Clinical: Mental Health
Proactive Release: 25 February 2020

10 February 2020

9(2)(a)

Email 9(2)(a)

Dear 9(2)(a)

Official Information Act (1982) Request

I write in response to your Official Information Act request, sent to MoH on the 5th December 2019 and partially transferred to us on the 23rd January 2020. You requested the following information:

Models of care for the following adult acute mental health facilities:

- **Tiaho Mai - acute MH ward - Counties DHB**

As context for this response, Counties Manukau Health (CM Health) provides health and support services to people living in the Counties Manukau region (approx. 569,400 people), as well as regional and supra-regional specialist services (Burns, Plastics and Orthopaedics). Our services are delivered via hospital, outpatient/ ambulatory and community-based models of care.

We employ more than 7,500 staff, and see more than 118,000 presentations at the Middlemore Hospital Emergency Department each year.

As requested attached is a copy of the Tiaho Mai Business Case - **Model of Care for an Adult Acute Mental Health Inpatient Unit**.

I trust this information satisfactorily answers your query. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Please note that this response or an edited version of this may be published on the Counties Manukau DHB website.

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive Officer
Counties Manukau Health

Released under Official Information Act - ref 05122019 Jenkin

Model of Care for an Adult Acute Mental Health Inpatient Unit

Released under Official Information Act - ref 03122019 Jenkin

Prepared: CM Health Mental Health Service

Counties Manukau District Health Board

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Note to the Reader:

- Please note that the generic term ‘service user’ or ‘service users’ has been used throughout this document to describe people who access mental health services. Within the mental health sector, Maaori service users are also referred to as ‘Tangata Whaiora’ and Pacific service users as ‘Tagata Ola’.
- Where the term ‘whaanau’ is used within this document, it refers to a service users family, extended family and significant others who may be important to the service user in supporting their recovery. ‘Partner’s in Care’ is the term utilised in Counties Manukau Health to identify a specific member of a service users whaanau who has been identified by them to participate in care planning, decision making and providing personal support during their inpatient stay.
- The acronym 'MHIPU' stands for mental health inpatient unit
- 'Tiaho Mai' is our current acute mental health inpatient unit based on the Middlemore Campus

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Executive Summary

"The building is so run down, the carpet heats up [under floor heating] and gets smelly [damp and drainage issues]. Staying in an open ward was frightening; one day when I was in the bathroom a male patient banged on the door and asked if I wanted to have sex. I was really frightened. Single rooms with single ensuites and lockable doors would make people feel so much safer at night. I tried to stay awake and alert because I was too frightened to sleep. I felt anxious all the time and it took weeks for me to feel better. The staff did what they could; they are very caring even though they have to work in crap conditions. I eventually started to feel better and was able to go home. My husband and I think it took much longer than it should have."

Counties Manukau Health is currently developing a business case to seek approval to replace our mental health inpatient unit, Tiaho Mai, with a new acute mental health inpatient unit (MHIPU) which will be based at Middlemore Hospital.

The current MHIPU is not fit for purpose; the layout and condition of the facility presents significant barriers to ensuring staff and service user safety and maintaining infection control standards, and creates a physical and psychological environment which is incompatible with a place of healing and recovery. The facility has also been identified as a leaky building and continues to deteriorate structurally.

It is expected that the new facility will:

- Have more beds to reduce the current overcapacity and enable service users to be offered a timely admission when it is appropriate for them to be treated in an inpatient environment
- Offer a fit for purpose facility which will enhance service delivery and staff and service user safety
- Offer the flexibility of spaces which can be configured to meet the needs of all services users including vulnerable groups whilst maintaining their safety, privacy, dignity and comfort.

We are proposing in this paper a recommended model of care to support service delivery in this new MHIPU. This paper outlines the principles and philosophy of care which gives the model of care its framework and how this might work - from an operational perspective - for service users.

In 2012, the Counties Manukau Health's Mental Health Service established Framework for Change (FFC) to address challenges that were impacting on the service's ability to deliver acute services in a manner which facilitates access, continuity and consistency of care and to ensure better mental health outcomes for service users. Some of these challenges include changing demographic growth and

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the complexity of presenting users, resulting in deficiencies in the system, such as, over occupancy in the inpatient unit, assessments for non-offending service users being conducted in the police hub, and low levels of staff, service user and family/whaanau satisfaction.

Under the FFC, a new acute pathway has been designed to address the deficiencies described above. The reconfigured acute care pathway provides for better organisation and integration between acute community services and the acute inpatient service.

Figure 1 is a visual representation of the new acute care pathway which features:

- A single point of entry to all CM Health mental health acute and hospital-based services
- A centralised intake and assessment to all services
- Improved access to the right service at the right time due to better understood service pathways
- Smoother discharge or transfer through supported discharge
- Incorporates greater delivery in home and community settings using home based treatment

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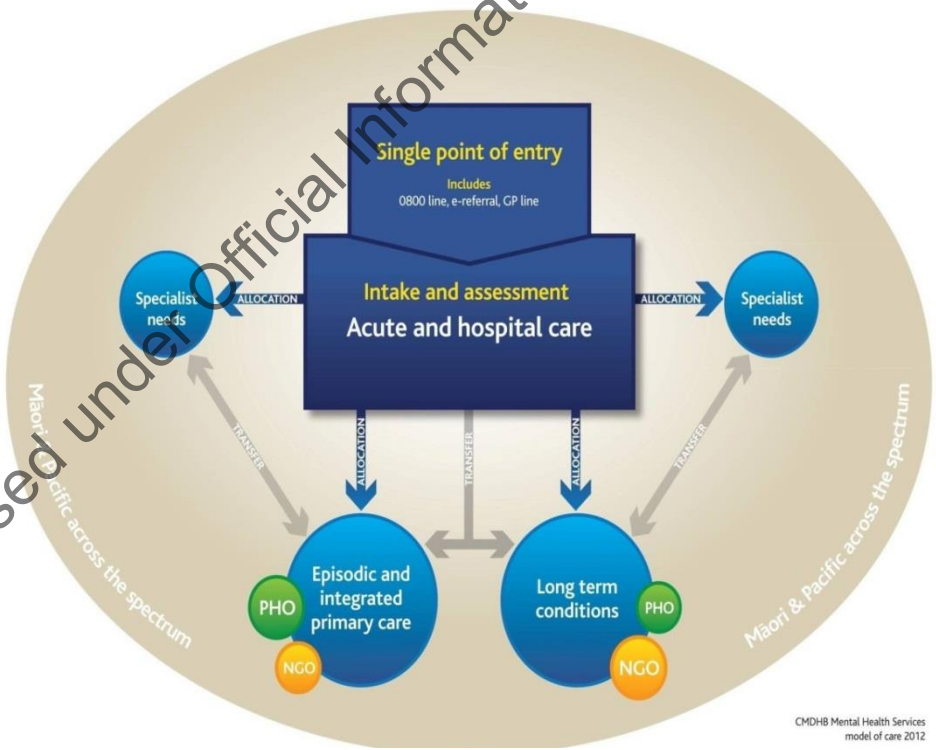
Figure 1: Acute Pathway under Framework For Change (FFC)



The current MHIPU's model of care is based on an integrated service delivery between seven community mental health teams and the adult acute mental health inpatient unit. Each of the community mental health teams has a number of inpatient beds allocated to them based on anticipated demand and population. Admissions and discharges are co-ordinated between all seven teams on a daily basis. Medical staff worked across the community mental health teams and inpatient unit. Over time and as the population and demand has grown, this model has become less efficient and the numerous points of interface between the community and inpatient unit led to disjointed service delivery.

The new model of care will streamline processes by reducing the points of interface with the inpatient unit and refining the clinical pathway based on the needs of the service user. Integration between all services remains a key objective for the new model of care. Only one community mental health team currently provides a 'home based treatment service'.

The implementation of the acute pathway for Framework for Change (FFC) will be central to the easing of pressure on the adult acute inpatient unit by ensuring that home based treatment (acute care) will be available to all the community mental health teams rather than just one. If admission to hospital is the best clinical intervention, the treatment aim of the inpatient unit will be to provide an intensive service in order that the service user can be discharged to a less restrictive environment as soon as possible to complete their acute episode of care.

The recommended model of care has been shaped and informed by the following:

- the review of mental health services in the development of Framework for Change
- literature review of best and emerging practice
- site visits to inpatient units recognised as centres of excellence
- understanding the demographic profile of our service users
- value stream analysis of current processes with a view to identifying waste and improving the quality of care
- feedback from workshops and focused group discussions with service users, whaanau, inpatient and community mental health staff, colleagues from other parts of the mental health system as well as the wider health system.

The emerging themes and views gathered propose a model of care for the new acute inpatient unit which will be guided by the following philosophy and principles of care:

- Recovery and resiliency: 'Resiliency is the capacity of individuals to cope well under adversity. A resiliency approach encourages individuals to build the capacity to care for their own mental health. It encourages social inclusion as an important tool for reducing the impact of mental health and addiction issues and supports families and communities to take part in that process. Recovery is commonly defined as living well in the community with natural

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supports'. The recovery approach stresses 'hope, self-determination, full citizen participation and a broad range of services and resources for people with mental disorders'. (Commission, 2012)

- Acknowledges that admission to a mental health inpatient unit can be a stressful and threatening experience for some service users and there is a need to provide a service which will reduce the stress, fear and emotional impact of an admission.
- Recognises that partnerships with service users and their whaanau are the key to achieving the best possible health outcomes.
- Acknowledges that admission to a mental health inpatient unit can distance a service user from their natural supports and there is a need to ensure that those supports (often family/whaanau) can participate in and support care planning, decision making and service delivery within the inpatient unit.

There will be strong patient and whaanau focus:

- service users will be at the centre and participate in decision making
- whaanau are actively engaged and supported in their role
- service users are treated in a culturally appropriate and sensitive manner
- functions, treatment and processes take into account a Tikanga Maaori approach to recovery as well as consideration of evidence based Maaori models of health
- vulnerable service users will have their needs met in an environment that is protective and consistent with therapeutic requirement
- service users will have their rights protected including treatment options being provided in the least restrictive environment and having their legal rights acknowledged and provided for
- service users will have their needs met in a safe and welcoming environment that is free of judgement and recognises the need for privacy.

The environment will be functional, safe and comfortable and the quality of services will be provided in line with good practice (Daw, 2011).

Broadly, the unit will pay particular attention to the key components of inpatient care. These are:

- Admission and reception, care planning, treatment and intervention
- Meaningful activity – therapeutic engagement, social interaction and recreation
- Follow up, discharge planning and community re-integration

Within the inpatient unit there will be the ability to deliver a high intensity care service and lower intensity care service. There will be "flexible" beds that can become either high intensity care beds or low intensity care beds depending on the needs of the inpatient population at the time. The "flexible" beds will have the ability to be operated in isolation if necessary to ensure that vulnerable service users

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can be cared for safely within the unit and integrated with the unit as they improve and the risks decrease.

Vulnerable users in an inpatient setting could be:

- People with mental disorders and physical co-morbidity
- People with mental disorders and intellectual disabilities
- Young people aged 16 and upwards who are more suited to an adult inpatient environment because of where they are developmentally
- Vulnerable women, including mothers with babies

Enablers that will support the delivery of the proposed Model of Care are:

- Continued partnership with our service users and their whaanau using a co-design approach
- Strong clinical governance through the Acute Forum and the MHIPU Clinical Governance
- A multidisciplinary workforce
- Good design of acute treatment environments and facilities
- The configuration of other acute functions: Mental Health Short Stay, Home Based Treatment and Crisis Respite
- Good integration and linkages with the hospital, diagnostic and clinical services
- Information systems.

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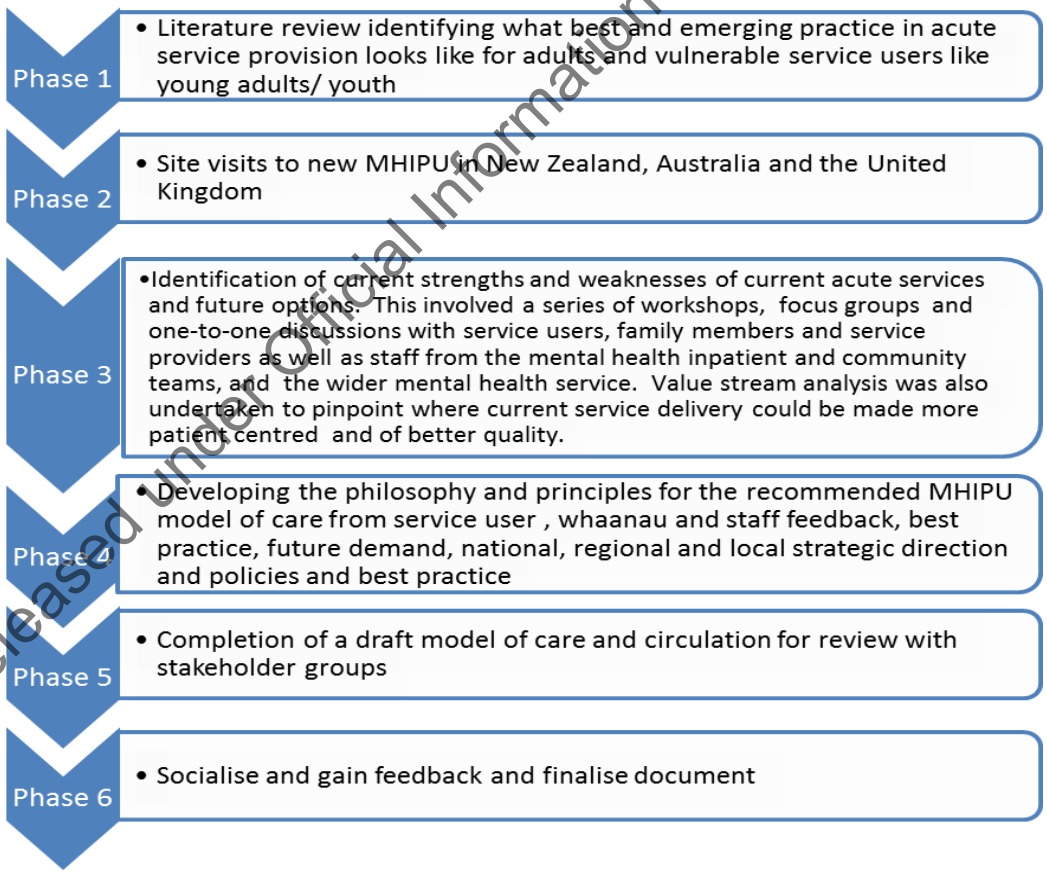
Introduction

Counties Manukau Health is currently developing a business case to seek approval to replace our mental health inpatient unit, Tiaho Mai, with a new acute mental health inpatient unit which will be based at Middlemore Hospital.

To support service delivery in this new facility, we are proposing a new model of care for the acute inpatient unit. This paper outlines the principles and philosophy of care which gives the model of care its framework and how this might work - from an operational perspective - for service users.

The model of care will be used to assist in the development of a detailed business case for submission to the Capital Investment Committee, and will set out the proposed unit's philosophy and principles of care, the scope of service, and will support the assumptions which sit behind the business case around demand, bed numbers, staff numbers, facility requirements, financial viability and value for money.

The development of this document has the contributions and feedback of external and internal stakeholders. The process used to develop the model of care has been:



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Section 1: What service users want and need

This section summarises the key themes and findings from the focused group sessions with current and past Tiaho Mai and Youth Respite service users. See Appendix 1 for a more detailed report on the co-design process and service user perspectives.

Co-Design: the Experienced Based Design (EBD) Approach

There is significant evidence that working with service users and their family/whaanau in a healthcare environment to better understand and improve their experience leads to better health and organisational outcomes. (NHS Institute for Innovation and Improvement, 2009)

Bringing service users, their whaanau and staff together is an exciting new way to improve care through the co-design of services. Key decisions and design of services and policies are frequently done without consultation with key stakeholders i.e. the service user and their whaanau. A co-design approach allows staff and stakeholders to work together as partners on specific ideas or projects.

We have taken a co-design approach to this project, for the development of this model of care, and will be using similar approaches for facility design.

There are four high level but key steps to the EBD approach. As detailed in the table below:

Key Steps	Activity /tools used	Our activity and progress to date of the report
Capture the experience	There are multiple methods that can be used and these include interviews with individual patients/whaanau, focus groups, shadowing, observation, filming	72 consumers and their whaanau were invited to participate in either an depth telephone conversations or focus group meeting during May and June 2014
Understand the experience	The rich information captured is organised into themes relevant to the context of the work. This might be across a service or process for example.	For this work we organised the data into the main themes that recurred frequently within the review of the literature. These included: the Environment Inside and Outside; Resources/Activities/Options; Privacy and Dignity; Safety; Food; Visitors; Partners in Care and Communication.
Improve the experience through co-design	It is only when consumers are actively involved in decisions about the design and designing any service or building that we can say that co-design has taken place.	It is recommended that a co-design event is planned for this project where staff, service users and whaanau can come together and describe their experience and work together to co-design the new MHIPU and Model of Care.

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Measure the improvements	Measurement can take different forms depending on the context of the work. When working closely with service users it is important to ensure the emotional aspects are not lost. **"***what matters more than raw data is our ability to place these facts in context and deliver them with emotional impact"* Daniel Pink. *A whole new mind*. 2008	Measure for this project are yet to be fully agreed, however an analysis of the level of co-design and of how the final building /model of care design reflects what service users and whaanau said during the capture phase would be a good indicator.

For the purposes of this project we have sought to capture and understand the experience. Recommendations will be made to improve and measure the improvement in the design of the new acute MHIPU.

Engaging service users and whaanau to capture their experience

To engage with service users and their whaanau, admission data was obtained for service users who were inpatients at Tiaho Mai in the six month period of September 2014 to April 2014.

Of the 371 service users identified, a random sample of 1 in 5 was taken which provided names of 72 service users from across the Counties Manukau mental health service areas of: The Cottage (North) 28; Manukau (Central) 25; Awhinatia (South) 12; and Te Rawhiti (East) 7.

Ethnicities included: Maori (21), Pacific (17), Asian (6) and Other (31). Each of the 72 service users identified was sent an individual invitation to attend a focus group or participate in a 1:1 interview in person or via the telephone. The letters were followed up with personal phone calls. In order to include the experience of young adults a similar approach was used to identify young people who had accessed local respite facilities in the same time period.

Throughout May 2014 focus groups were held at a number of community sites in the afternoons, early evenings and one Saturday afternoon. Group interviews were also held in Tiaho Mai and at Child and Adolescent Mental Health services and a youth respite facility. In-depth telephone interviews were held with people who requested this approach.

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Understand the Experience

The experience of service users and their whaanau was recorded and the information was assembled into themes:

- Environment Inside and Outside
- Resources /Activities/Options
- Privacy and Dignity
- Safety
- Food
- Visitors
- Partners in Care and Communication.

Of the rich and detailed information captured the themes evolved quite quickly:

- Preference for a colourful homely environment
- Bedrooms with comfortable beds
- Plenty of natural light and opening windows with free flowing air
- Easy access to outdoor areas with flourishing gardens and private spaces to sit with whaanau or visitors in the outdoors would be welcomed
- Multi-use activity rooms with quiet spaces and space for vigorous activity, music or exercise
- Service users described feeling uncomfortable with having only their bedrooms to go to for 'chill out' or quiet time
- Adequate private meeting rooms and private space to meet with whaanau and visitors was described as being essential to people's recovery and wellbeing
- Improved privacy in the treatment/clinic room area is essential to restore people's sense of dignity and safety
- Lockable bedrooms and bathrooms for privacy and improved safety were also identified as a priority
- Flow of the rooms and shared spaces should include consideration of privacy when moving distressed people to clinic rooms, or low stimulus areas
- Availability of technologies such as Wi-Fi internet access and iPods for listening to music were also highlighted
- Aa spiritual space reflective of the diverse cultural needs of our community would be appreciated
- Service users and whaanau members spoke well of staff and their care and treatment in a currently challenging environment of Tiaho Mai, although a clear opportunity for improvement was identified in relation to communication
- Having clear treatment plans and which involved service users and their whaanau in their development was essential to upholding the principles of partnership and participation

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- Maaori service users spoke of welcoming the opportunity to korero with staff in Maori and the importance of easy access to the Whare (at Nga Whetumarama)
- A number of people spoke of waiting lengthy time periods to be given information relating to their care and treatment
- One family member spoke of her skills and ability to advocate for her family which was effective in eliciting a timely response from staff
- It was identified that families whose cultural norms were traditionally more humble may be less comfortable to advocate for themselves in a healthcare setting and may receive less than optimal information and engagement from staff working in a busy and challenging environment

Improving the experience of our service users and their whaanau aligns with the well documented principles of patient and family centred care, that is, patients deserve high quality health care and their views and experiences are integral to improvement efforts. These principles include: patients are involved in decision making and their preferences are respected; effective treatment is delivered by staff you can trust; ready access to reliable health advice; empathy and emotional support; patients have clear comprehensible information and support for self-care; physical comfort and a clean, safe environment; involvement of family and friends and support is offered to them; continuity of care and smooth transitions are essential to resilience and wellbeing.

Improving the Experience of Service Users and their Whaanau

Effective solutions to improve service user and whaanau experience won't just come from better listening; they'll come through better discussion and deliberation. By working together to create solutions, ideas can be articulated without judgement followed by a shared responsibility to explore and learn.

It is essential at this next stage of developing the new model of care that service users and staff are able to review the learning from previous stages and be engaged in describing what 'fantastic' looks like both for the physical space and for the model of care delivery.

The mental health service will be coming together on the 12 August 2014 with service users and whaanau as well as partners in the sector like the Police, Justice, unions and local mental health service providers to review this proposed model of care.

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Section 2: Current utilisation of mental health services

This section provides a snapshot of the current utilisation of acute services. The service user profiles and current usage of Tiaho Mai is presented as well as more general mental health usage figures from a recent CM Health report, *Populations who have received care for mental health disorders: An Overview*. (Winnard, et al., 2014)[1]

In 2011, it was estimated that 35,180 or nearly 1 in 10 adults aged 18 and over living in Counties Manukau received care for a mental health disorder[2]. If people who were treated for mental health conditions in primary care and were not dispensed psychotropic drugs were added, the 'wider' population receiving care for mental health disorders would be larger at approximately 1 in 6 adults or 15.7% of the adult population aged 18 and over.

Key findings from the 2011 CM Health report:

- Maaori were more likely than other ethnicities to be receiving specialist mental health care, having contact with specialist mental health services and /or identified as receiving care for a psychotic disorder
- About 30% of all mental health service contacts were with Maaori service users (Maaori is 14% of the total CMDHB adult population)
- 59% were female compared to 41% male
- The elderly (aged 75+) had the highest prevalence of care for mental health disorders
- People living in the most socioeconomically deprived areas (Quintile 5) were more likely to have had contact with specialist mental health services or received care for psychotic disorders but were less likely to have received care for depression and/or anxiety
- People who had received care for mental health disorders had a higher prevalence than those who weren't identified as receiving care for mental health disorders of having long term conditions such as diabetes, cardiovascular disease, chronic obstructive pulmonary disease, and congestive heart failure.
- over 3,700 youth aged 12 years to 19 years of age received care for a mental health disorder. This is 5.7% of the population age group.
- Youth were increasingly likely to receive mental health care as their age increased from 12 years to 24 years.

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[1] At the time of writing, the Census 2013 estimated resident population count is scheduled for release in November 2014.

[2] that is, they were seen by a specialist mental health and addiction service or had a hospital admission which resulted in a mental health or addiction diagnosis or have been prescribed a psychotropic drug dispensed from a community pharmacy.

Tiaho Mai service user profile

This snapshot of our inpatient unit service users has been profiled from inpatient data from July 2012 to June 2014.

- 48% of inpatients were between the ages of 18 and 35 years old
- 34% of inpatients were between the ages of 36 and 50 years old
- The ratio of males to females is about 1.5 males to every 1 female inpatient
- 21% of inpatients were Pacific
- 35% of inpatients were Other
- 33% of inpatients were Maaori
- 9% of inpatients were Asian
- 33% of inpatients stayed at the unit up to 7 days
- 47% of inpatients stayed at the unit between 8 to 28 days
- 20% of inpatients stayed at the unit for more than 29 days

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Section 3: Future Population Demand

This section gives the reader a brief overview of the Counties Manukau population profile and future growth. This is based on Census 2006 as Census 2013 was unavailable at the time of this report.

CM Health provides health and disability services to an estimated 521,000 people who reside in the local authorities of Auckland, Waikato District and Hauraki District.

The population of our district is growing at a rate of approximately 1.5% per year, the second fastest growing population (behind Waitemata DHB) compared with other DHBs.

Overall, the district population is expected to grow by approximately 8,300 residents each year for the next 11 years. From 2014 to 2025, the number of new residents in Counties Manukau is projected to be 91,600.

Key demographic features:

- 38% Pakeha and Other, 23% Pacific, 16% Maaori and 23% Asian
- Under current population projection assumptions, the Asian population in the district will increase the fastest (120%, between 2006 and 2026), followed by Pacific (64%), then Maaori (33%), while our Pakeha population will reduce in absolute numbers (-7%).
- 24% of our population is aged 14 years and younger. 14% of New Zealand's children live in Counties Manukau, and we have the highest number of 0 to 14 year olds of all the DHBs
- Maaori are relatively young compared to non-Maaori/non-Pacific, with estimates that 37% of the Maaori population is aged 15 years and younger
- 34% of the Counties Manukau population live in areas classified as being the most socio-economically deprived in New Zealand (with a deprivation index of 9 or 10).
- If the 2006 situation persists, 57% of Maaori, 79% Pacific and 43% of 0 to 14 year olds in Counties Manukau will live in areas with a deprivation index of 9 or 10

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Section 4: Framework for Change (FFC) and the adult acute pathway

This section outlines a key programme of service development and improvement for CM Health's mental health service called the Framework for Change (FFC). FFC considers the whole system of mental health services and clarify the relationships and interfaces of the inpatient unit within this whole system. The development of FFC started in 2012 and is currently in the early implementation stages for the acute care pathway, with the plan to implement the non-acute pathway in late 2014.

The CM Health mental health service is currently engaged in a programme of service development and improvement known as the Framework for Change. The expected outcome of this programme is a reconfigured acute care pathway for adults. The expected timeframe to complete the service reconfiguration and ensure it is sustainable is 12 to 18 months (June 2014 – December 2015)

The second phase of the Framework for Change will be the development of the non-acute care pathway for adults. The expected outcome for this piece of work is a reconfigured service, some parts of which will be integrated within primary health. The expected timeframe to begin this piece of work is December 2014.

The whole system of mental health services is conceptualised as three interlinked tiers.

- Tier One: The whole system of care which is the framework that encompasses all Counties Manukau Health's mental health services to all age groups.
- Tier Two: The Acute Care Pathway which is the framework that encompasses all acute/urgent mental health services.
- Tier Three: The Non-Acute Care Pathway which is the framework that encompasses all non-urgent mental health services.

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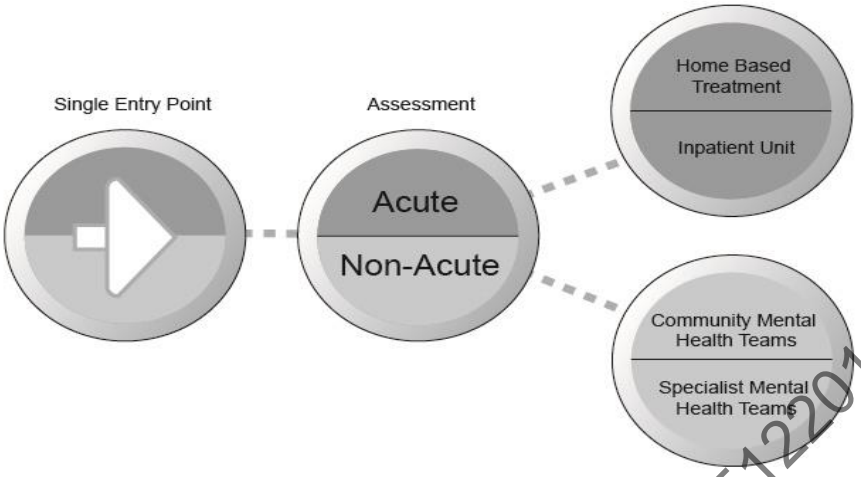
The following diagram illustrates the two Pathways and their linkages.



The Acute Care Pathway refers to the following services:

1. Intake and Assessment and Crisis Resolution (including the Emergency Centre and Police Station)
2. Home Based Treatment
3. Community alternatives to Inpatient Care (NGO)
4. Inpatient Unit (including Supported Discharge)

The Non-Acute Care Pathway refers to the following services:

1. Community Mental Health Teams
2. Specialist Community Mental Health Teams (such as clinical/cultural teams, Intensive Care Team)

The broader model of service delivery for CM Health mental health services is described in the diagram below.

Within the model a single entry point for all services is outlined as is the relationship between the entry point and all other mental health services. Inpatient (hospital) care is one of a number of acute services. The emphasis of the Acute Care Pathway is easy access to the right service at the right time and easy discharge or transfer between services as determined by the mental health needs of the individual.

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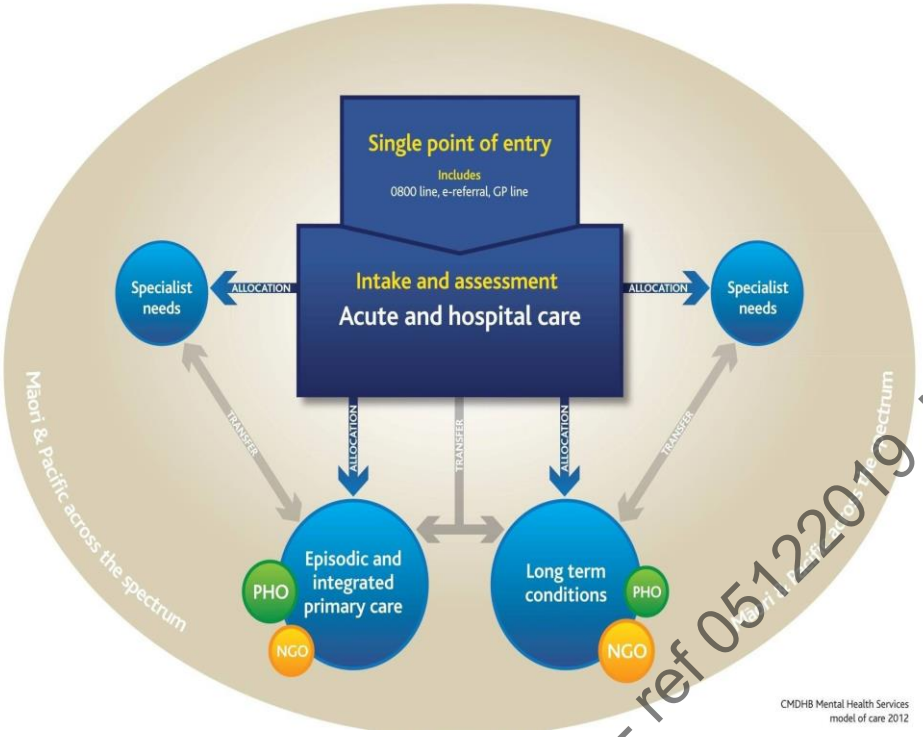

The Acute Care Pathway

Acute mental health services provide a service to those people experiencing, at risk of, or recovering from a mental health crisis. An integrated Acute Care Pathway refers to interlinked services and agencies that work closely together to support service users and their whaanau to resolve an acute mental health issue. Given that inpatient admissions are of shorter duration than in the past, the focus of an admission is to work with the service user and their whaanau until they can have their care delivered by a less restrictive and intensive service. It is therefore important that the acute community services and the inpatient services work closely together.

The expected outcomes of implementing the reconfigured Acute Care Pathway for adult services are: (Sorensen, 2014)

<u>Reduced</u>

- waiting time for a response to a referral (urgent and non-urgent)
- waiting time to access a bed in the inpatient unit and respite
- inpatient occupancy
- inpatient admissions
- readmission rate
- inpatient length of stay

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Improved

- access to acute treatment in the community
- quality through reduced variation
- access to cultural assessments and relevant interventions to meet the needs of our diverse population

Increased

- service user satisfaction
- service user choice
- staff satisfaction

More Effective

- Standard Operating Procedures across the Acute Pathway

The beginning of the Acute Care Pathway is when an individual is first referred to Intake and Assessment and the end of the pathway is when the individual's care is transferred to another non-urgent service, or follow up team.

There are 3 distinctive services within the Acute Care Pathway.

1. **Intake and Assessment:** This is the single point of access for all referrals. The role of the Intake and Assessment service is to determine:
   - what the reason is for the referral and what the needs are of the service user
   - how quickly mental health services need to respond to the referral (triage – urgent/non-urgent)
   - comprehensive assessment which will determine the service that will be best to meet the identified needs
   - facilitate the transfer of the service user to the service that best can meet the identified needs

   All urgent referrals will be processed within the Acute Care Pathway. All non-urgent referrals will be processed within the Non-Acute Care Pathway. The Intake and Assessment service is mobile and can undertake assessments in a variety of community settings.

   Mental health service users present for help in a number of different places including at the police station (The Manukau Police Hub) or at the Emergency Department. The Hub and the Emergency Department are considered a part of the Intake and Assessment service and the process for determining the reason for the referral and needs of the service user (assessment) and the speed of the response (triage) will be the same.

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2. **Home Based Treatment:** This is the service that delivers intensive, acute clinical care to service users either in their own home or in a community facility. The aim of the Home Based Treatment service is to provide acute care within the community that the service user lives which enables the service user to continue to get support from their usual sources.

   The Home Based Treatment services aims to minimise disruption for service users. Sometimes the treatment environment that is offered is a respite facility or an admission to Tupu Ake. Tupu Ake is a community (NGO run) service that offers an alternative to admission. The clinical service is provided to service users admitted to Tupu Ake from the Home Based Treatment clinicians.

   Access to the Home Based Treatment service is via Intake and Assessment for a new referral. A service user who is already receiving a non-acute service may access Home Based Treatment from their regular clinical team. In the case of an existing service user the Home Based treatment team offers a more intensive service than the regular or home team can which can prevent relapse and admission to hospital.
   The expectation is that the key worker from the home community team remains closely involved with the service user and their whaanau throughout the acute episode of care and they will facilitate the transfer back to the home service at the appropriate time.

   This model of service delivery ensures that services can be responsive by increasing the level of intensity as required by the service user and decrease the intensity when no longer required. The aim is to prevent admission to hospital.

3. **Inpatient Unit:** Admission to hospital (the most intense service that is offered from within the acute pathway) may still be the option that best meets the needs of the service user and the best environment to manage the identified risks. The Inpatient Unit provides a 24 hour clinical service within an environment that is safe, welcoming and comfortable.

   Most service users who are admitted to a mental health inpatient unit have more than one diagnosis with the second often being substance use issues and/or physical health issues. The Inpatient Unit can provide assertive treatment and close monitoring and assessment. Access to the Inpatient Unit is via Intake and Assessment or Home Based Treatment.

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The treatment aim of the Inpatient Unit is to provide an intensive service in order that the service user can be discharged to a less restrictive environment as soon as possible to complete their acute episode of care. For this reason most service users who are discharged will have their care transferred to Home Based Treatment or to Supported Discharge.

Inpatient services and Home Based Treatment services closely align because both provide assertive treatment interventions within different environments. The skill set of staff that work within these services should be interchangeable.

The Supported Discharge Team is a small group of clinicians based with the Inpatient Unit who aim to provide a short term "wrap around" service to support service users and their whaanau post discharge.

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Section 5: The Recommended Inpatient Unit Model of Care: Philosophy and Principles of Care

This section captures the philosophy and principles of care which we feel should underpin the MHIPU model of care. These have been identified from service users, whaanau, best practice, literature review, service reviews, staff consultations and discussions.

Function of the Inpatient Unit

The MHIPU will facilitate timely admissions and discharges. It will offer comprehensive multi-disciplinary assessments, provide diagnostic clarity and intensive treatment and plans. Discharge planning will usually involve transfer to another component service within the Acute Care Pathway (i.e. Supported Discharge or Home Based Treatment) so it is vital that the community arm of the Acute Care Pathway and all other stakeholders are involved in planning throughout this stage.

Philosophy and Principles of Care

For the past decade, Recovery principles have shaped all mental health services, including the Acute Care Pathway. Under the guidance of the Mental Health Commission and *Blueprint II* the challenge is to now strengthen the approach to recovery principles as well as incorporating the principles of resiliency and people-centred and directed approach.

The aim is to provide a service user centred framework consistent with the principles of Recovery that is also in alignment with evidence based best practice. A people-centred approach is one where there is real partnership between people with mental health and addiction issues, their whaanau and their service provider.

Resiliency is the capacity of individuals to cope well under adversity. Utilising resiliency approach encourages individuals to build capacity for their own health issues including mental health.

It is noted that the "Recovery philosophy stresses hope, self-determination, full citizen participation and a broad range of services and resources.." this refers to a set of values about a person's right to build a meaningful life for themselves with, or without the continuing presence of mental health symptoms. Recovery is based on the ideas of self-determination and self-management. It emphasizes the importance of hope in sustaining motivation and supporting expectations of an individually fulfilled life.

The MHIPU will be guided by the principles of Trauma Informed Care. "Trauma Informed" means that there is a need to understand that the impact of violent and

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damaging experiences has a profound impact on a service user's physical, emotional, economic, mental and spiritual wellbeing. The experience of trauma can also affect a person's response to a stressful or threatening situation. Admission to a mental health inpatient unit can often be experienced as stressful and threatening. A Trauma Informed Care system aims to provide a service that is designed to reduce the stress, fear and perceived threat of an admission in order to not add to the 'trauma burden' of the individual.

Patients and their whaanau/family need a broad range of opportunities to provide feedback about their experiences of using CMDHB services. (CMH 2012) . Ongoing feedback mechanisms will ensure that MHIPU are responsive to the experiences and needs of service users and their whaanau.

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Service Users and their Whaanau as Partners in Care

- Partnerships with patients and their whaanau are the key to achieving the best possible health outcomes. (CMH 2012)
- CMH recognises the important role that family, whaanau and significant others can play in supporting a person's recovery during their time in hospital. (CMH 2012)
- Wherever possible and as soon after admission as is practicable, clinicians will support the patient to define who will be their identified 'Partner in Care' and how they and other members of their whaanau will be involved in care, care planning and decision making. (CMH 2012)
- Service user strengths, needs and preferences will be acknowledged and supported as part of their recovery and will inform decision making.
- Service users will have their rights protected including treatment options being provided in the least restrictive environment and ensuring that their legal rights are acknowledged and provided.
- Service users will be able to access a continuum of acute care services and non-acute care services with the ability to have services increase in intensity and decrease in intensity according to their need and the needs of their participating whaanau.
- Whaanau members who are participating as Partners in Care will be actively engaged and supported in their role
- Service users will be treated by staff who will provide a participatory culture that is culturally appropriate and sensitive.
- Functions, treatment and processes will take into account a Tikanga Maori approach to recovery as well as consideration of evidence based Maori models of health e.g. Te Whare Tapa Wha.
- Service users who are assessed as having a particular vulnerability will have their needs met in an environment that is protective and consistent with therapeutic requirements.

- Service users will have their needs met in a safe and welcoming environment that is free of judgement and recognises the need for individual difference, diversity and privacy.

Functional, Safe and Comfortable Environment

- The physical environment will be consistent with therapeutic requirements and facilitate a feeling of safety with good visibility, logical flows and comfortable facilities.
- The physical environment will be able to have a degree of flexibility as to the use of each space and enable the care of acutely unwell service users to occur with privacy and dignity.
- The physical environment will include spaces that can be adapted to meet the needs of vulnerable and/or highly agitated and distressed service users in a way that supports evidence based best practice. The spaces will cater for different levels of acuity and different phases of care.
- The physical environment will support the admission and transfer of care process to occur in a safe and welcoming space that is large enough to include the admitting clinicians and accompanying whaanau. Admission to the unit is seen as a key clinical activity and an opportunity to establish a therapeutic alliance that can be developed over the course of the episode of care.
- The physical environment will have up to date technology and be able to meet future needs. Service user and staff safety and the effectiveness and efficiency of care will be enhanced by the readily accessible technology systems that integrate with the other community acute services and automate clinical and administrative systems.
- The physical environment will provide adequate space for a range of therapeutic interventions (e.g. sensory modulation) to promote well being and recovery.
- The physical environment will provide adequate non clinical space to meet the requirements of staff, including training requirements.
- The physical environment will be decorated in a manner that reflects and respects the vibrant and diverse cultures within our community. Cultural artefacts (taonga) will also demonstrate our commitment to the delivery of culturally responsive service provision.

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Satisfying, Challenging and Rewarding Excellence

The MHIPU will be a desirable place to work because staff are valued and there is a work culture that encourages and fosters outstanding performance, innovation, and leadership. The evidence of outstanding performance will be enhanced service user experience and better health outcomes.

Cultural Diversity

- The Inpatient unit services a wide range of ethnicities. Maaori and Pacific service users have high utilisation rates and generally spend longer periods in hospital. Counties Manukau is also home to a growing Asian population.
- In order to better meet the needs of our diverse population, we will work towards achieving an equitable workforce balance reflective of our community's demographics (CM Health, 2014). At the same time, we must enhance the cultural skill sets of the current workforce regardless of their own ethnicity. The development and training of cultural leaders (champions) via the cultural capability strategic objective will allow trained staff to share their cultural knowledge across the inpatient service.
- The inclusion and participation of whaanau is an essential part of the recovery journey for Maaori, Pacific and Asian people. We are committed to creating a service that understands that individual wellbeing is intrinsically linked to the wellbeing of the entire whaanau (Whaanau ora).
- The Marae provides an environment that equalises the power balance between Whaiora, whaanau and the clinical team which in turn encourages more collaborative and ultimately more meaningful interactions for both parties. Furthermore the Marae supports the development of cultural therapies such as mirimiri (massage) and whakamoemiti (blessings) and facilitates a more humanistic and service user/whaanau centred approach to mental health care provision.
- Pacific and Asian service users will also benefit from culture specific rooms. For each of these ethnicities, hospitality and the sharing of food (manaakitanga) is part of the rituals of engagement.
- First impressions are important when building relationships. We will work towards greeting service users in their own language to further support engagement thereby showing our commitment to respectful and collaborative care.
- Cultural assessment and formulation will be offered whenever possible to enhance the service user, whaanau and clinicians understanding of the many possible origins and contributing factors to the service user's distress. It will also provide enriching possibilities for improved health practices that might include cultural practices relevant and appropriate to each unique service user.

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Interlinked Services

The MHIPU is one component within the Acute Care Pathway and links to other services – especially Intake and Assessment and Home Based Treatment and community mental health service providers. All interface points will be clearly described and the agreed processes audited. The provision of services within the Acute Care Pathway will be driven by the needs of service users.

Standards for Adult Inpatient Mental Healthcare

The Royal College of Psychiatrists has developed an occasional paper, *Do the right thing: how to judge a good ward; Ten standards for adult inpatient mental healthcare* that identifies ten standards that will be used to check on the quality of services that are provided. (Daw, 2011)

1. **Bed occupancy rates of 85% or less.** Ensuring that there are always some vacant beds means that service users can be admitted in a timely way to a local bed and retain links with their personal support networks. Delays in admission may cause symptoms to worsen. Admission to an out of area bed can cause a disconnection from whaanau which may increase length of stay and a further sense of isolation and alienation.
2. **Ward size maximum of 18 beds.** Smaller wards facilitate a more personal and comfortable environment. They enable a good relationship with staff and help to ensure that care planning is tailored to meet an individual's needs.
3. **A physical environment that is fit for purpose.** The layout, design, decoration and ambience provided by the physical surroundings all play a role in fostering a therapeutic environment for service users and for staff. Access to fresh air and the outdoors is as important as access to quiet, private spaces on the unit. The unit should have appropriate spaces for the community team to provide in-reach services. The unit should have separate toilets and sleeping accommodation for men and women.
4. **The ward as a therapeutic space.** The ward needs to be a therapeutic space that can help a service user to gain control over their recovery. It should provide spaces that support a structured therapeutic system of activities on weekdays and weekends alike. There should be a range of activities that are offered to services users. It is very important that service users have a range of activity choices, particularly when the admission to hospital has been involuntary.
5. **Proportionate and respectful approach to managing risk and safety.** Therapeutic interventions should support a lowered risk profile. As the service user improves and the risk issues are reduced, the environment should correspondingly be less restrictive. Safety results from good relationships and interactions between staff and service users. Staff aim to develop a relationship of trust which contributes to lowered risk and improved safety for all.

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6. **Information sharing and involvement in care planning.** Service users and their family/whaanau wish to be listened to and supported. They need the relevant information provided and explained . They need, to the extent that is feasible, to be directly involved in decisions about their care and in care planning. Even for those individuals who are very unwell, this aids in autonomy and instils belief in recovery. For people detained against their will this includes seeking consent to treatment and recording that fact, or, when the individual lacks capacity, ensuring that they are actively involved in decisions about treatment.
7. **A recovery-based approach: links with the community and other agencies.** A recovery based approach underscores most aspects of inpatient care. Inpatient units are a **part** of the wider community and links with the Counties Manukau community are essential. This means linkages with specific community services and linkages with the wider community as a whole. Those experiencing day to day life in the inpatient unit need to have appropriate, community-related activities that are integrated into their care plans.
8. **Access to psychological interventions ("talking therapies").** Inpatient units should provide access to a range of psychological interventions for the acute illness phase of psychosis and other diagnoses. Psychological therapies need to be provided by staff who have the appropriate skills and experience.'
9. **Personalised care, staffing and daily one to one activities:** Every staff interaction with service users and their whaanau needs to make a positive contribution towards patient and whaanau centred care. (CMH PWCC Strategy 2012) . One to one interaction on a daily basis is the key to building a trusting therapeutic alliance and to reviewing the health issues at the broadest level. One to one interaction provides the listening time that service users value so highly. Disturbed and erratic behaviour can be minimised with regular one to one sessions.
10. **Providing socially and culturally capable care.** Delivering culturally capable care is the ability to feel confident and comfortable working in partnership with people from different cultures. Delivering culturally capable care means going beyond such obvious but central matters as diverse religious practices, English language requirements, dietary requirements and cultural observances. It should also include staff training to address attitudes and beliefs that cause misunderstanding between groups that may result in unequal treatment.

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Section 6: What the recommended Inpatient Unit Model of Care will look like in practice

This section walks the reader through what the recommended model of care philosophy and principles will look like for a service user from the point of referral to discharge from the MHIPU and subsequent follow up in the community. The different vulnerable groups of service users are described including what their needs are and how they may be met.

The development and enhancement of community based mental health services has meant that most people who experience an acute mental health episode can have their care delivered at home or in an acute alternative facility such as respite or Tupu Ake (an NGO peer-led facility). Admission to hospital can still be required when community options are insufficient to meet the needs of the individual or it is not safe or appropriate to provide a service within the community.

The key principles underlying admission to the MHIPU are the provision of the least restrictive environment (while still ensuring safety) and the transfer of care to a less intensive service when appropriate. Inpatient treatment is the most intensive treatment service that is provided within the Acute Care Pathway.

Under the changes proposed through Framework for Change, access to the MHIPU for a service user who has been newly referred will be via the Intake and Assessment service or the Home Based Treatment service. Access for an existing service user of a non-acute service will be via Home Based Treatment or the Mental Health short stay service.

The diagram on the left shows the pathway from Intake and Assessment to the other services within the Acute Care Pathway for a service user who has been newly referred, whilst the diagram on the right shows the pathway for an existing service user to access admission to the MHIPU.

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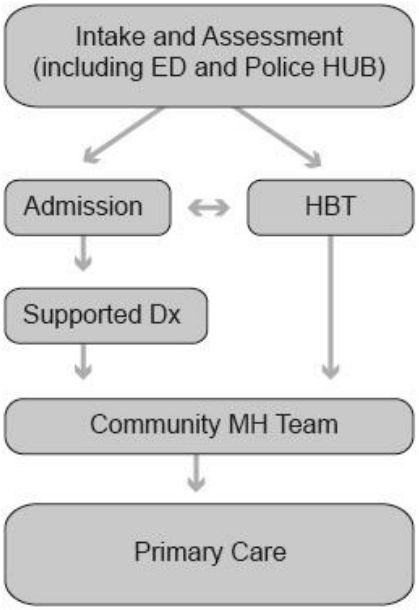
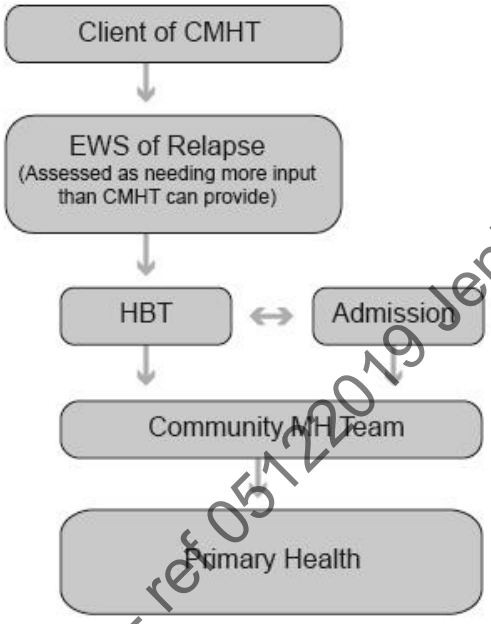
Proposed Admission Pathway



Current Admission Pathway



The decision to admit to the MHIPU is made by clinicians in either the Intake and Assessment service or the Home Based Treatment service. The rationale for this is that clinicians in these components are actively involved in acute treatment provision and can determine, in consultation with the service user and their whaanau, whether care can best be provided in a community environment or in hospital.

The decision to admit is based on a number of variables that need to be carefully assessed on a case by case basis. The following is a high level pathway that outlines the steps to be considered prior to admitting someone to hospital.

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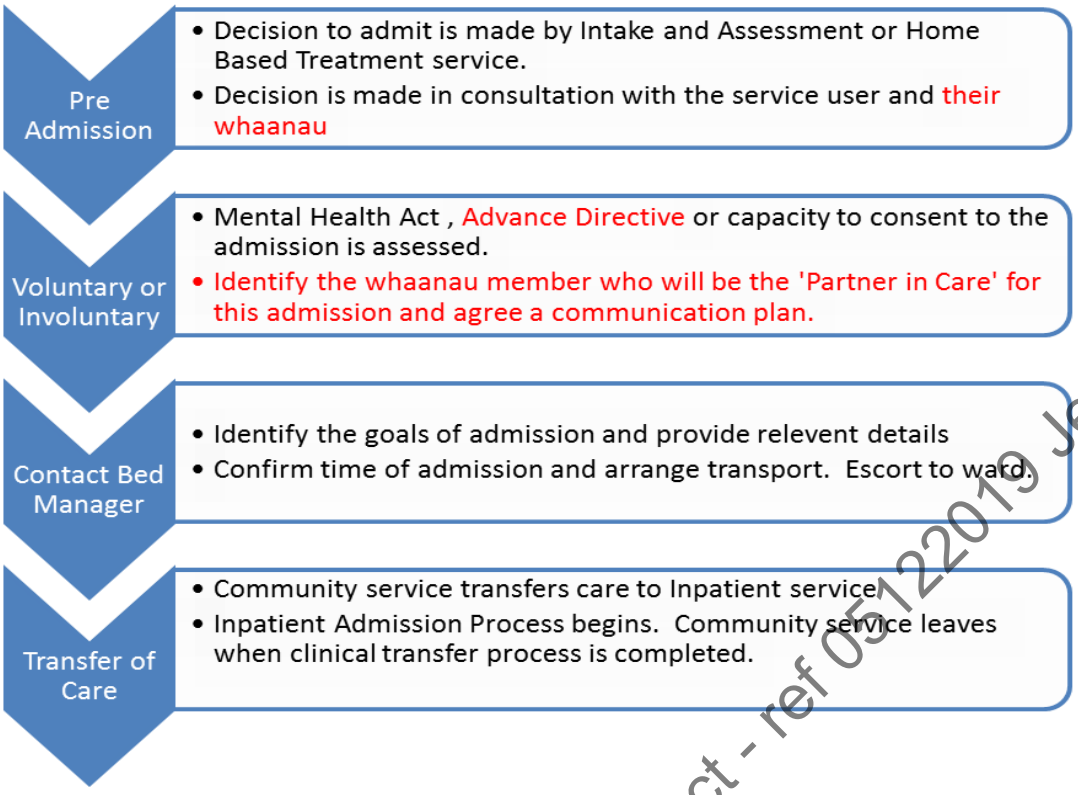

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Stages of Inpatient Service Provision

The MHIPU will offer an in-depth evaluation and treatment of a wide range of mental health disorders and co-morbidities. The unit will facilitate care provision in an environment that reduces the current challenge of over-occupancy and an over pressurised environment that has prompted a more custodial and less engaging and therapeutic model of care.

Broadly speaking there are three primary stages of inpatient service provision: Admission, Treatment Programme and Discharge. However, within each stage there are multiple steps.

1. **Admission- Whakapiri/Engagement.** (Durie, 2013)The admission process is considered to be a **key event** that, if undertaken fully can go a long way to ensure that the service user and their whaanau members feel welcomed, safe and comfortable in the inpatient unit. Spending time to engage with the service user and their whaanau will ensure a better experience and a better quality of service delivery. The aim of the admission/whakapiri process is to get to know each other and to determine the needs of the service user. While the decision to admit is made by the community component the decision as to where the best and most appropriate place to provide a service from within the inpatient unit is made by the inpatient clinicians as a part of the admission process. The default admission environment for the inpatient unit will be the Marae. Admissions via the Marae will alleviate anxiety for many Maaori service users and their whaanau and will enhance meaningful engagement. It is very important that, as a part of the admission process, the

service user (who may have been admitted involuntarily) is given a range of choices from the outset.

2. **Treatment Planning and Implementation – Whakamarama/Enlightenment.** The treatment planning and implementation process aims to "switch on the light" for service users and their whaanau in order to lead to an increased level of awareness and shared understanding of their health issues and how these can best be managed. Treatment involves biological interventions, psychological interventions and "milieu therapy" which means that the unit as a whole is considered as a community. Service users learn about themselves by participating in the life or community of the inpatient unit by helping to resolve everyday problems and participating in a supportive and caring environment.

3. **Discharge Planning and Implementation – Whakamana/Empowerment.** Interventions from all parts of the service should aim to lead to a service users sense of empowerment. This means that the service user is able to participate in their community and be able to sustain and enjoy positive relationships and actively contribute to their whaanau. This is the capacity for self-determination. The principle goals of discharge planning are to ensure the continuity and co-ordination of ongoing care outside of the inpatient unit environment. The critical factor to ensure safe discharge planning is the identification of the immediate short term needs of the service user and their whaanau and ensuring that these are clearly communicated to the follow up team.

Meeting the Needs of Vulnerable Service Users

The MHIPU must create an environment where all service users feel safe and secure. Clinicians need to pay attention to the 'mix' of service users who may be accommodated in one area with the view to ensuring that those who have been identified as vulnerable are not unnecessarily exposed to those who have been identified as presenting with challenging or confrontational behaviour.

MHIPU planners have generally referred to female service users who do not feel safe alongside of males or who are vulnerable to sexual exploitation as vulnerable. However, males may also feel vulnerable within the inpatient environment and some are considered vulnerable because of a physical health issue that impacts on their mobility or general sense of well being.

Other service users who may experience a period of vulnerability during an inpatient stay are young adults or adolescents, women with post natal or ante natal mental health issues or those who are confused or disoriented due to a variety of causes.

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The Vulnerability Rating Scale is a clinical tool that has been developed to be used during the admission process. The tool is used to identify vulnerable service users with the view to ensuring that placement within the MHIPU is appropriate to meet their needs. (Placeholder1)

It is no longer sufficient to provide one area for one group of vulnerable service users. There is a need to provide flexible spaces that can be operated in isolation, if necessary, and that are large enough to accommodate the service user and appropriate staff mix.

Ideally these spaces will have the ability to be separated from each other, joined in single, double or triple configurations, or able to be included in the general bedroom wing. They should also have some (limited) access to an outside space that is contained. This will provide space for service users who are agitated to 'pace' and to access fresh air and a degree of privacy while still being accessible to staff. Service users who are vulnerable should be able to access meaningful activity - including fitness or exercise equipment - without having to feel exposed.

Acuity

There are a variety of factors that lead to service users being admitted with an extremely high level of acuity. These service users present challenges for staff to manage and there may be a risk of physical assault both towards staff and other service users. Sometimes these service users cannot be adequately cared for on the open wards.

Service users who are assessed as being a high risk to others are usually managed within a separate space that can potentially be locked within the MHIPU. It offers a higher level of staffing to service user ratio and a high degree of visibility and a higher level of individual care. These spaces are often referred to as "Intensive Care Units" or "High Dependency Units" (HDU).

Managing Acuity

What Happens Now?

Client A is a 20 year old female who was admitted after experiencing a long period of acute psychosis. This was her first contact with MHS. Her family had struggled to care for her at home and were exhausted. She was initially admitted to the LDU area but transferred to HDU areas and finally to seclusion. She was moved out of seclusion to the "low stimulus environment" (LSE) where she was cared for by at least 3 staff members at all times. She was extremely unwell. This meant that the LSE and the seclusion rooms were unavailable for anyone else.

Client B was admitted and urgently needed access to the LSE. Client A was moved again to another area (less desirable) to allow Client B to access the LSE.

Meanwhile Client C had been assessed as requiring seclusion.

Client B had to be moved from the LSE to facilitate Client C accessing seclusion.

Client A was still assessed as requiring LSE but this area was unavailable. She assaulted one of the staff members providing a service to her.

The MHIPU's High Dependency Unit will not be operated as a separate ward and a clear Standard Operating Procedure will be developed that will describe access, treatment, and transfer from this area to the Low Dependency Units. It is expected that the High Dependency Unit will offer the most intensive biological treatment options and will have a corresponding high level of nursing observations. Planning

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for reintegration to the Low Dependency Unit should start at the time the service user is transferred into the HDU.

There will be a range of alternative spaces within the High Dependency area. These spaces should meet the criteria for "low stimulus" which means that they should be quiet with minimal intrusive elements that service users who are acutely unwell often find disturbing and distressing. A range of spaces will mean that there is the ability to offer this highly intensive service to more than one service user at a time. It is important that the "low stimulus areas" do not compromise the ability to use of the seclusion rooms if necessary.

Co-morbid Disorders

Co-morbidity between mental and physical disorders is well documented in literature. People with mental disorders have higher prevalence of chronic physical conditions compared to people without mental disorders of the same age. People with chronic physical conditions are also more likely to experience mental disorders compared to those without physical conditions. (Oakley Browne MA, 2006)
The common co-morbid medical conditions diagnosed and managed in Tiaho Mai including the following:

1. Diabetes Mellitus – Type 1 and Type 2
2. Respiratory problems – chronic obstructive airway disease, asthma, obstructive sleep apnoea
3. Cardiovascular- hypertension, ischemic heart disease, cerebrovascular accidents, cardiomyopathy, cardiac arrhythmia.
4. Gastro intestinal – bowel obstruction, chronic constipation, acute abdominal pain, gastroenteritis, gastric ulcer, toxic mega colon
5. Endocrinology – thyroid problems, pituitary problems
6. Nicotine dependence, Drug and alcohol related problems
7. Neurological problems – seizures, dementia, delirium, neuropsychiatric manifestation of head injury.
8. Infections- urinary tract infection, systemic sepsis, pneumonia, skin infection
9. Dermatology disorders – dermatitis
10. Organ failure- renal, liver
11. Malignancy

The following non psychiatric conditions can cause acute behavioural disturbance:

- Hypoglycaemia – diabetes, malnourished alcoholic
- Hyperglycaemia – diabetes, patients on clozapine or olanzapine
- Hypoxia – pneumonia, chronic airway disease
- Sepsis – systemic sepsis, urinary infection in elderly
- Cerebral insult – trauma, stroke, seizure, encephalitis, meningitis, tumour
- Cardiac – arrhythmia, acute coronary syndrome
- Metabolic disturbance – hyponatremia, hypercalcaemia, thiamine deficiency
- Withdrawal – alcohol, benzodiazepines

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- Drug effects – steroids, alcohol, prescribed medications and interactions, recreational drugs
- Organ failure – renal, liver
- Others – urinary retention (elderly), faecal impaction (elderly, dual disability service users, service users on clozapine), pain, emotional upset, environmental changes and perioperative.

Currently the physical evaluation of the service users admitted to Tiaho Mai is under taken by House Officers with oversight, supervision and support by GP Liaison Consultants.

Medical emergencies and complex medical issues are referred to appropriate medical teams.

Young Adults

Profound impact of mental illness on a young person's developmental trajectory is the basis for consideration of inpatient services. The long term impact of on-going service input must be factored into care planning for young people in the MHIPU. A young person's early experiences of inpatient services can inform their on-going engagement with mental health services, and therefore their long term outcomes for health and wellbeing.

Young people's needs in an inpatient unit require stability and consistency, flexibility and choice, and access to developmental appropriate activities, therapies, resources and environments that enable participation in all areas of wellness and recovery. The expectation about a young person's ability to participate in these areas is impacted upon by developmental age as well as illness.

The MHIPU will consider provision of inpatient services for young people aged 16 and upwards as an additional service to current regional youth inpatient psychiatric services such as Child and Family Unit (CFU). Young people would be considered for admission to the CMH unit on the basis of their likely ability to

Young Adults
The potential difference

Johnny is a 16year old, physically well-developed male who resides between his parents and girlfriends place, predominantly with his parents during the week. Johnny has a diagnosis of schizophrenia and has had difficult admissions before to the Child and Family Unit due to his aggression and behaviour on the ward. Johnny plans to leave school at the end of the year and enter employment and would like to flat with girlfriend. Johnny is the youngest of five children, his siblings are adults and he plays in a club rugby team with his siblings and socialises with adults. When unwell he displays verbal and physical aggression towards peers. He currently would be admitted to the Child and Family Unit (CFU) where his behaviour is difficult to manage in an environment where there are several younger people and developmentally younger activities. In order to better meet Johnny's needs could be better met with the proposed inpatient unit providing flexible spaces, a trauma informed care and environment, group therapy and activities that are more developmentally appropriate such as budgeting, vocation planning, exploring housing and independent living. His social situation and structure has already transitioned into an 'adult' world and he may further benefit from care and treatment that continue to support his progress into adulthood.

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participate in an adult inpatient environment, taking into account their developmental and psychosocial history.

Typically, but not exclusively, admission to the MHIPU would be considered in meeting the needs of young people:

- Who have left school or plan to leave in the current school year
- Who are living independently
- Transitioning /Engaged in the work force
- With strong, well engaged whaanau and personal supports within Counties-Manukau, who have had a previous admission to CFU and have expressed a preference for admission to a local inpatient unit.
- Who lack active whaanau support
- With severe mental health and forensic histories where current services i.e. CFU may not be best suited to meet their needs.

Admission to the MHIPU for young people under 18 will continue to occur through Whirinaki clinical teams. Consideration for this process will need to be incorporated into the admission process as previously described. A well thought out educational, supportive and developmentally appropriate admission process will be required in order to support young people , engaging and supporting their whaanau participation throughout the inpatient experience.

Young adults need rules and boundaries that foster and develop routine rather than routines put into place that young people are required to attend. The activities need to be meaningful and engaging. For example, access and choice within an occupational therapy program in the unit would, for participation in activities between 8am -8pm, encourage development of a routine. Activities will promote developmental skills acquisition such as creative activity groups, as well as groups that meet social and vocational needs, and access to education such as Northern Health Schools. Maintaining access to their community and wider social networks is an important aspect of inpatient care for young people.

Young people have varied developmental needs that the MHIPU will meet with flexibility, options, trained and capable staff, and trauma informed care. Clinical staff including medical cover will need to have experience in working with young people in order to meet their needs. Senior medical officers from Whirinaki CAMHS should provide psychiatric oversight and continue as the young person's responsible clinician. There will need to be a recognition that some young people's needs may conflict with those of more vulnerable service users.

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Mothers with Babies

Mothers who need an inpatient admission who are able to maintain care of their baby will be able to access the mother and baby unit via Starship Hospital. Mothers who are acutely unwell who cannot manage care of their baby will be admitted to the adult inpatient unit. However, Mothers who are pregnant and postpartum have specific needs during their hospital stay.

The space will need to be flexible and include

- Space for visiting babies, to enhance the mother and baby relationship and reduce risk of too many people in the baby's world. A quiet space that mothers could put baby to sleep with support staff help if required.
- Adequate privacy and suitable chairs for feeding babies if required
- Access to areas that can enhance attachment and participation in mothering roles such as changing tables.

As with other inpatient clients mothers of baby's also experience trauma related conditions, which often are not obvious to the mother at the time and maybe her first experience of feeling symptomatic of related anxieties to adjustment to parenting, self-identity, social and personal relationships. The event of the baby while often a triggering factor is also the means to recovery, therefore specific mother and baby interventions for acutely unwell mothers need to be included.

Counties Manukau hosts numerous ethnic and cultural groups who hold specific cultural practices around pregnancy, birth and child raising. It is important that these are considered in the development of physical space and interventions

All staff working in the unit will require basic skills training in perinatal mental health conditions to support mother with her inpatient admission and plan for recovery.

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Section 7: Enablers which will support the recommended model of care

This section outlines the enablers which need to be in place to support the key processes described in Section 6.

Co-design and integrating the service user voice	When commissioning the new facility and implementing the recommended Model of Care future co-design events which include staff, service users and whaanau will be essential in ensuring that the co-design approach has integrity and truly reflects partnership and a shared decision making approach.
Clinical Governance	Clinical governance for the MHIPU will be provided by: • The Acute Forum – this forum which will be established as a part of FFC will provide clinical oversight to the Acute Clinical Pathway. This group is responsible for the operations of the Acute Clinical Pathway as a whole with emphasis on the linkage points between the components of service. • MHIPU Governance Group – this group consists of senior clinical leaders who work within the unit and will be responsible for the operations and clinical processes and procedures that occur within the unit.
Workforce	The inpatient unit will work from a multi-disciplinary team approach. The rationale for this approach is that a multi-disciplinary team working together is known to maximise clinical effectiveness. Multi-disciplinary teams take a comprehensive and holistic view of the service users' needs and offer a range of skills and expertise to meet the needs and to support each other in doing so. Establishing the Peer Support Specialist role within the MDT of the MHIPU will bring an evidenced based service user perspective to the MDT and will strengthen recovery oriented practice. Peer Support staff have lived experience of recovery and are specifically trained to use their experience to coach and support others in their recovery. They support service users to advocate for themselves and have hope for their future.

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Design of acute treatment environments and facilities	Design principles which will underpin the treatment environments and facilities • Welcoming and gives service users and their whaanau a sense of security and safety • A sanctuary and place of healing • Aesthetically pleasing (eg quality art on the walls) • Whaanau and child friendly • Affords service user privacy • Flexible spaces which can be changed around to accommodate different needs depending on acuity, gender, vulnerability, special needs (e.g. mother and baby) • Affords easy access to safe spaces (other than their bedroom) where service users can be alone or express strong emotions privately, room • Meets the cultural/spiritual needs of service users • Provides opportunity for a range of recreational and leisure activities relevant to the needs of a variety of service usersGood line of sight for service users and staff for safety purposes • A sense of spaciousness particularly in corridors and main traffic areas • Marae that is dedicated to the use of the Mental Health Inpatient Unit and can be used for admissions and cultural therapies and interventions • Spaces which promote active engagement between staff and service users • Meets the staff needs for workspaces which recognise the need for quiet focus and privacy • Supports Green and Healthy Hospital Design and Construction The functional brief is attached in Appendix 2 which gives more detailed information on how these principles are translated into functional spaces.
Configuration of acute functions	• Mental Health Short Stay • Home based treatment • Crisis respite

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Linkages to wider Hospital, Diagnostic, and Clinical Services	***PAR Team*** Service users admitted to Tiaho Mai at times present with medical emergencies needing urgent specialised medical interventions. The Patient At Risk Team or PAR Team provides 24/7 clinical and professional leadership and support to staff caring for patients in the acute setting. The Team was established in 2009 following the amalgamation of two teams of senior nurses; Clinical Nurse Advisors and the Clinical Nurse Specialists for the Physiologically Unstable Patient programme. Middlemore Hospital uses an early warning score to monitor adult patients for deterioration in physical health called the PUP scoring system (physiologically unstable patient). This scoring system utilises physiological observations to be recorded and scored with a resulting graded response strategy. The PAR Team consists of senior skilled nursing staff who have competencies in advanced cardiac life support, emergency procedures and clinical assessment of the acutely unwell patient or patients at risk of deterioration. ***Emergency Centre including Mental Health Short Stay*** CM Health mental health service will operate a Mental Health Short Stay from September? 2014 in collaboration with the Emergency Department. This is a key component of the mental health acute pathway within Framework for Change and will provide a safe place for enhanced and/or extended assessment and observation for some mental health service users where it is not possible to undertake that assessment or observation in the home or community environment. Afterhours mental health assessments will also be undertaken at the Short Stay Unit where this is appropriate. Further to assessment and observation, clinicians will be able to determine if the best course of action is a referral to the acute inpatient unit, a community based acute alternative, or discharge home. The Short Stay Unit will support four service users at any one time, providing enhanced assessment and observation 24 hours a day and 7 days a week. The service user's length of

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	stay is expected to be not longer than 48 hours. ***Pharmacy*** Pharmacy services provided to mental health include supply of medicines and clinical pharmacy services. Supply services are provided to Tiaho Mai each day including weekends. Two major systems of supply are used, automated dispensing (ADM) system (Pyxis) and individual patient dispensing. To enhance safety, medications access through the ADM occurs through "profile" mode –i.e. itemised list of pharmaceuticals is created for each patient. A clinical pharmacy service is also provided during the week to Tiaho Mai. The purpose of this service is to ensure optimal pharmaceutical therapy is provided to the patient. A mental health pharmacist reviews therapy, determines appropriateness of medicines and doses and acts as the source of medicine information to all health professionals within the CM Health mental health service. The pharmacist also supports the patients by providing education to patients in the best use of medicines. The current service is provided at a specialist level providing specialist advice on choice of therapy in complex patients. The pharmacist regularly attends the inpatient multi-disciplinary meetings. ***Pathology Service*** A wide range of tests and services are provided by the laboratory including a blood collecting service at Middlemore Hospital and the Manukau Super Clinic. The main laboratory service is located on the ground floor of the Galbraith Block at Middlemore Hospital (entrance opposite the railway station). There are additional specimen collection and histology services available at the Manukau Super Clinic, Browns Road, Manukau - on the ground floor next to Module 1. The specimen collection areas are open Monday-Friday, 0800-1700. However, the Lab receives and processes samples 24 hours a day.

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	The service users admitted to Tiaho Mai undergo set of basic lab tests and specialised investigations on a case by case basis. ***Medical Imaging Services*** Radiology services are provided at Middlemore Hospital and the Manukau SuperClinicTM. Radiology at Middlemore incorporates ultrasound, vascular, interventional procedures, CT, MRI, plain films and theatre x-ray. The SuperClinicTM (specialising in ambulatory care) offers a specialised mammography department, an ultrasound, CR plain film rooms and theatre x-ray. Medical Imaging requirements are similar to those in other inpatient ward areas. All service users admitted with first episode psychosis are referred for a CT Head as one of the routine investigations. Referral for other medical imaging like MRI is on a case by case basis. ***Theatres (ECT)*** ECT is an effective and safe treatment for a range of Mental Health Disorders and needs to be available as a treatment option for clients under the care of Mental Health Services. Counties Manukau DHB is committed to ensuring the quality of the ECT service is in accordance with recognised and accepted standards to promote both the safety and the efficacy of the treatment. There is also a commitment to making the treatment acceptable to all ages and all cultural groups. Electroconvulsive Therapy is performed at Middlemore Hospital Theatre, on Tuesday and Friday mornings from 8.00am. However access to theatre spaces on other days may be used in the context of high numbers of clients having ECT or due to public holidays. ECT is administered only by designated ECT Psychiatrists. Registrars or House Surgeons may assist with ECT as part of their training, under direct supervision of the ECT Psychiatrist. Each ECT treatment is fully documented both on paper and in the client's computerised record.

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	Medical Wards At times service users admitted to Tiaho Mai have acute medical issues needing specialist care and intervention. Treating team including House Officers and GP liaison consultants seek advice and support from the medical team and transfer the service users in need of acute medical intervention to the medical ward for further management. Occasionally the clients admitted to the medical ward with medical issues also present with significant acute mental health issues needing mental health assessments and interventions which are initially provided by consultation liaison psychiatry team and at times the service users are transferred to Tiaho Mai for further mental health care and interventions.
Information systems	• A live dashboard akin to the Middlemore Central CapPlan dashboard which can show occupancy across all the mental health beds both in the community and in-house. Real time review of actual patients in rooms / beds, those awaiting discharge (discharge lounge) and those awaiting admission (Admission lounge) • Shared patient management systems with all care providers, i.e. primary care and NGOs; access to a shared record which provides a longitudinal view of the patient journey to support early intervention and provide a synthesized summary of all interactions with health services (including tests, results, medications, and offer the ability to drill down to more detail to provide context where needed • Ability to have evidence based information available to the clinicians and service users at the point of care, to support decision-making in line with best practice and current knowledge • Technology to manage access and exit to rooms and specific parts of the new unit with the ability to monitor and access live reporting of those in the unit and those who have left or entered the unit, to support user choice and manage safety and risk • Wi fi access in the new unit for all users • New unit to have rooms set up with built in wireless videoconferencing facilities • Service User and Partner in Care access to interactive therapeutic tools and other applications that help enhance health literacy and build recovery and resilience strategies.

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	• Technology that enables service user access and collaboration in their personal health records, as appropriate. • Duress system with voice enabling function • Telemedicine for the purposes assessment and MDT review to support improved patient experience (1) self-care – e.g. access to therapeutic tools on line / apps to support recovery and prevent relapse (2) connecting with families whilst in care using apps and shared care planning (3) remote access – e.g. Support for multi-disciplinary teams and family meetings with service users and their families in remote locations (4) health literacy interactive electronic therapeutic tools/ apps for service users and families *This list will be added to/ refined when there is greater clarity around Project SWIFT deliverables.*

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Appendices

Appendix 1: Findings from service user interviews
Appendix 2: MHIPU Functional Brief

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- Canberra Hospital: Mental Health Inpatient Unit, 14 May 2014
- Royal Melbourne Hospital: John Cade Unit, 15 May 2014
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- Sunshine Hospital, West Melbourne: Mental Health Hospital, 16 May 2014

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