identifying a range of suitable options and working through processes of negotiation with receiving agencies[15].

- In a number of instances the young people had psychiatric disorders that on their own did not cross the threshold to service in the community mental health system.[16] It is noteworthy that there were examples of successful negotiations that led to services accepting the referrals by exception[17]. The investigators did not find any example where it was not possible to organise a reasonable system of care for an individual.
- The inevitable challenges arose during this process, such as the changes in established long-term relationships between the clinicians of BAC and the young people; the differences between the culture and approach to care provided in services for adolescents and the culture and approach to care in adult services; the impact of the young person's developmental stage and maturity on their health-seeking attitudes and behaviors; and, adolescent's resistance to transfer from a service where they felt safe and 'connected' in a relatively closed environment to a community system of care and, in the case of transfer to an adult system, the different expectations of their maturity and health-seeking behaviour and the different expectations of involvement of their family.
- Whilst there was some drop-out from some aspects of the care organised, the investigators did not identify any examples where a young person was completely lost to care, nor where a core component of care was completely missing.
- There were numerous examples of the BAC staff working in a collaborative way with receiving agencies, as evidenced by the number of times young people were escorted to the other agencies[19], the detailed discussions and documentation in relation to risk management[20], maintaining contact post-transfer of care[21] and joint working by staff across the agencies[22]. These activities would be considered best-practice in transitional care and in the main appear to have been implemented.

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15 Refer Appendix D –
16 See for example, Appendix D –
17 See for example, Appendix D –
18 Refer Appendix –
19 See for example, Appendix D –
20 See for example, Appendix D –
21 See for example, Appendix D
22 See for example, Appendix D –
23 Refer Appendix D -

- There were examples where brokerage funding was very necessary and secured from Health to facilitate a high quality transition[24].
- The investigators confirm that:
    - the health care transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families;
    - the transition plans for individual patients were appropriate and took into consideration patient care, patient support, patient safety, and service quality.
- Further the investigators commend the work of the transition team for the quality and comprehensiveness of the plans and for their efforts that included 'going the extra mile' to secure the range of services required by the young people.
- The investigators confirm that the governance model put in place within Queensland Health to manage the oversight of the health care transition plans was appropriate.
    - The governance arrangements supported collaborative clinical decision-making at the local level and provided an appropriate pathway for escalation of clinical and transition planning issues.
    - Cross membership of committees was designed to support communication flow and membership was sufficiently senior to facilitate authoritative decision-making and action (eg: sourcing of brokerage funds and funds for family members to travel to participate in transition planning meetings[25]).
    - Available minutes and agendas of meetings indicate regular frequency of meetings and the involvement of carers and patients in decision-making.
    - The investigators noted that some transitional planning documentation was incomplete/missing and there was a delay in the appointment of the Project Officer, however it is the view of the investigators that these were minor issues and did not have a material impact on the planning for or transition of the patients.
    - In relation to the time-frames given for the process of transition planning to be developed and enacted, it is noted that the deadline was achieved albeit with a sense of pressure and urgency for the clinical staff especially towards the end. The investigators did not identify, however, an individual case in which more

[24] Refer Appendices C and D –
[25] Refer Appendix D –

time might have resulted in BAC staff providing a better transition plan or process.

**Recommendation**

- The investigators make a general mental health system recommendation. Transitional mental health care for young people is internationally recognized as a complex and often difficult process and poor outcomes such as disengagement from care are well-documented. The BAC process demonstrates positive learnings in relation to good quality transitional planning. It is recommended that these learnings be considered for distillation into the development of a state policy (or review of the current transfer of care policy) that supports mental health transition for vulnerable young people.

EXHIBIT 40

## HSCI_Corro

**From:** DG Dg correspondence
**Sent:** Monday, 13 April 2015 10:39 AM
**To:** Legal
**Subject:** DG076547 FINAL
**Attachments:** DG076547 FINAL.pdf; DG076547 - Guideline for transfer of care_v06_April.pdf; DG075647 - Action plan for implementing recommendation_trf of care.pdf

**Importance:** High

Good morning

Please find attached letter signed by the Acting Director-General.

Signed letter and attachments emailed and posted to OHO today.

Thank you
Kind regards
Axele

Axele-Brigitte Mary
Kathryn Gawne
Elizabeth Head

Office of the Director-General | Department of Health | Queensland Government

e. www.health.qld.gov.au

EXHIBIT 40

Queensland Government

Enquiries to: Ms Janet Martin
Acting Director, Clinical Governance
Mental Health Alcohol and Other Drugs Branch
Telephone:
File Ref: DG076547

10 APR 2015

Mr Leon Atkinson-MacEwen
Health Ombudsman
Office of the Health Ombudsman
PO Box 13281 George St
BRISBANE QLD 4003

Dear Mr Atkinson-MacEwen

Thank you for your letters dated 23 December 2014 and 12 March 2015, in relation to section 228(3) Notices to Require Information under the *Health Ombudsman Act 2013* pertaining to your investigation concerning the Barrett Adolescent Centre (BAC). I thank your office for providing extensions to the due date for provision of this information and apologise for the delay in responding.

Please accept the following information as my statement in response to questions raised in relation to complaint reference number .

1. **A statement outlining the total number of individual patients of the BAC who required transition care planning due to the BAC closure.**

Public announcement of the closure of the BAC was made on 6 August 2013.

Good clinical practice requires that discharge planning is commenced at the time of admission, and further developed over the period of admission. Therefore, a portion of the patients in the BAC on 6 August 2013 were already on a recovery trajectory that included discharge or transition prior to the announcement of BAC closure. Relevantly, all patients were provided with individual plans for discharge or transition that related to their care needs and alternative care options (if required).

It is considered that the eight inpatients discharged in close proximity to the closure of the BAC (that is, from December 2013 to January 2014) were the portion that required the most complex transition planning. However, some of the group were already transitioning due to their individual recovery trajectory, rather than because of any specific BAC changes.

The actual date of closure of the BAC was flexible, based on each patient having the most appropriate alternative care options (if ongoing care was required) in place.

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EXHIBIT 40

2. **A statement providing data and information about BAC patient mortality (suicide) rates during the past three years of operations (that is, provide inpatient suicide rates and rate of suicide in the first 12 months after discharge from the BAC).**

Linking data from the Consumer Integrated Mental Health Application (CIMHA), Queensland Hospital Admitted Patient Data Collection (QHAPDC) and Registrar General of Queensland reveals that from January 2011 to December 2013, there were no recorded deaths from suspected suicide of consumers of the BAC either while an inpatient, or at any time following discharge. I note that the Registrar General of Queensland does not record deaths occurring outside of Queensland.

There were of consumers who had been discharged from the BAC on the following dates:

- 
- 
- 

The above information refers to 'suspected' suicides as opposed to 'confirmed' suicides as the cause of death information received from the Registrar General of Queensland is based on the contents of the death certificate as opposed to the findings of the coroner.

3. **Details of any significant remedial or improvement action being undertaken by Queensland Health in response to identified issues or concerns raised in relation to the transition and care planning measurers undertaken following the decision to close the BAC.**

On 14 August 2014, the Director-General appointed three health service investigators under section 190(1) of the *Hospital and Health Boards Act 2011* to provide expert advice, regarding the way the transition for BAC's inpatients at that time were managed by Queensland Health, and adequacy of patients' transition plans, including whether the plans met patients' and families' needs.

The health service investigation report, *Transitional Care for Adolescent Patients of the Barrett Adolescent Centre*, found that the transition team and clinical staff of the BAC acted according to best practice standards relating to clinical planning for BAC patients and their transition out of the centre. The report also found that the patient plans were appropriate, no consumer was lost to follow-up and no important part of care was lost during the transition period.

A letter dated 12 January 2014 from the then Director-General of Queensland Health to the parents/guardians of former BAC patients included the following statement:

> ... a multidisciplinary review of the care arrangements now in place for the group of young people who transitioned from the BAC. I am aware a number of them are now successfully placed in care arrangements with support from a range of public, private and non-government providers. I would not seek to disrupt those arrangements. However if a parent of any of this group is not satisfied with the support they are receiving, the Department of Health will arrange a multidisciplinary review of their child's care either in the public or private system.

I am aware that the have sought and received support from their local Hospital and Health Service, Children's Health Queensland and the Department of Health in accessing additional specialist mental health care from both private and public services.

4. **A statement as to whether or not the recommendation has been fully accepted, plus accountability and timeframe for implementation of the recommendation.**

One recommendation was made by the health service investigators in their report *Transitional Care for Adolescent Patients of the Barrett Adolescent Centre*. The recommendation states that *transitional mental health care for young people is internationally recognised as a complex and often difficult process and poor outcomes such as disengagement from care are well documented. The Barrett Adolescent Centre process demonstrates positive learnings in relation to good quality transitional planning. It is recommended that these learnings be considered for distillation into the development of a state policy that supports mental health transition for vulnerable young people.*

This recommendation has been fully accepted and its implementation is addressed below in items 5 and 6.

5. **A copy of any Queensland Health action plan or implementation plan addressing the recommendation made in the final investigation report entitled 'Transitional care for Adolescent Patients of the Barrett Adolescent Centre' dated 30 October 2014 (page 12).**

Please find enclosed a copy of the action plan for implementing the recommendation in the report *Transitional care for adolescent patients of the Barrett Adolescent Centre* (attachment 1).

6. **A statement as to who in Queensland Health is responsible for oversighting or monitoring the implementation of the report's recommendation.**

The *Hospital and Health Boards Act 2011* states that the Chief Executive's functions include 'to monitor and promote improvements in the quality of health services delivered by the Services' and 'to monitor the performance of Services, and take remedial action when performance does not meet the expected standard'. Hospital and Health Services have functions including 'to monitor and improve the quality of health services delivered by the Service, including, for example, by implementing national clinical standards for the Service'.

The Mental Health Alcohol and Other Drugs Branch, Department of Health, is drafting a guideline for Hospital and Health Services to support the transition of vulnerable young people requiring mental health services. Hospital and Health Services across the State will be consulted in the development of the guideline. Once finalised, it is the responsibility of Hospital and Health Services to ensure that local policies, procedures and practices are amended or developed as required to implement the guideline. The Mental Health Alcohol and Other Drugs Branch will audit implementation of the guideline by Hospital and Health Services six months after the guideline has been endorsed.

EXHIBIT 40

7. **A (marked-up) copy of any revised state policy (transfer of care policy) that supports mental health transition for vulnerable young people (if available).**

Please find attached the first draft of the *Guideline on the transition of care for young people receiving mental health services* currently under development (attachment 2). Hospital and Health Services have not yet been consulted on its contents. Consultation on the draft will commence by the end of April 2015.

Should your officers require further information, the Department of Health's contact is Ms Janet Martin, A/Director, Mental Health Alcohol and Other Drugs Branch, on telephone

Yours sincerely

**Dr Michael Cleary**
**Acting Director-General**
**Queensland Health**

EXHIBIT 40

Department of Health

Guideline

Document Number # <insert number here>

# Guideline for the transition of care for young people receiving mental health services

## 1. Purpose

This Guideline provides recommendations regarding best practice for transitional care planning and management to support public sector mental health alcohol and other drug services to meet the mental health needs of vulnerable young people.

## 2. Scope

This Guideline provides information for all employees, contractors and consultants within the Department of Health and Hospital and Health Services involved in the transition of young people from child and youth mental health services to other parts of the mental health system, including, but not limited to:

- transfer from a child and youth mental health service to an adult mental health service
- transfer from a specialist and/or more intensive mental health service to a less intensive service, for example, Evolve Therapeutic Services to a Community Child and Youth Mental Health Service
- transfer from a child and youth mental health services to another child and youth mental health service in a different geographical area
- transfer from a child and youth mental health service to a General Practitioner or other primary health care provider, private practitioner or non-government organisation.

## 3. Related documents

Authorising Policy and Standard/s:

- National Standards for Mental Health Services 2010
- National Practice Standards for the Mental Health Workforce 2013 (particularly standard 8: Transitions in Care)
- *Mental Health Act 2000*
- *Hospital and Health Boards Act 2011*

Procedures, Guidelines and Protocols:

- Information sharing between mental health workers, consumers, carers, family and significant others (Queensland Health 2011)

Queensland Government

Forms and templates:

- Statewide suite of clinical documentation

## 4. Guideline for the transition of care for young people receiving mental health services

### Background

Adolescence and young adulthood is a particularly important time for mental health intervention. The prevalence of adolescent mental health problems in Australia is substantial, accounting for more than half of the disease burden in this age group. 2.3% of young people aged between 13 and 18 years of age will experience severe mental illness. In Queensland this accounts for 8,060 young people with severe and persistent mental illness.

Primary diagnosis for this vulnerable group of young people is likely to include psychotic illness, severe mood disorder or complex trauma with deficits in psychosocial functioning. This group may also include young people presenting with social avoidance, disorganised behaviour, emerging personality vulnerability and risk of self-harm. Some may experience family dysfunction.

The importance of transitioning vulnerable people from child and youth mental health services to other support services is critical to ensure continuity of care and avoid preventable poor outcomes. Transitioning young people, who may be at risk, from one level of care to another, among multiple providers and across settings can be a complex task. Poor transitioning can lead to the emergence of symptoms of mental health problems or illnesses, mental health crises, requirements for admission, poor satisfaction with care, unmet needs, medical or treatment errors and a higher burden of cost.

Optimal transition will involve adequate planning, good communication between all service providers and key family members or carers, and continuity of care. The transition process acknowledges that this transition often occurs within the broader context of when a young person is transitioning from dependency on caregivers to independence more generally and therefore has the potential to be a vulnerable time for all young people.

### Context

This guideline was developed following the October 2013 release of the report *Transitional Care for Adolescent Patients of the Barrett Adolescent Centre* and takes into account the findings presented in this report. The report's recommendation states that transitional mental health care for young people is internationally recognised as a complex and often difficult process and poor outcomes such as disengagement from care are well documented. The Barrett Adolescent Centre process demonstrates positive learnings in relation to good quality transitional planning. This guideline captures these learnings.

In developing this guideline acknowledgement is given to the work of the Agency for Clinical Innovation in New South Wales and Trapeze, the Sydney Children's Hospitals Network which produced the document: *Key Principles for Transition of Young People from Paediatric to Adult Health Care.*

## Principles and best practice elements for the transition of care for young people

### 1. A systematic and formal transition process

A formal transition process needs to be developed and documented, including the steps involved in a smooth transition. The documentation and communication of the formalised plan needs to be shared with all parties involved. This needs to be communicated to all parties in a developmentally appropriate way. The multidisciplinary team need to be aware of various parts of the transition they need to prepare for and have responsibility for. A gradual and generous timeframe needs to be formally structured into the transition process. This recognises that poor handover, and the loss of a supportive and sometimes long term relationship due to the changing of care arrangements, can have a negative impact on a young person's mental health. Organised, structured and formal planning helps to mitigate any negative impact.

Services involved in the transitioning of young people need to have:

- documented transition guidelines and policies which are accessible to all involved in the transition
- clear referral pathways
- a focus which is developmentally appropriate.

### 2. Early preparation

A young person requiring transition needs to be identified as early as possible. The identification should involve notifying the young person, their family and other carers, and relevant services of the impending transition. Evidence suggests that identification should ideally occur (where possible and appropriate) six months prior to the actual transition.

Preparation involves the young person in all decision making processes regarding the transition. Supporting and enabling their decision making in this early phase will help to manage the young person's expectation of the transition which will assist in minimising the stress and impact of the transition.

Preparation will involve:

- identification of all stakeholders
- negotiating service options with the young person and their family or carer
- selecting the most suitable service option and ensuring its availability
- development of plans – these need to be formalised and documented highlighting any special needs of the young person
- introduction of the young person to the receiving service or care arrangement and their key contact, such as the person responsible for receiving the young person, in advance of the transition
- a focus on recovery and relapse prevention.

The timing of the transition needs to attempt to ensure that the actual transition does not occur during a crisis period for the young person.

### 3. Identification of a local transition coordinator/facilitator

A transition coordinator should be identified as responsible for the planning and coordination of the transition process.

The transitional coordinator or lead professional responsible for the transition needs to ensure that:

- the young person will experience continuity of care throughout the transition
- clear and regular communication occurs with all stakeholders, and that all communication is understood; this may involve for example that written communication is followed up verbally
- a lead professional or local transition key contact is identified in the receiving service/care arrangement and all plans and communication involve this person.

### 4. Good communication

Good communication between all relevant stakeholders is essential to effective transition. Aspects of good communication include:

- identification of all those relevant to the transition process
- openness, transparency, collaboration, and a willingness to work together need to be a culture of working with the young person and their family and this needs to be reflected in all interactions
- developmentally appropriate language and style/mode of communication. This will be different for the young person, the young person's family or carer and the service and professionals involved in the young person's care. This may involve social media modes of communication.
- established systems for joint communication between all parties.
- comprehensive written communication – in a format and level that all relevant parties understand. Age and literacy level appropriate communication tools should be used.
- the young person and family's privacy must be respected and confidentiality obligations must be adhered to.

Further information for professionals to understand their confidentiality obligations can be found in the *Hospital and Health Boards Act 2011* and in the *Information sharing between mental health workers, young persons, carers, family and significant others* document.

Documentation of communication and information shared needs to be documented in the young person's clinical record.

### 5. Individual transition plan

All young people need an individualised transition plan which is developed in partnership with the young person and family/carer. All the relevant people need a copy of the plan and understand all the elements of the plan.

Managing the transition process with individual patients needs to involve a comprehensive assessment which includes the following components:

- the young person's mental health
- the young person's physical health
- pharmacological or other interventions
- education and vocational requirements
- housing and accommodation needs.

As transition can be a challenging time for a young person, it is important that the young person, family and carers and the receiving service are aware of signs of distress or deterioration in the young person's mental health. It is important to identify and work with the young person's strengths to assist in making the transition a positive experience.

Extensive investigation needs to occur in collaboration with the young person, their families and carers to identify suitable and available services to provide coordinated care.

### 6. Encourage and enable young people to self-manage

The process of teaching and encouraging young people to self-manage, be actively engaged in decision making and being able to advocate for themselves and navigate their environments should be carefully planned and developmentally appropriate.

The young person needs to be given opportunities to self-manage and negotiate in a safe and supportive environment. Transition may be a time of heightened emotions and therefore these opportunities should be encouraged before the transition occurs so that the young person has some positive experiences at achieving or negotiating options.

When the young person's needs are complex and their capacity to self-manage is limited, there should be more emphasis on the family and carer's involvement in this process and the understanding that this may need to be an ongoing role.

### 7. Follow up and evaluation

Follow up will be required to ensure young people have effectively engaged with the receiving care arrangement.

Contact should be maintained with the young person from their original service post transition. This contact can be gradually reduced as the young person settles into their new environment. When contact is to be ceased this should be well prepared for and understood by the young person and their families and at a point where all parties agree that this is appropriate.

Monitoring and evaluation of patient outcomes after transition is required to inform future planning. Future planning may include another transition the young person may need to face for example, as their service needs change or as they recover. This monitoring and evaluation may also however assist to inform future planning for other young people.

## 5. Review

This Guideline is due for review on: 1 July 2016

Date of Last Review: Not applicable

## 6. Business Area Contact

Mental Health Alcohol and Other Drugs Branch

## 7. Definitions of terms used in the policy and supporting documents

| Term | Definition / Explanation / Details | Source |
|---|---|---|
| young people | Any person receiving a mental health service from a child and youth mental service or a service that services young people such as some specialist services that usually target adults | |
| transfer | The act of moving the young person from one care facility to another, or to another care arrangement | |
| transition | The process and period of changing care arrangements for a young person | |

## 8. Approval and Implementation

Policy Custodian:

Director, Clinical Governance, Mental Health Alcohol and Other Drugs Branch

Responsible Executive Team Member:

Executive Director, Mental Health Alcohol and Other Drugs Branch

Approving Officer:

Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

Approval date: DD Month YYYY

Effective from: DD Month YYYY

## Version Control

| Version | Date | Prepared by | Comments |
|---|---|---|---|
| V.1 | 12/01/2015 | L Billing | Initial draft |
| V.2 | 08/04/2015 | F Ward | |

EXHIBIT 40

# Action plan: Implementing the recommendation from the report Transitional care for adolescent patients of the Barrett Adolescent Centre

| Project Lead: Clinical Governance Team, Office of the Chief Psychiatrist<br>Work Unit: Mental Health Alcohol and Other Drugs Branch, Department of Health | Start Date: February 2015<br>Completion date: June 2015 | Status update as at: April 2015 |
|---|---|---|
| Focus Area: Transition of care for young people receiving mental health services<br>Detail: Implementing the recommendation from the report Transitional care for adolescent patients of the Barrett Adolescent Centre (October 2014)<br>Resources: Work package to be met within existing resources of the Clinical Governance Team, Mental Health Alcohol and Other Drugs Branch | | |

| Intended outcomes | Actions | Status | Timeframes |
|---|---|---|---|
| An approved guideline on the transfer of care for young people receiving mental health services | Research the contemporary evidence regarding best practice transition of care for young people | Literature review and review of publically available care guidelines from other jurisdictions complete.<br>Limited evidence exists in relation to the mental health care context. | February 2015 |
| | Review of pre-existing relevant Hospital and Health Service guidelines and procedures | Complete. | February 2015 |
| | Drafting of guideline | | March/April 2015 |
| | Draft guideline available for consultation | Draft 90% complete. | April 2015 |
| | Identify key stakeholders for consultation and involvement in the review process | In progress.<br>To include statewide Mental Health Alcohol and Other Drugs Clinical Network | April 2015 |

EXHIBIT 40

## Action plan: Implementing the recommendation from the report Transitional care for adolescent patients of the Barrett Adolescent Centre

| | | | |
|---|---|---|---|
| | Disseminate for first round of consultation | | 20 April 2015 |
| | Review and incorporate feedback into guideline | | 11 May 2015 |
| | Disseminate for second round of consultation if required | | 18 May 2015 |
| | Endorsement by the Mental Health Alcohol and Other Drugs Clinical Network | | 19 June 2015 |
| Executive endorsement of guideline | Escalate guideline for executive approval with<br>- memorandum for communication to Hospital and Health Services<br>- approval to upload to internet | | 30 June 2015 |
| Implementation of guideline by Hospital and Health Services | Communication regarding the guideline via multiple channels | | July 2015 |
| | Audit of implementation of the guideline (to be undertaken by the Mental Health Alcohol and Other Drugs Branch) | | December 2015 |

Guideline

Document Number: QH-GDL-365-5:2015

# Guideline for the transition of care for young people receiving mental health services

## 1. Purpose

This Guideline provides recommendations to support public sector mental health services in the provision of effective transitional care planning and management to meet the mental health needs of vulnerable young people.

## Scope

This Guideline provides information for all employees, contractors and consultants within the Department of Health and Hospital and Health Services involved in the transition of young people from child and youth mental health services (CYMHS) to other parts of the mental health system, including but not limited to, transfer from a:

- CYMHS service to an adult mental health service
- specialist and/or more intensive mental health service to a less intensive service, for example, Evolve Therapeutic Services to a Community CYMHS
- CYMHS to another CYMHS in a different geographical area
- CYMHS to a General Practitioner or other primary health care provider, private practitioner or non-government organisation.

## 2. Related documents

**Authorising Policy and Standard/s:**

- National Standards for Mental Health Services 2010
- National Safety and Quality Health Service Standards 2012
- National Practice Standards for the Mental Health Workforce 2013 (particularly standard 8: Transitions in Care)
- *Mental Health Act 2000*
- *Hospital and Health Boards Act 2011.*

**Procedures, Guidelines and Protocols:**

- Information sharing between mental health workers, consumers, carers, family and significant others (Queensland Health 2011)
- Guiding principles for admission to Queensland Health child and youth mental health acute inpatient units
- Guiding principles for the management of adolescents in Queensland Health adult acute mental health inpatient units.

Queensland Government

**Forms and templates:**

- Statewide suite of clinical documentation.

## 3. Guideline for the transition of care for young people receiving mental health services

### Background

Adolescence and young adulthood is a particularly important time for mental health intervention. The prevalence of adolescent mental health problems in Australia is substantial, accounting for more than half of the disease burden in this age group. Of the total population of young people aged between 13 and 18 years of age, it is estimated that 10% have mental health needs and 2.3% have a severe mental illness[1]. In Queensland this accounts for 8,060 young people with severe and persistent mental illness[2].

Primary diagnoses for this vulnerable group of young people are likely to include psychotic illnesses, severe mood disorders, eating disorders and complex trauma with deficits in psychosocial functioning. This group may also include young people presenting with social avoidance, disorganised behaviour, emerging personality vulnerability and risk of self-harm or suicide. Some may experience family dysfunction.

The importance of transitioning vulnerable people from CYHMS to other support services is critical to ensure continuity of care and avoid preventable poor outcomes. Transitioning young people, who may be at risk, from one level of care to another among multiple providers and across settings can be a complex task. Poor transitioning can lead to the re-emergence of symptoms of mental health problems or illnesses, mental health crises, requirements for admission, poor satisfaction with care, unmet needs, medical or treatment errors, and a higher burden of cost.

The key aims of transition planning are to ensure that:

- service provision is matched as closely as possible to the needs of the young person and delivered by the most appropriate service/s to meet those needs
- the young person and their family/carer are the key decision-makers regarding the services they receive
- care is delivered across a dynamic continuum of specialist and primary level services with decisions based on the needs and wishes of the young person and their family/carer and not service boundaries
- processes are in place to identify and respond early should the young person experience crisis or re-emergence of a mental health concern.

Optimal transition will involve adequate planning, good communication between all service providers, the young person and key family members or carers, and continuity of care. Transition between service providers often occurs within the context of a young person's movement to independence from their family of origin/ caregivers and therefore has the potential to be a vulnerable time for all young people.

[1] General Epidemiology data provided by the Mental Health, Alcohol and Other Drugs Branch
[2] Australian Bureau of Statistics, 2011, Census of Population and Housing

**Department of Health: Guideline for the transition of care for young people receiving mental health services**

## Context

This Guideline was developed following the November 2014 release of the report *Transitional Care for Adolescent Patients of the Barrett Adolescent Centre*. The report's recommendation states that *"transitional mental health care for young people is internationally recognised as a complex and often difficult process and poor outcomes such as disengagement from care are well documented. The Barrett Adolescent Centre process demonstrates positive learnings in relation to good quality transitional planning".* This Guideline captures these learnings.

In developing this Guideline, acknowledgement is given to the work of the Agency for Clinical Innovation in New South Wales, Trapeze, the Sydney Children's Hospitals Network which produced the document: *Key Principles for Transition of Young People from Paediatric to Adult Health Care* and the New Zealand Department of Health *Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/Alcohol and Other Drugs Services 2014.*

### Principles and best practice elements for the transition of care for young people

### A systematic and formal transition process

The development and documentation of a formal transition process forms the basis of a contemporary approach to the transition of care for young people. This will include steps involved in a smooth transition and the development of an individual transition plan. The transition plan should be developed and communicated to key stakeholders involved in the young person's care and communicated to the young person in a developmentally appropriate way. The multidisciplinary team needs to be aware of their delegated responsibilities for various parts of the transition process. Timeframes will be developed to reflect an individual approach to transition and provide for a gradual and generous timeframe reflective of the young person's needs. The process should recognise that poor handover, and the loss of supportive and sometimes long term relationships due to the changing of care arrangements, can have a negative impact on a young person's mental health. Formal transition planning helps to mitigate these risks.

Services involved in the transitioning of young people need to have:

- documented transition guidelines and policies which are accessible to all involved in the transition
- clear referral pathways
- a focus which is developmentally appropriate.

In developing transition plans, including the level and scope of services to be provided, it is important to acknowledge population groups with special needs. Such groups include, but are not limited to, young people with a history of trauma, abuse and/or neglect or who are in the care of the Department of Communities, Child Safety and Disability Services.

### Early preparation

A young person requiring transition needs to be identified as early as possible. Evidence suggests that identification ideally occurs (where possible and appropriate) six months prior to the actual transition. The identification process will involve notifying the young

person, their family and or carers, and services, including cultural support services where relevant, of the impending transition.

The young person must be involved in all decision making processes regarding the transition. Supporting and enabling their decision making in this early phase will help to manage the young person's expectations which will assist in minimising the stress and impact of the transition when it occurs.

Preparation will involve:

- identification of all stakeholders
- negotiating service options with the young person and their family or carer
- selecting the most suitable service option and ensuring its availability
- development of plans–these need to be formalised and documented highlighting any special needs of the young person
- in advance of the transition, introduction of the young person to the receiving service or care arrangement and their key contact, such as the person responsible for receiving the young person
- a focus on recovery and relapse prevention.

The timing of the transition, where possible, needs to avoid any crisis the young person may be experiencing including consideration of relapse of symptoms.

### Identification of a local transition coordinator/facilitator

The role of transition coordinator within the transitioning team will be identified at the onset of transition planning and is responsible for the planning and coordination of the transition process. The transition coordinator must have sufficient seniority to facilitate authoritative decision making and action.

The transition coordinator or lead professional responsible for the transition needs to ensure that:

- the young person will experience continuity of care throughout the transition
- clear and regular communication occurs with all stakeholders, and that all communication is understood; this may include a requirement that all written communication is followed up verbally
- a lead professional or local transition key contact is identified in the receiving service/care arrangement and all plans and communication involves this person.

### Good communication

Clear, effective and timely communication between all relevant stakeholders is essential to effective transition. Aspects of good communication include:

- identification of all those relevant to the transition process
- openness, transparency, collaboration, and a willingness to work together
- a culture of working with the young person and their family or carer which is reflected in all interactions

- developmentally appropriate language and style/mode of communication. This will be different for the young person, their family or carer and the service and professionals involved in the young person's care. This may involve social media modes of communication
- established systems for joint communication between all parties
- comprehensive written communication–in a format and level that all relevant parties understand. Age and literacy level appropriate communication tools must be used.
- sensitivity and responsiveness to the needs of Aboriginal and Torres Strait Islander people
- alternatives to meet the communication needs of those from culturally and linguistically diverse backgrounds
- the young person and family/carer's privacy must be respected and confidentiality obligations adhered to
- all communications and information shared are documented in the young person's clinical record.

Information to assist professionals understand their confidentiality obligations can be sourced from the *Hospital and Health Boards Act 2011* and the Information sharing between mental health workers, consumers, carers, family and significant others document.

### Individual transition plan

All young people need an individualised transition plan which is developed in partnership with the young person and family/carer. All the relevant people need a copy of the plan and need to understand all the elements of the plan.

Managing an effective transition process with a young person involves a comprehensive assessment which includes the following components:

- the young person's mental health
- the young person's physical health
- psychosocial needs including support for family/carers
- cultural and spiritual needs
- pharmacological and therapeutic interventions
- educational and vocational requirements
- housing and accommodation needs.

Transition can be a challenging time and may precipitate a crisis, so it is important to be aware of early warning signs of distress and develop corresponding management strategies. The young person, family or carer and the receiving service are to be made aware of these risks including signs of distress or deterioration in the young person's mental health. It is important to identify and work with the young person's strengths to assist in making the transition a positive experience.

Thorough investigation and identification of suitable supporting services and coordinated care will occur in collaboration with the young person and their family and or carer.

### Encourage and enable young people to self-manage

The process of teaching and encouraging young people to self-manage, be actively engaged in decision making, be able to advocate for themselves, and navigate their environments must be carefully planned and developmentally appropriate. Equivalency of service is to be adopted only where it is demonstrated that this level of service needs to be maintained.

The young person needs to be given opportunities to self-manage and negotiate their care requirements in a safe and supportive environment. Transition may be a time of heightened emotions and therefore opportunities are to be encouraged before the transition occurs so that the young person has some positive experiences at achieving or negotiating options. Self-management includes assisting the young person to identify signs of distress within themselves and implementing strategies to actively manage any symptom deterioration. Actively engaging the young person in development of these strategies will assist in ensuring that the young person will use them.

When the young person's needs are complex and their capacity to self-manage is limited, greater emphasis on the ongoing role of family and carers in the transition process should be considered.

### Follow up and evaluation

Follow up is essential to ensure young people have effectively engaged with the receiving care arrangement.

Contact is to be maintained with the young person from their original service after transition. This contact can be gradually reduced as the young person settles into their new environment. When all parties agree that the transition has been successfully completed, contact can be ceased. This must be well prepared for and understood by the young person and their family or carer.

Monitoring and evaluation of the young person's outcomes after transition is required to inform future planning. Future planning may be for another transition the young person may need to face, for example as their service needs change or as they recover. This monitoring and evaluation may also assist to inform future planning for other young people.

Monitoring and evaluation is to occur by both the transferring and receiving service until the transition is completed and contact with the originating service is no longer required.

Monitoring and evaluation after transition is to be undertaken by the receiving service.

## 5. Review

This Guideline is due for review on: (Note: date to be inserted upon endorsement)

**Date of Last Review:** Not applicable

## 6. Business Area Contact

Mental Health Alcohol and Other Drugs Branch

## 7. Definitions of terms used in the policy and supporting documents

| Term | Definition / Explanation / Details | Source |
|---|---|---|
| young people | Any person receiving a mental health service from a child and youth mental service or a service that targets young people, e.g. specialist youth services with an age range of 16- 24 years. | |
| parent and/or carer | Refers to the parent(s) or person(s) that take legal responsibility for the adolescent and provides direct care. This includes birth parents, step parents, adopted parents, foster parents, legal guardians, custodial parents or other appropriate primary care givers. | The Royal Australasian College of Physicians (RACP). Standards for care of children and adolescents in Health Services 2008, Paediatrics and Child Health Division, RACP, Sydney Australia. |
| transfer | The act of moving the young person from one care facility to another, or to another care arrangement. | |
| transition | The process and period of changing care arrangements for a young person. | |

## 8. Approval and Implementation

**Policy Custodian:**

Director, Clinical Governance, Mental Health Alcohol and Other Drugs Branch

**Responsible Executive Team Member:**

Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

**Approving Officer:**

Executive Director, Mental Health Alcohol and Other Drugs Branch

**Approval date:** **21 September 2015**

**Effective from:** **21 September 2015**

## Version Control

| Version | Date | Prepared by | Comments |
|---|---|---|---|
| V.01 | 08/04/2015 | F Ward | Initial draft |
| V.02 | 04/06/2015 | K McLachlan-Murphy | consultation with HHS |
| V.03 | 16/06/2015 | K McLachlan-Murphy | consultation with MHAOD Clinical Network |
| V.1 | 07.09.2015 | L Wagner | Final Version |