accept that high quality clinical research informs clinical practice and vice versa. The importance of securing external funding for research is highlighted by the number of staff complaints about the demands on their time of administrative paperwork, including data collection, competing with patient care.

The Youth Day Programme (YDP) functions separately from the YIU and very differently to the Child and Family Day Programme (CFDP). It is not clear what proportion of YIU patients participate in the YDP either before or after their admission to the YIU. An attempt to include inpatients in the YDP in the past proved difficult as the patients were too unwell to participate fully. The YDP is a therapeutic programme rather than a school based programme, as is the case for the CFDP, with specific treatment modules or activities aimed at assisting young people with specific problems in the context of their underlying psychiatric disorder. School re-entry for YIU clients is seen as the responsibility of Youth Specialty Services rather than that of the YIU or YDP. It was pointed out that there is significant gap in services for those 15 years and over who are having difficulty attending school as Group Special Education Services are only available for those aged 14 years and younger.

Consumer/Family representatives and the Pukenga Atawhai commented positively on their acceptance and involvement in both units. However, they did feel that they could be more actively involved in the YIU as families have at times felt excluded from the YIU. They recognize that young people over 16 years may be more reluctant to involve family members than younger children. The recent appointment of a youth representative to the YIU is seen as a positive step in this regard. Staff induction about the role of the youth representative may be important in ensuring better use of the youth representative. The Pukenga Atawhai commented that information about ethnicity is not always accurately recorded, perhaps because some staff are simply reluctant to ask. If this is the case it could easily be rectified. They also highlighted the importance of Karakia, Taiaha and Kapahaka in the healing process for many Maori children and adolescents.

The Child and Family Inpatient Unit (CFIU)

Unlike the YIU, the CFIU has a long history, starting as a child psychiatry unit in 1982 in a vacant paediatric ward in the Christchurch Hospital before moving to the Burwood Hospital site and more recently to the Princess Margaret Hospital. Historically it has functioned as a medium to long stay unit for severely disturbed children who could not be managed on an out-patient basis. A significant proportion of these young people were from disadvantaged, dysfunctional families, many were in the care of Child, Youth and Family Services and many had a Disruptive Behaviour Disorder (Oppositional Defiant Disorder or Conduct Disorder often with comorbid ADHD and/or Learning Disorder). Under the leadership of Prof Philip Ney the key therapist was 'the Primary' who was responsible for her child's programme and the other clinicians often felt they needed the primary's permission before they could see a child. The situation at that time was further complicated by there being three independent mental health services for children and adolescents, namely the child inpatient unit, the adolescent inpatient unit at Sunnyside Hospital and the outpatient unit at Whakatata House. The subsequent closure of the Sunnyside Unit provided the funding for the Youth Specialty Services. It is important to acknowledge the role of the current Clinical Head, Dr Bill Watkins, who has been involved in CAFMHS from the early 1980s when there were few child psychiatrists in a much less integrated service than is the case now. In addition to his clinical responsibilities Dr Watkins has held a university appointment throughout that time.

In recent years the CFIU has increasingly admitted younger adolescents, often for relatively brief admissions. The CFIU also has facilities for admitting family members with a child, however it is not clear to what extent 'family admissions' are used for assessment or as part of a planned treatment programme, particularly with younger children. The Child Day Programme is a school-based programme functioning primarily as a step down unit for the CFIU.

I spoke to the mothers of a few children who had been admitted to the CFIU whose names and phone numbers were provided by the Unit. They all described very positive experiences with the CFIU and its staff.

Dr Bill Watkins, and the Charge Nurse Manager, Sandra Heemi, of the CFIU provided me with a folder of materials relating to the unit, its Principles, Philosophy and Procedures. The Principles and Philosophy set out the diverse population and purposes the Unit serves and the importance of a Social Psychiatry Model, Family Systems Model and Behaviour Management Principles in guiding the Unit's interventions with children and families.

In the course of discussion a number of issues have been raised in relation to the CFIU, including:

- The (past) use of LDTO and the Mental Health Act
- The role of the primary nurse
- Elective admissions
- Length of stay and bed occupancy
- Child and Family Day Programme
- Recording systems

LDTO and the Mental Health Act.

Given the CFIU's origins in the general hospital system, that is outside the mental health system, it is perhaps not surprising that there has been a reluctance to accept the Mental Health Act as the most appropriate vehicle for dealing with disturbed young people requiring inpatient care. Mental Health Acts are usually drafted with the needs of adult psychiatric patients in mind (the NZMHA appears to be no exception). The use of the MHA with children, particularly those under the age of 16 years, has been criticised in New Zealand and elsewhere as they are often seen as not taking the developmental needs of the child or the responsibility of parents for the health and well-being of their child into account. There may also be a real or perceived conflict between mental health and child protection legislation in this regard.

A particularly contentious point in the present context has been the use of *seclusion* (locked door time out) as an appropriate way of dealing with aggressive or 'out of control' behaviour in young people when less extreme measures have proved unsuccessful. Seclusion is differentiated from 'exclusionary time out' by the child's inability to leave the area in the case of seclusion.

This topic, including the relative merits of *restraint* whether physical or chemical, has been extensively but not conclusively reviewed in the American Academy of Child and Adolescent Psychiatry⁵. The authors comment that in a review of 20 deaths occurring during seclusion or restraint all child deaths occurred in 'therapeutic holds'. The authors conclude that in situations where less restrictive measures have failed to de-escalate a child's behaviour

The use of seclusion should be considered the option of first choice because it is medically safer than restraint and it preserves a greater degree of patient autonomy than restraint.
(p145)

The authors also point out seclusion is prohibited in some jurisdictions and that neither seclusion nor restraint should ever be used as a form of punishment. While the latter may appear self-evident, it is important to remain mindful of the potential for seclusion and restraint to be misused, particularly with younger children.

Seclusion has also been considered in the Australian context⁶. The authors note that the prohibition of locked seclusion in one unit (not their own) led to a marked increase in the use of chemical restraint. In their own study (an 11 bed inpatient unit for young people <18 years), they noted that patients with a diagnosis of ADHD and DBD were significantly more likely to require seclusion as were those with a past history of physical abuse.

The only reason for spending so much time on the question of seclusion/LDTO is the important part played by the issue in the lead up to this review. Although the use of LDTO is no longer permitted, it remains a contentious issue as evidenced by a letter from the current Clinical Head to the Minister for Health, dated 20/9/2007, a copy of which was made available to me.

⁵ *Practice parameter for the prevention and management of aggressive behaviour in child and adolescent psychiatric institutions, with special reference to seclusion and restraint.* J. Am. Acad. Child Adolesc. Psychiatry, 2002, 41 (2 Supplement):4S-25S

⁶ Fryer, MA, Beech, M, Byrne, GJA. (2004) *Seclusion use with children and adolescents: an Australian experience.* ANZ Journal of Psychiatry. **38**:26-33

The CFIU ceased using LDTO in April 2007 however the Clinical Head continues to express his reservations about this. He cites the literature reviewed above as the main reason for his opposition to the ban on LDTO. He also expressed his reservations about utilising the Act because of the stigma attached to its use for children and families. While respecting this point of view, it fails to take account of the safeguards that a Mental Health Act can provide against the possibility of institutional abuse and it is not consistent with the growing use of mental health legislation as the framework for CAFMHS in New Zealand and Australia.

Data provided by the Unit indicate that between April and December 2007 there were 45 admissions with 291 instances of Time Out, excluding use of the 'time out chair'. Of these 23% involved the child being in the bedroom or time out room with the door closed (but presumably not locked). Restraint, full or partial, was used on 70 occasions. Staff of the CFIU commented on the lack of high dependency facilities (HDU) however, concerns were expressed about the problems associated with sharing an HDU with the YIU given the vulnerability of the younger children and the severe disturbance of many adolescents.

The Clinical Director, Dr Harith Swadi, has indicated that neither he nor the Minister is opposed to the use of seclusion provided it is conducted in accordance with the provisions of the Mental Health Act (the Act). s71(2) of the Act allows the use of seclusion in an area designated for the purpose, with the authority of the responsible clinician except in an emergency, with each episode to be recorded in accordance with s129(1). It is beyond the scope of this review to advise whether children and young people admitted to the CFIU meet the definition of 'Mental Disorder' as defined in the Act. It may be necessary to seek legal advice about this as the most common indication for seclusion in child and adolescent units is aggressive rather than suicidal behaviour.

The primary nurse

Few would dispute the benefits of each child on the Unit having a primary nurse who is familiar with his/her history and family provided the nurse is an active member of the multidisciplinary team. It is clearly the role of the nursing staff to manage the daily programme, including the behavioural management programme, in consultation with other clinicians. I saw little evidence to suggest that other clinicians are denied access to children now although it was acknowledged that their main role is often with family members. It is not clear to what extent other non-pharmacological treatments, such as CBT, family therapy, individual psychotherapy are included in the treatment programme and if so who provides them.

Elective admissions

One feature of the CFIU has been its willingness to admit children for more intensive assessment than can be conducted in the community, particularly for children and families living some distance from Christchurch. The same may be said for the elective admission of a young person who is 'treatment resistant' or requires stabilisation on a new medication such as clozapine. A number of people spoke positively about the service provided by the CFIU in this way.

Length of stay/ bed occupancy

One problem for this review has been the lack of comparable data for the two units, apart from the Child and Youth Inpatient Units Activity Data: July 2004 – December 2007. Data are often recorded

in different forms, for different periods making comparison difficult if not impossible. There appears to be no data for the CFIU comparable to the 600 Inpatient Study. The main difference evident from the Activity Data⁷ is the mean LOS; for 245 discharges from CFIU it is 40 days compared to 30 days for 231 discharges from the YIU. While a ten day mean LOS difference may not seem a lot it amounts to almost 2500 bed days over three and a half years, or 700 a year.

Data provided by the CFIU for the period 1/1/2004 – 31/12/2007 indicate a mean LOS use of 45 days with a median of 26 days and a maximum of 332. By contrast, mean Bed day use (presumably the number of days on which the bed was actually occupied) was 25 days with a median of 15 and maximum of 237 days. These figures suggest beds are only used for about 60% of a child's admission, supporting the earlier comment that leave arrangements affect real and apparent occupancy. Over these four years 75% of 'bed days used' were for less than 30 days and less than 10% greater than 60 days. For this period it is interesting to note that over 80% of admissions were of 12-17 year-olds and 60% of admissions were female.

Child and Family Day Programme

The CFDP has been described as a form of 'partial hospitalisation', that is children attend daily for a school-based programme, rather than a day programme in which young people attend for specific treatment or modules while continuing to attend their 'home' school, as occurs with the Youth Day Programme.

Referrals to the CFDP are almost exclusively drawn from those in transition from the inpatient unit to the community and returning to mainstream school. The CFDP is a largely school-based programme focusing on remedial teaching, learning and behaviour management. It is part of the Southern Regional Health School, staffed by two teachers supported by a teaching assistant and 2.7 EFT day programme staff. Children generally attend the CFDP for 1-2 school terms. Although no data were provided to support the claim, staff indicated that about 90% of children attending the CFDP are successfully reintegrated into mainstream education. The CFDP operates during the school year with the clinical staff maintaining some contact with patients during the school holidays. Staff indicated a willingness to consider extending the programme during the holiday period, subject to appropriate funding. It is important to note that funding of the CFDP and recording of attendances is different to that for the YDP, making comparison difficult.

A number of clinicians expressed their concern about the difficulty they have experienced in referring young people from the community to the CFDP as they believe it is a valuable resource to which they would like more ready access. Concerns were expressed by staff about the increased workload and the delays that may occur if more children were referred directly to the CFDP instead of having a period as inpatients prior to commencing in the CFDP.

Recording systems

It is acknowledged that the two inpatient units have different recording systems in a number of areas, making comparison difficult. These include:

- Risk assessment

⁷ Child and Youth Inpatient Units Activity Data: July 2004 – December 2007

- Standardised data collection
- Funding formula for the two day programmes

Child and Adolescent Units in Australia

I have spoken to a number of psychiatrists in Victoria, NSW and Queensland in order to compare services with CAFMHS. In all three states there has been a significant expansion of inpatient units for children and adolescents. While most units theoretically admit young people from 0-19 years, most admissions are adolescents between 12-18 years. Questions about occupancy rates and leave arrangements are commonly raised in Australia as well. While there are some 5-day units this is not appropriate for acute admission units.

Victoria, with a population of over five million, has five adolescent inpatient units in metropolitan Melbourne. There is also one child and family unit, the 12 bed Eagle Unit located at the Austin Hospital, which also has the facilities to admit one family. All units are gazetted, meaning they are able to admit involuntary patients under the Mental Health Act, and all are located in or affiliated with paediatric or general hospitals. There is also one private adolescent unit, non-gazetted, at the Albert Road Clinic. The adolescent units are all acute psychiatric units but I do not have detailed diagnostic or LOS information.

Most admissions to the Eagle Unit are 'planned' but there are a growing number of crisis admissions, usually only for a few days, for the acute management of suicidal behaviour. The usual LOS is 5-6 weeks but occasionally admissions last considerably longer, in rare instances over a year. Extended stays such as these most often arise in children who do not respond to the usual treatment programme. In many cases there are complex protective concerns and/or family problems leading to difficulty discharging the child. Younger children, those younger than nine years, are usually admitted with their families for up to four weeks. Parents sometimes go to work from the Unit. While the Unit is gazetted the provisions of the MHA are rarely used as parental consent is generally considered sufficient. Although the Unit has a time-out room it is never locked. Physical restraint or 'therapeutic holding' is used as required. The majority of admissions to the Eagle Unit are boys with Disruptive Behaviour Disorders aged 9-12 years.

New South Wales has a population of almost seven million and is divided into eight health regions. Each region has an 8-12 bed child and adolescent inpatient unit or one is planned. While most young people admitted are over 12 years old, all units have the capacity to admit primary school aged children. The mean LOS is around 21 days with some young people remaining considerably longer. In addition, the Coral Tree Unit (formerly Arndell) has a Family Admission Unit and a day programme for younger children. Redbank House does not admit children without their families but has a day programme for younger children. The Children's Hospital at Westmead (formerly the Royal Alexandra Hospital for Children) has a gazetted unit for those <16 years at the time of their first admission. Young people with Eating disorders are usually admitted to the Adolescent Medical Unit. The Sydney Children's Hospital (formerly Prince of Wales Children's Hospital) has eight beds on the Adolescent Medical Ward that serve principally as a consultation-liaison service. A high intensity, gazetted, long stay unit with 12 beds and two family admission rooms is planned at the Concord Hospital for treatment resistant young people from the acute units. Finally, an adolescent forensic unit with ten male and six female beds is being completed as part of a forensic hospital adjacent to Long Bay Gaol.

Queensland, with a population over four million, has two inpatient units that are to be combined in the proposed Queensland Children’s Hospital in Brisbane as well as a unit on the Gold Coast.

RECOMMENDATIONS

The recommendations set out below are framed in the context of the three areas defined in the terms reference. Where I consider a recommendation requires further explanation this will be provided in the form of a footnote. The recommendations are intended as ideas for consideration and I recognise that decisions about their implementation are the responsibility of management based on clinical, financial and other priorities.

1. *Delineate a standardised and appropriate philosophy for Service Delivery and Clinical Practice across the Inpatient spectrum of the CAF Service.*

1.1. CAFMHS should develop a model of excellence based on best clinical practice, high quality training and research.⁸

1.2. Research, both internally and externally funded, should be strongly encouraged throughout the CAFMHS and closer links sought with appropriate university departments with a strong research track record⁹. Mechanisms to encourage research within CAFMHS and IMHSCYF should be developed, such as:

1.2.1. Planning for future academic leadership of CAFMHS¹⁰

1.2.2. designated funding for research for pilot projects or to attract staff with a proven research record

1.2.3. performance incentives for securing external research funding and/ or publishing research findings in peer reviewed journals.

1.3. CAFMHS should develop closer links with organisations responsible for training professionals who work in CAFMHS to ensure that CAFMHS is seen as a centre of excellence in training psychiatrists, nurses and allied health professionals in child, adolescent and family mental health.¹¹

⁸ CAFMHS has the core ingredients, including skilled staff, to develop such a model which would make it a leader in the field in New Zealand and internationally. Such a model would attract and retain high quality staff, improve staff morale and greatly enhance the inpatient service of CAFMHS, as described below.

⁹ This recommendation is intended to encourage staff to appreciate how good clinical research can inform clinical practice and vice versa. It also aims to build on New Zealand’s outstanding contribution to child and adolescent mental health research.

¹⁰ It may be necessary to plan several years ahead to recruit a person with appropriate training and academic interests and fund them to spend 1-2 years overseas before returning to a leadership position in CAFMHS.

¹¹ Involvement in training ensures that staff are well informed about current ‘best practice’ and ‘evidence-based’ practice rather than adhering to cherished ideologies.

1.4. The present CFIU and YIU be redesignated as a single entity to indicate that they represent the most intensive, most restrictive and most expensive component of a comprehensive CAFMHS delivered by the CDHB for residents of the South Island of New Zealand¹².

1.4.1. A title such as Inpatient Mental Health Services for Children, Youth and Families (IMHSCYF) may be considered suitable. This will be used as a working title in subsequent recommendations.

1.4.2. IMHSCYF should develop a common philosophy for the provision of inpatient services for children, youth and their families, including a clear statement about the place of inpatient services in the full range of services provided by CAFMHS.¹³

2. Draw up a model for the delivery of age appropriate and evidence based Inpatient Services taking into account their relevance to the wider CAF Service.

2.1. IMHSCYF should include an Acute Adolescent Inpatient Unit, a Family Admission Unit and possibly a 'partial hospitalisation' therapeutic school programme, as described below.¹⁴

2.2. IMHSCYF should

2.2.1. extend existing liaison and outreach programmes through FMHS to the West Coast, Otago and rural Canterbury regions to ensure that young people needing the specialist services of IMHSCYF are able to access these services in a timely and clinically appropriate manner.¹⁵

2.2.2. extend existing programmes for family members/whanau to ensure that they are involved in the treatment of young people admitted to IMHSCYF unless there are protective or other concerns that make their involvement inappropriate.¹⁶

2.2.3. develop common policies and protocols for admission¹⁷; data collection regarding admissions, length of stay, discharge; policies regarding leave;

2.2.4. ensure that all admissions comply with the requirements of the Mental Health Act, including agreed procedures for time-out, seclusion and restraint when necessary for the safe management of a child or young person.¹⁸

¹² As will be seen below, the recommendations include a substantial reconfiguration of inpatient services across the CAFMHS age spectrum and therefore a redesignation of the service is recommended to ensure that staff, other CAFMHS, the CDHB, consumers and the community all see IMHSCYF as different from the services currently offered by the CFIU and YIU.

¹³ Inpatient services should be seen as part of the continuum of care for children, youth and families with mental health problems together with day programmes, specialist community based services and primary care in the community.

¹⁴ An added benefit of considering the inpatient service as one entity is that it will provide trainees in psychiatry, child and adolescent psychiatry and other disciplines with a broader training experience.

¹⁵ See also, Family Admission Unit below.

¹⁶ The model of consumer/carer representatives is to be applauded and should be preserved and extended, particularly in the YIU/AAIU.

¹⁷ Inpatient care should only be used when less restrictive approaches have not been successful or are contra-indicated because of severity of illness, family dysfunction or the inability of local services to meet the need.

- 2.2.5. develop policies, in consultation with the Director of Area Mental Health Services for the CDHB, regarding expected occupancy levels, recording of leave arrangements, staffing levels etc.
- 2.2.6. develop policies for closer collaboration and staff sharing between the units during periods of high demand.
- 2.3. The Acute Adolescent Inpatient Unit (AAIU) for the intensive assessment and/or treatment of acute psychiatric disorders should be established, incorporating and expanding the services currently provided by the YIU and CFIU.
- 2.3.1. the admission criteria for the AAIU should be extended to include young persons between the ages of 12 and 18 years.¹⁹
- 2.3.1.1. This is likely to require an increase in the number of beds, possibly 10-12, may be necessary to accommodate this change.²⁰
- 2.3.2. The Unit's admission policy should provide for elective or semi-elective admission of young people for short periods of intensive observation for the assessment of those with complex diagnostic problems or during significant changes to medication, such as the introduction of clozapine, where close observation that is not available on a less restrictive basis is required.²¹
- 2.3.3. The AAIU should have a High Dependency Unit that can accommodate at least two acutely disturbed young people, if necessary, with higher levels of security than is currently possible.²²
- 2.3.4. The current systematic data collection used by the YIU is to be applauded and could be retained or adapted for use in the IMHSCYF.
- 2.3.5. The facilities of the Family Admission Unit (see below) should be used to complement the services provided by the AAIU, particularly for geographically remote families.²³

¹⁸ While acknowledging the Clinical Head and Charge Nurse Manager's objections to the use of the MHA for this purpose and their preference for the previous LDTO it is consistent with current practice elsewhere and provides some protection for patients against the misuse of such procedures.

¹⁹ This is recommended as clinically appropriate and consistent with practices elsewhere. It represents a major change from the current admission guidelines for the YIU and will require staff to develop skills in dealing with a wider age group.

Consideration will also need to be given to the most appropriate facility for the admission of children under 12 years who require a period of inpatient care for assessment or treatment. At present less than 20% of admissions to the CFIU are under 12 years, many of whom are likely to be suitable for admission to the proposed family admission unit or the therapeutic school programme. Occasionally the AAIU may be required to admit young people aged 10-12 years for brief crisis admissions with a view to early discharge or admission to the FAU once stabilised.

²⁰ Examination of admission data for the YIU and CFIU is necessary to estimate the number of beds required, taking into account occupancy levels and a possible added demand for beds if the AAIU is seen as more readily accessible to young people throughout the South Island.

²¹ Such admissions are important in providing a full range of services for acutely ill young people. They will also increase bed utilisation.

²² This may reduce the number of young people allowed to leave the Unit because of concerns about aggression.

2.3.6. The establishment of a Youth Assessment and Mobile Support Team, possibly in association with the YSS and/or FMHS, should be considered.²⁴

2.4. A Family Admission Unit (FAU) should be established within the facilities currently occupied by the CFIU and CFDP to accommodate families with a disturbed child whose assessment and/or treatment is likely to benefit from the intensive involvement of family members and who cannot be properly managed within the community.²⁵

2.4.1. The FAU should be redeveloped to accommodate up to 2-3 families for admissions of 2-4 weeks duration.²⁶ It may be appropriate to run this unit on a weekday only basis.²⁷

2.4.2. The following groups of children and adolescents may benefit from family admission:

2.4.2.1. Younger children with severe mood disorders or psychoses and those with complex diagnostic problems, including pervasive developmental disorder, with multiple comorbidities, etc.,

2.4.2.2. Children and families who require tertiary level services but whose distance from Christchurch makes it impractical for them to access such services without admission,

2.4.2.3. Young people (<18 year olds) with severe eating disorders,²⁸

2.4.2.4. Families of young people admitted to the AAIU where the assessment and/or treatment of the young person would be enhanced by more intensive involvement of family/whanau than can be achieved in the community.²⁹

2.4.2.5. There may be an opportunity to pilot programmes such as those for the intensive treatment of children with disruptive behaviour disorders, attachment disorders and/or children in abusive families.³⁰

²³ This may increase utilisation of the Unit by families outside metropolitan Christchurch and adjacent towns as well as complementing the treatment options currently available for acutely disturbed adolescents. The involvement of family members during a young person's inpatient stay is likely to increase the chances of sustained improvement after discharge.

²⁴ Such a service could provide urgent assessment in the community of acutely disturbed young people prior to admission to the AAIU as well as providing active outreach and treatment support after discharge. An active outreach service is likely to reduce length of stay and the morbidity associated with prolonged hospitalisation as well as improving treatment adherence. This is consistent with current trends in the management of first episode psychosis.

²⁵ The intention is to develop the FAU in a unique role as the primary admission and treatment unit for younger children and families as well as supplementing the services provided by other units such as the AAIU and the adjacent Eating Disorders Unit.

²⁶ Experience in Victoria suggests that families are willing to accept admissions of this duration to help a child, sometimes with one or both parents going out to work from the unit. Longer admissions may occasionally be necessary for some families, such as those of young people with severe eating disorders.

²⁷ This may be more attractive to families as well as having positive budgetary implications.

²⁸ There is an opportunity to develop collaborative treatment programmes with the Eating Disorders Unit and/or the AAIU for the management of these young people.

²⁹ It is widely accepted that gains made during an inpatient stay are often not maintained unless there is active family involvement and careful transition to community-based services.

- 2.5. The role of the school programme in the CFIU and the CFDP needs to be reviewed in consultation with the Ministry of Education if the proposed changes to CAFMHS are adopted³¹.
- 2.6. The establishment of a 'partial hospitalisation' therapeutic school programme (TSP) as one component of IMHSCYF should be considered.³²
- 2.6.1. Such a programme would involve daily or almost daily attendance for psychiatric, psychological and educational assessment and treatment/ remediation. Only in exceptional circumstances should young people remain in the programme for more than a school term.
- 2.6.2. The TSP should develop its own admission criteria however it is expected that most referrals will come from the CFSS, in consultation with local educational services. It should not be seen as a transitional unit from the FAU however, some children may be referred from the FAU.
- 2.6.3. The emphasis of the TSP should be remedial education combined with the full range of clinical services available in CAFMHS in situations where less intensive intervention is insufficient.

³⁰ The recent *Inter-agency plan for Conduct Disorder/ Severe Antisocial Behaviour (2007-2012)* noted "Conduct disorder/ severe antisocial behaviour, particularly in younger children is also one of the strongest predictors of poor long-term outcomes into adulthood, including criminal offending, substance abuse, and mental health problems." CAFMHS, and the FAU in particular, may have an important part to play in the development and piloting of innovative early intervention programmes in conjunction with the Ministries of Education and Social Development, as described in the above report.

³¹ The Child and Family Day Programme (CFDP) was not specifically included in the terms of reference for the review. However, if the recommendations described above, including the recommendation to establish a therapeutic school programme, are accepted this will have significant implications for the CFDP as this is largely a school-based programme.

If the AAIU is established then the Southern Regional Health School may also have an important role to play in providing specialist educational assessment and support as well as liaison with mainstream schools for those young people who are still attending school or wish to resume mainstream education.

³² Such a programme is likely to be most appropriate for primary school aged children in the greater Christchurch area with psychiatric, learning and behavioural problems who require more intensive intervention than is available in the community. It could become an important component of the Conduct Disorder initiative referred to above.

3. Make recommendations regarding any necessary service changes required to operationalise that model of service delivery.

It is difficult to make recommendations regarding service and operational changes until management decides which recommendations will be adopted. Many of the operational changes are best left to the management team, in consultation with the Clinical Director and Service Manager, who are more familiar with local facilities and requirements. This said, there are some matters that should be addressed as a matter of priority. These include:

3.1. Recruitment of allied health professionals, particularly psychologists, to both the YIU and CFIU.

3.2. Youth Inpatient Unit

3.2.1. Appropriate arrangements for medical cover for inpatients need to be negotiated with the Princess Margaret Hospital.³³

3.2.2. Provision for direct viewing from the nurses' station of young people in the HDU is an urgent priority and could easily be achieved.³⁴

3.2.3. The format of the twice weekly clinical meetings should be reviewed.³⁵

3.2.4. Ensuring that admission data properly record the ethnic origin of all young people and that family/ whanau are involved when appropriate.

3.3. Child and Family Inpatient Unit

As described above, the recommendation is to discontinue the CFIU in its current format and establish a family admission unit in its place. However, if this is not to proceed then it is suggested that

- greater emphasis be placed on family admissions, particularly with younger children. This is likely to require some retraining of staff.
- meetings occur between the Clinical Director, Service Manager and the Clinical Heads and Charge Nurse Manager of the YIU and CFIU to rationalise the admission policies for the two units. This may include revision of the age criteria and consideration of running the CFIU as a five day unit.

³³ While there may not be a frequent need for medical cover it is not satisfactory that medical cover is not available in a hospital setting. This may be a safety issue, in the event of a young person being admitted with an underlying medical problem or in the event of a suicide attempt not requiring urgent transfer to acute medical facilities. The use of a medical officer for this purpose is not appropriate as it depends on the skills of the officer in question.

³⁴ This is a priority safety issue as it is currently not possible to see a young person in the HDU from the nurses' station. This means a nurse must be present in the HDU if there are concerns for a young person's safety. This may occasionally be a safety issue for the nurse as well.

³⁵ While accepting the benefits of twice weekly reviews for risk assessment and clinical monitoring, repetition of the clinical details of each young person at each meeting seems an unnecessary demand on staff time.

- a review of data collection by the YIU and CFIU be carried out to establish an agreed common data base similar to the one used in the '600 Inpatient Study'.

3.4. If management decides to proceed with the recommendation to establish IMHSCYF

3.4.1. capital works will be necessary to:

- 3.4.1.1. accommodate 10-12 young people in the AAIU
- 3.4.1.2. set up a two bed High Dependency Unit (HDU)
- 3.4.1.3. adapt the CFIU to admit 2-3 families simultaneously
- 3.4.1.4. accommodate the TSP

3.4.2. consultation with the Eating Disorders Unit is necessary to establish a conjoint programme for the management of young people with eating disorders

3.4.3. consultation with the Ministry of Education should occur about the future role of the Southern Regional Health School in IMHSCYF

Appendix 1

**Terms of Reference
Child, Adolescent and Family Service
Inpatient Services Review**

Scope

Following the SMHS discussions with the MoH, a decision to cease the use of locked door Time Out as part of clinical intervention/treatment at CFU was made. The decision was taken in full recognition of the impact it might have on service delivery and clinical practice.

The MoH approved that decision on the basis that it is only part of a general review of inpatient services delivered by CDHB for children with mental health problems

The CFU has been in operation for over 20 years and has seen significant changes in its function over the years especially in the last 5-7 years. There is a timely need for a strategy for service delivery to that age group consistent with national and international trends in service delivery.

It is now well over 5 years since the Youth Inpatient Unit opened. The YIU provides services to 16-17 year olds only.

Although the two units share a spirit of cooperation and collaboration, significant differences in philosophy and clinical process exist.

It seems appropriate now to review the provision of inpatient clinical and service delivery both locally and regionally. To this end, it is necessary to view this within the wider context of the CAF Inpatient care options including the Child and Family Unit and the Youth Inpatient Unit.

Purpose

1. Delineate a standardised and appropriate philosophy for Service Delivery and Clinical Practice across the Inpatient spectrum of the CAF Service.
2. Draw up a model for the delivery of age appropriate and evidence based Inpatient Services taking into account their relevance to the wider CAF Service.
3. Make recommendations regarding any necessary service changes required to operationalise that model of service delivery.

Process

External Reviewer

Completion Date

February 2008

Appendix 2

DR BOB ADLER

INPATIENT UNIT REVIEW – 11TH – 13TH FEBRUARY 2008-02-01

MON – 11/02/08	MEETING / DETAILS	VENUE
0730-0900	Breakfast Meeting with: Vince Barry, General Manager Assoc Prof, Phil Brinded, Chief of Psychiatry, SMHS George Schwass, Operations Manager, SMHS Dr Harith Swadi, Clinical Director, CAF Service Kaye Johnston, Service Manager, CAF Service	Cup Café 127 Hackthorne Road Cashmere (Table booked in the name of Kaye Johnston)
0900-1030	Harith and Kaye accompany Dr Adler to meet with staff and outline process.	
0900-0945	Child and Family Inpatient Unit	Seminar Room Child & Family Unit
0945-1030	Youth Inpatient Unit	Meeting Room Youth Inpatient Unit
1030-1130	Consumer/Family Representatives Trish Lumb Casey McNab Julie Grainger Theresa Parker	Kotuku Meeting Room First Floor Heathcote Building TPMH
1130-1230	Dr Matt Eggleston, Clinical Head, CFSS Craig Scott, Clinical Manager, CFSS	Kotuku Meeting Room
1230-1300	LUNCH	Kotuku Meeting Room
1300-1500	CFIU Business Meeting – observe and meet staff Meet staff Look through notes, systems policies etc Meet with Primary Nurses Jason Watson CFIU Day Programme	Seminar Room Child & Family Unit Nurses Station
1500	CFIU Clinical Review meeting Sit in on part then meet with	Seminar Room CFIU
1530-1630	Dr Bill Watkins, Clinical Head, CFIU	Bill Watkin's office CFIU
1630-1730	Chris Howison, Consultant Psychologist, CFIU	Chris Howison's office CFIU
1700	Phone calls/information required	

TUE – 12/02/08	MEETING / DETAILS	VENUE
0830-0930	Southern Regional Health School Chris Parsons Principal/Teachers	Child & Family Inpatient Unit Health School TPMH
0930-1000	Lesley Dixon, Pukenga Atawhai, CFIU Te Pora Ehau, Te Pakake, Te Korowai Atawhai Donna Roberts, Pukenga Atawhai, YIU	Kotuku Meeting Room Heathcote Building
1000-1030	BREAK	Kotuku Meeting Room
1030-1130	Dr Valerie Black, Clinical Head, FMHS Tim Butcher, Clinical Manager, FMHS	Kotuku Meeting Room Heathcote Building
1130-1200	BREAK	Kotuku Meeting Room
1200-1300	LUNCH	Kotuku Meeting Room First Floor Heathcote Building
1300-1500	YIU Clinical Review and meet key staff Look at documents/policies/notes etc	Meeting Room Youth Inpatient Unit Nurses Station
1500-1600	BREAK	Kotuku Meeting Room
1600-1700	Phone calls as required: Regional Consultants from other South Island Districts Starship Hospital, Auckland Processing of documentation	Kotuku Meeting Room First Floor Heathcote Building TPMH
1700	Phone calls/information required	

WED – 13/02/08	MEETING / DETAILS	VENUE
0900-1000	Dr Brian Craig, Clinical Head, Youth Inpatient Unit	Bellbird Meeting Room
1000-1100	YIU Business Meeting and meet key staff, documents, policies etc	Meeting Room Youth Inpatient Unit
11.00-12.00	Dr Nabeel Pirwani, Consultant, Youth Inpatient Unit and Youth Specialty Services	Kotuku Meeting Room Heathcote Building
1200-1230	Look around Youth Day Programme accompanied by Jo Kennedy	Youth Day Programme TPMH
1230-1300	LUNCH	Kotuku Meeting Room
1300-1400	Dr Daniel Svoboda, Clinical Head, YSS Nigel Loughton, Clinical Manager, YSS	Bellbird Meeting Room First Floor Heathcote Building TPMH
1400-1500	Craig Cowie CAF Service Acting Nurse Consultant	Bellbird Meeting Room First Floor
1500-1530	BREAK Harith and Kaye	Kotuku Meeting Room First Floor Heathcote Building
1530-1630	Give key staff preliminary feedback	Seminar Room, CFIU
1630-1700	BREAK	Kotuku Meeting Room
1700	Phone calls/information required	

Abbreviation Key:

SMHS	Specialist Mental Health Services
CAFMHS	Child Adolescent and Family Mental Health Service
TPMH	The Princess Margaret Hospital
CFSS	Child and Family Specialty Service
CFIU	Child and Family Inpatient Unit
YIU	Youth Inpatient Unit
FMHS	Family Mental Health Service
YSS	Youth Specialty Service