Department of Health

Queensland Government

MEMORANDUM

To: Chief Executives, Hospital and Health Services

Copies to: Executive and Clinical Directors, Authorised Mental Health Services

Chair, Child and Youth Mental Health Alcohol and Other Drugs Clinical Group

Chair, Mental Health Alcohol and Other Drugs Clinical Network

From: Associate Professor John Allan, A/Executive Director, Mental Health Alcohol and Other Drugs Branch, Department of Health

Contact No:

Fax No:

Subject: Consultation: Guideline for the transition of care for young people receiving mental health services

File Ref:

On 5 November 2014, the Department of Health released the health service investigation report Transitional care for adolescent patients of the Barrett Adolescent Centre (the Report).

The Report stated '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.'

The recommendation was accepted by the Queensland Health Director-General and a draft statewide Guideline developed, informed by the learnings from the Report and a statewide and national review of any policies or guidelines relating to the transition of care.

Feedback on the draft Guideline for the transition of care for young people receiving mental health services is now being sought (attached).

Could you please provide your written feedback (preferred option is via tracked changes and inserted comments) to by **Friday 22 May 2015.**

Upon completion of this first phase of consultation, the Guideline will be submitted to the statewide Mental Health Alcohol and Other Drugs Clinical Network for review with the goal of obtaining endorsement at the meeting scheduled for 19 June 2015.

Should you have any questions please contact Ms Jackie Bartlett, A/Manager, Clinical Governance, Mental Health Alcohol and Other Drugs Branch at [redacted] or telephone [redacted]

[redacted]

Associate Professor John Allan
A/Executive Director
Mental Health Alcohol and Other Drugs Branch
05/05/2015

From: MHAODCN
Sent: Friday, 5 June 2015 4:58 PM
To: MHAODCN; Allie Perich; Andrew Brownlie; Andrew Dacey; Ben Norris; Bob Green; Brett Emmerson; Darren Neillie; David Lie; Donna Jones; Gail Robinson; Irene McCarthy; Jan Kealton; Janet Ceron; Janet Martin; Jason B Lee; Jeremy Hayllar; John Allan; John Reilly; Julie Henderson; Katie Draper; Kimina Andersen; Linda Hipper; Lucille Griffiths; Lynette Anderson; MHAODCN; Niki Parry; OCP-MHAODB; Rob Rolls; Ruth Fjeldsoe; Sally Plever; Sandra Eyre; Stephen Stathis
Subject: Request for feedback from the MHAODCN on transition guidelines for young people

Dear Mental Health Alcohol and Other Drugs Clinical Network members

Please find attached the draft Guidelines for the transition of care for young people receiving mental health services.

Consultation has already occurred with the Hospital and Health Services (see attached memorandum) and I am now seeking feedback from the Clinical Network prior to tabling the final document for endorsement at the next meeting on the 19 June 2015.

Could I please receive feedback (preferably via tracked changes) to this email address by close of business on Monday 15 June 2015?

As mentioned the aim is to incorporate any changes and resubmit the final draft to the Clinical Network on the 16 June for endorsement at the meeting on the 19 June.

From: Jan Kealtor
Sent: Thursday, 11 June 2015 10:43 AM
To: MHAODCN
Subject: RE: Request for feedback from the MHAODCN on transition guidelines for young people

Hi Janet
I think this is a very good document, so no changes from me.
See you next week,
Jan

Jan Kealton
Mob

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 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 Standards:

- 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.

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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. 2.3% of young people aged between 13 and 18 years of age will experience severe mental illness[1]. In Queensland this accounts for 8,060 young people with severe and persistent mental illness.

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. The transition between providers often occurs within the context of a young person's

[1] Reference for statistic

[illegible] independence [illegible] and therefore has the potential to be a vulnerable time for all young people.

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, ~~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* and ~~also~~ 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 ~~A~~formal transition process ~~needs to be~~forms the basis of a contemporary approach to the transition of care for young people. This will include ~~developed and documented, including the steps~~ involved in a smooth transition and the development of an individual transition plan. The transition plan should be developed and communicated to key~~The documentation and communication of the formalised plan needs to be shared with all parties~~ stakeholders involved in the young persons care and communicated to the young person in. ~~This needs to be communicated to all parties in a~~ a developmentally appropriate way. The multidisciplinary team should be aware of their delegated responsibilities for ~~need to be aware of~~ various parts of the transition process ~~they need to prepare for and have responsibility for~~. Timeframes will be developed to reflect an individual approach to transition and provide for a ~~A~~gradual and generous timeframe ~~needs to be formally structured into the transition process~~where necessary. The process should recognise that ~~This recognises that poor~~ 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 F~~formal transition planning helps to mitigate ~~any negative impact~~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 the transition plan, 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. [illegible] The identification [illegible] will involve notifying the young person, their family and other carers, and relevant services, including cultural support services where relevant, of the impending transition. [illegible]

[illegible]he young person [illegible] 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[illegible] 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
- 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~~should be flexible to [illegible] to consider [illegible] symptom[illegible]

Identification of a local transition coordinator/facilitator

The role of transition coordinator within the transitioning team ~~must~~ 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

Commented [JM1]: Yes although it is important to highlight the point as early in the guideline as possible

Commented [KRZ]: You could probably move this to the section on development of the transition plan itself

- a lead professional or local transition key contact is identified in the receiving service/care arrangement and all plans and communication involve 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's privacy must be respected and confidentiality obligations adhered to
- all communications and information shared are documented in the young person's clinical record.

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.

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 [illegible] understand all the elements of the plan.

Managing [illegible] transition process with a young person [illegible] involves a comprehensive assessment which includes the following components:

- the young person's mental health
- the young person's physical health
- psychosocial and cultural 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 [illegible] management strategies. The young person, family or carers 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.

~~Extensive~~ The rough investigation and [illegible] of supporting services and coordinated care [illegible] needs to occur in collaboration with the young person and ~~their~~ families and carers, ~~to identify suitable and available services to provide coordinated care.~~

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, being 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 [illegible]

The young person [illegible] be given opportunities to self-manage and negotiate [illegible] in a safe and supportive environment. Transition may be a time of heightened emotions and therefore these opportunities are to 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 must be more~~ greater emphasis on the ongoing role of family and carer's ~~involvement~~ in ~~this~~ the [illegible] process should be considered. ~~and the understanding that this may need to be an ongoing role.~~

~~Self-management includes assisting~~ the young person identify signs of distress within themselves and implementing strategies to actively manage any symptom deterioration [illegible]

Follow up and evaluation

Follow up ~~will be required~~ 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 [illegible] transition. This contact can be gradually reduced as the young person settles into their new environment. When [illegible] this must be well prepared for

Commented [JMS5]: I mean that even tho there is a transition, presumably the young person is older and therefore developmentally should be able to self-manage to a greater degree, therefore the same level of service won't necessarily be required the same level of service should only be offered if required not just because it was offered/accepted previously

Commented [AL6]: Not sure what this sentence is referring to?

Commented [JMS7]: agreed - done

Commented [KR8]: I would move this to paragraph 2

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 [illegible] 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 [illegible] 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:to be determined 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 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	
v.3	04/06/2015	K McLachlan-Murphy	Incorporate feedback from consultation with HHS

Department of Health

Mental Health Alcohol and Other Drugs Clinical Network

June 2015

Minutes

Date and time:	19 June 2015, 9.30am – 11.30am
Location:	Conference Room 1.4, Level 1, 15 Butterfield St, Herston, Brisbane
Chair:	Dr Darren Neillie
Secretariat:	Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch (MHAODB)

Attendees:

Name	Representation
Dr Darren Neillie	Chair
Mark Wheelehen (proxy for Assoc Prof Gail Robinson)	Central Clinical Cluster Clinical Representative
Julie Henderson	Southern Clinical Cluster Representative
Dr Brett Emmerson	Mental Health (MH) Clinical Collaborative
Emma Foreman (proxy for Donna Jones)	MH Benchmarking Unit
Lucille Griffiths	MH Allied Health
Andrew Brownlie	MH Nursing
Dr Jeremy Hayllar	AOD Treatment Physician
Linda Hipper	Alcohol and Other Drugs (AOD) Service Improvement Group
Dr David Lie	Older Persons MH Clinician
	Carer Representative
	Carer Representative
	Consumer/Client Representative
Assoc. Prof. John Allan	A/Executive Director, MHAODB
Dr John Reilly	A/Chief Psychiatrist, MHAODB
Ruth Fjeldsoe	Director, Information and Performance Unit, MHAODB
Janet Ceron	Director, Legislation Unit, MHAODB
Janet Martin	A/Director, Clinical Governance Team, MHAODB
Sandra Eyre	Director, Planning and Partnerships Unit, MHAODB
Ben Norris	Manager, Planning and Partnerships Unit, MHAODB
Brent Dixon	Senior Project Officer, Mental Health Act Review and Implementation Team, MHAODB
Allie Perich	Principal Project Officer, MHAODB

Apologies:

Donna Jones	MH Benchmarking Unit
Rob Rolls	AOD Treatment Nursing
Assoc Prof Gail Robinson	Central Clinical Cluster Clinical Representative
Dr Stephen Stathis	Child and Youth MH Clinician
Kimina Andersen	Aboriginal and Torres Strait Islander MH Clinician
Bob Green	Forensic MH Clinician
(To be recruited)	AOD Allied Health
(To be recruited)	Psychiatrist
(To be recruited)	Mental Health Consumer Representative

Absent:

Dr Jason Lee	Northern Clinical Cluster Clinical Representative
Lynette Anderson	Aboriginal and Torres Strait Islander MH Worker

Discussion items:

Item	Discussion
1.	**1.1 Open and Welcome** **1.2 Apologies** **1.3 Membership changes** Welcome to Sandra Eyre, who has taken over from Marie Kelly as Director, Planning and Partnerships Unit, MHAODB.
2.	**Presentations** **2.1 Consultation-Liaison Psychiatry Special Interest Group** (Dr John O'Callaghan) CLP_20150619.ppt ◦ Refer to attached presentation ◦ Additional discussion points included: - C/L funding issues – complex area nationally - Need for greater integration of C/L with AOD services – various models around the state. Can be partly addressed within AOD models of service (under development). **2.2 Draft Mental Health Bill 2015** (Bobbie Clugston) MH Bill_20150619.ppt ◦ Refer to attached presentation ◦ Emphasis on least restrictive practice – Advance Health Directives to be taken into account ◦ Introduction of draft Bill to parliament currently scheduled for September 2015 ◦ Still open for public consultation – submissions due 26 June 2015. **2.3 Consumer and Carer Partnership project update** (Caroline Zinnermann and Emma Foreman) Cons_Carer_Partnerships_190615.ppt ◦ Refer to attached presentation ◦ Project aimed to look at current practices in HHSs partnering with consumers and carers, and

	make recommendations about how to improve consumer/carer engagement ◦ Draft final report currently with West Moreton Executive ◦ Report will then come to Clinical Network for review and endorsement ◦ Clinical Network may consider contributing further funding to this area in 2015-2016 financial year, depending on recommendations made in final report and other priorities identified by the Clinical Network ◦ Report recommendations can also be looked at as part of the development of the Queensland Health Mental Health Alcohol and Other Drugs Services Plan 2016-2021 (under development) ◦ Acknowledgement of work done by Caroline and West Moreton in short time frame.
3.	**Business arising from the previous minutes** **3.1 Previous minutes endorsed:** 24 April 2015 (attached) MHAODCN_minutes_24April2015.doc **3.2 MHAOD Clinical Network budget 2015-16** (Janet Martin) • $60,000 transferred to Metro South for the AOD model of service project ◦ $30,000 transferred to West Moreton for the emergency department/mental health acute care project ◦ $110,000 project funding remaining. *All other matters arising from the previous minutes are addressed in the update from the Chair*
4.	**Update from the Chair** (Darren Neillie) **4.1 Promoting least restrictive practices:** **4.1.1 National Seclusion and Restraint Reduction Forum 2015** o Held in Melbourne, 28-29 May 2015 o Approx 35 Qld attendees o National Mental Health Commission released position paper and statement on seclusion, restraint and restrictive practices in mental health services on 29 May 2015 – available at: http://www.mentalhealthcommission.gov.au/our-work/national-seclusion-and-restraint-project/our-position-paper-a-case-for-change.aspx o Nationally: some progress continues to be made in reducing seclusion and restraint use in mental health settings, however there are wide variations between jurisdictions and it is timely to renew commitment in this area o Need for further discussion and definition of chemical restraint o Victoria has invested approximately $2.5 million in a statewide roll-out of Safe Wards, an evidence-based program originating in the UK with a focus on reducing aggression and restrictive practices on inpatient units. **4.1.2 Roundtable update** Roundtable Program_FINAL o Friday 26 June 2015 o Final program attached o Aim: to promote the implementation of evidence-based strategies and programs that support least restrictive practices in mental health acute inpatient units o The focus is on adult acute mental health inpatient settings in line with the current focus on moving towards a less restrictive model of care in these units o Will include presentations on peer worker models, Safe Wards, the Wide Bay project on reducing AWOP, increasing structured activities on wards, and ways to better predict (and prevent) escalations in aggression o Summary and outcomes of the Roundtable to be provided next meeting.

4.1.3 Reducing rates of patient absence without permission (AWOP)

- Update postponed to next meeting.

4.2 Impact of NEAT target on emergency mental health services project

- Results of the survey will be presented to the Clinical Network
- Project plan being developed – scope and methodology yet to be finalised
- Funding - $30,000 from MHAOD Clinical Network and $25,000 from the Clinical Access and Redesign Unit
- Related issues: following a request from the Minister's office, a project is going ahead to strengthen suicide prevention activities in emergency departments. Collaboration between MHAOD Branch, the MHAOD Clinical Network, the Qld Emergency Department Strategic Advisory Panel and the Qld Centre for Mental Health Learning. Tasks include:
  - Reviewing, updating and delivering an education package for ED clinicians
  - updating the QH Guidelines for Suicide Risk Assessment and Management to include clinical best practice guidelines for emergency departments
  - updating the Queensland MIND (Mental Illness Nursing Documents) Essentials resource (a mental health resource for generalist nurses which includes caring for a person who is suicidal).

4.3 Queensland Clinical Senate (QCS) update for noting

- QCS met 12-13 March 2015 – report now available at http://www.health.qld.gov.au/clinical-practice/engagement/clinical-senate/meetings-publications/previous-archive/default.asp
- Next QCS meeting will be 30-31 July 2015 (topic: obesity prevention strategies)
- Concerns were raised earlier this year that the current QCS membership does not appear to include carer representation. This was raised with the QCS Executive Committee, and a response received. A reply to the QCS by Darren Neillie on behalf of the Clinical Network will accompany a response by [redacted] highlighting the importance of a voice for carers in addition to consumers.
- Up to date information regarding QCS meetings, including meeting reports and documentation, presentations and resources, can be found at the following link: http://www.health.qld.gov.au/clinical-practice/engagement/clinical-senate/meetings-publications/

5. Older Adult Services (David Lie)

- Statewide Older Persons MHAOD Clinical Group has been established
- Significant AOD issues noted in older adults
  - rising rates of alcohol-related dementia
  - throughput on wards is a significant issue, especially with violent patients
    - nursing homes reluctant to take admissions with an aggression risk
    - need to consider how we manage patients requiring a non-acute, high-complexity service - possibly escalate issue to Qld Clinical Senate
  - need to look at the data. Most AOD data has an age cut-off of 50 yrs. MHAOD Branch is looking at possibilities for replacing ATODS-IS. Ruth Fjeldsoe would appreciate relevant HHS contacts with whom to discuss issues.
  - Older persons MOS – scope of authority is an important issue.

6. Alcohol and Other Drugs (AOD) Service Improvement Group (Linda Hipper)

- There is a need for review and re-writing of a number of guidelines/other documents, e.g. opiate treatment guidelines - SIG has limited capacity
- Revision of dual diagnosis guidelines is almost complete
- 2014 harm reduction results available, e.g. Hep C numbers are down in Qld, heroin use has declined, use of steroids has increased. Age profile change – survey respondents are older.

7.	**Mental Health Alcohol and Other Drugs Performance Framework** - update deferred
8.	**Queensland Mental Health Benchmarking Unit update** (Emma Foreman) • Acquired Brain Injury benchmarking report completed • Next benchmarking rounds: Extended Treatment and Rehabilitation, Community Care Units • Benchmarking Unit website is to be upgraded.
9.	**Clinical Cluster updates** **9.1 Northern** • Update deferred to next meeting **9.2 Central** • Update deferred to next meeting **9.3 Southern** Julie Henderson • General update – deferred due to unforseen time constraints in the meeting.
10.	**Mental Health Clinical Collaborative update** (Brett Emmerson) Attached documents presented for endorsement. Due to unforseen time constraints in the meeting, the documents were deferred for out of session endorsement. MHCC TOR_April 2015_V1.doc MHCC Workplan Achievements_July 2015-June 2016_V1.doc MHCC Workplan July 2015-June 2016_V1.doc **Addendum:** documents were endorsed out of session.
11.	**Operational Plan** **10.1 Activities under the priorities of the Network** **10.1.1 Consumer/Client and Carer** ***Consumer and Carer Partnership project update*** o Refer to Item 2.3 ***Consumer and Carer Workforce Network*** o Refer to item 9.3 **10.1.2 Models of Service (MOS)** o Deferred to next meeting – expect out-of-session work **10.1.3 Outcomes/Key Performance Indicators** o Deferred **10.1.4 Integration of AOD and MH** o Deferred pending outcome of AOD model of service project **10.1.5 Child and Youth Services** ***General update*** – deferred

	Implementing the recommendation from the report: Transitional care for adolescent patients of the Barrett Adolescent Centre  Guideline_transfer_ for endorsement.pdf o Guideline for the transition of care for young people receiving mental health services – for endorsement (attached). Outcome. endorsed o Thank you to Jan Kealton and Planning and Partnerships Unit for providing feedback **10.1.6 Communication** ***Facilitating leadership and networking for Indigenous mental health workers*** – update deferred. ***Links with statewide groups*** o Refer to item 2.1.
12.	**Open Forum** Nil issues raised
Out of Session Business	
13.	Nil
General Business	
14.	Please note upcoming business: • Reviews of Models of Service • Reviews of Clinical Network Terms of Reference, membership and operational plan

Next meeting:
21 August 2015
9:30-11:30am
Conference Room 1.4, first floor, 15 Butterfield St, Herston

Full schedule of meeting dates for 2015:
13 February
24 April
19 June
21 August
16 October
4 December

Least Restrictive Practices Roundtable:
Friday 26 June 2015

Meeting close

Queensland Government

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

Telephone:
File Ref:

Mr Leon Atkinson-MacEwen
Health Ombudsman
Office of the Health Ombudsman

Dear Mr Atkinson-MacEwen

Thank you for your letter dated 10 July 2015, inviting my comments in relation to your draft investigation report into the appropriateness of the transition care planning arrangements for patients at the Barrett Adolescent Centre.

A Commission of Inquiry has now been announced into the closure of the Barrett Adolescent Centre (the Commission of Inquiry), which will commence on 14 September 2015. The Department wishes to co-operate with the Office of the Health Ombudsman. However, the Department must also ensure that its response does not impact on the Commission of Inquiry, given that its published terms of reference suggest that the Commissioner will be inquiring into matters addressed in your draft report.

With the above issues in mind, I have considered this matter carefully and I am able to comment as follows, and I request that these comments be included in the final investigation report.

Please note that the name of one of the appointed health service investigators is Ms Tania "Skippen", rather than "Kippen", as referred to in the *Report: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre*.

Response to Limitations of Department of Health's Investigation

Limitation 1: The omission of engagement with receiving services to assess the adequacy of healthcare transition plans in meeting the needs of the patients and their families

The Department considered that given the limitation of the investigator's powers under the *Hospital and Health Boards Act 2011* and difficulties associated with accessing confidential information from the private sector, the investigator would be unable to obtain a complete picture of the adequacy of the healthcare transition plans for these patients during the investigation.

Office
19th Floor
Queensland Health Building
147 - 163 Charlotte Street
BRISBANE QLD 4000

Limitation 2: Investigators did not assess the suitability or effectiveness of the alternative care options available to the young people at the time in meeting their complex needs.

At page 3 of your draft report, you state ... *Client profile information provided in Appendix D of the Department's investigation report highlights the significant impact of the transition process for the young people and, in some cases, the inadequacy of services in meeting the needs of the young person and disengagement by the young person with planned services. Examples include ...*

I am concerned that the extracts of information relating to three patients, who are used to illustrate this point, currently include information that may lead to the identification of a patient by reference to a receiving health service. I ask that you address this concern before finalising your report.

The terms of reference for the Commission of Inquiry include 'the adequacy of the care, support and services that were provided to transition clients and their families'. Therefore, it is inappropriate for me to provide any further comments in relation to this identified limitation.

Limitation 3: The deaths of the young people were not specifically referred to or addressed in the Department's investigation report.

The deaths occurring in 2014 of the three former Barrett Adolescent Centre inpatients are reportable deaths under the *Coroners Act 2003* and are the subject of an ongoing coronial investigation. Accordingly, it would have been inappropriate for the Department of Health, or the health service investigation commissioned by the Department, to specifically address the circumstances surrounding these deaths until the Coroner has completed their investigation.

Response to Recommendations

Recommendation 1: The Mental Health Alcohol and Other Drugs Branch ensure that the guideline for the transition of care for young people receiving mental health services include a comprehensive reference to best practice transition care principles and detail expectations regarding follow up and evaluation processes to ensure appropriate and effective care arrangements.

The draft Guideline for the transition of care for young people receiving mental health services was developed following a comprehensive review of available literature and pre-existing local, national and international guidelines. The attached guidelines were endorsed by the Mental Health Alcohol and Other Drugs Clinical Network on 19 June 2015. Please ensure that these draft Guidelines are kept confidential until such time as the final version is released.

The final version of the Guideline will be provided to your office by 30 September 2015, in accordance with your proposed monitoring plan.

Recommendation 2: The Department of Health fully implement the Action Plan: Implementing the recommendation from the report Transitional care for adolescent patients of the Barrett Adolescent Centre.

I note your proposed monitoring plan and will comply with the timeframe of the three progress reports required.

Should your officers require further information, the Department of Health's contact is Ms Janet Martin, Acting Director Clinical Governance, Mental Health Alcohol and Other Drugs Branch, on telephone [redacted].

Yours sincerely

[redacted]

Michael Walsh
Director-General
Queensland Health

6 - 8 - 2015

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 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

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:

Executive Director, Mental Health Alcohol and Other Drugs Branch

Approving Officer:

Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

Approval date: 30 June 2015

Effective from: 20 July 2015

Version Control

Version	Date	Prepared by	Comments
V.1	08/04/2015	F Ward	Initial draft
v.2	04/06/2015	K McLachlan-Murphy	consultation with HHS
v.3	16/06/2015	K McLachlan-Murphy	consultation with MHAOD Clinical Network

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 **Work Unit:** Mental Health Alcohol and Other Drugs Branch, Department of Health	**Start Date:** February 2015 **Completion date:** June 2015	**Status update as at:** April 2015

Focus Area: Transition of care for young people receiving mental health services
Detail: Implementing the recommendation from the report Transitional care for adolescent patients of the Barrett Adolescent Centre (October 2014)
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. 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. To include statewide Mental Health Alcohol and Other Drugs Clinical Network	April 2015

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 - memorandum for communication to Hospital and Health Services - 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

Department of Health

COVERSHEET FOR POLICY & SUPPORTING DOCUMENTS

The information captured on this coversheet will facilitate entry of policy documents into the Department of Health Policy Register and will support publication, search and retrieval of the document via the Department of Health internet site.

This document should accompany the Brief for Approval submitted to the authorising EMT member.

Completed form to be sent to

	Guideline for the transition of care for young people receiving mental health services
	1.0
	☐ Policy ☐ Protocol ☐ Standard ☒ Guideline ☐ Procedure Other: please specify
	☒ New Document ☐ Reviewed document
	Not applicable
	Youth, adolescent, mental health, transition, guideline, guidelines, acute care, transition plans.
	Guidelines for the transition of youth and adolescents under child and youth mental health services (CYMHS) to another health service including adult mental health service, other child and youth health services and community health services.
	Mental Health Alcohol and Other Drugs Branch
	Bernadette Klopp, A/Manager, Clinical Governance, Mental Health Alcohol and Other Drugs Branch, 3328 9547
	Director, Clinical Governance, Mental Health Alcohol and Other Drugs Branch
	Dr William Kingswell, Executive Director, Mental Health Alcohol and Other Drugs Branch
	21/09/2015
	21 September 2015
	• National Standards for Mental Health Services 2010 • National Practice Standards for the Mental Health Workforce 2013 (particularly standard 8: Transitions in Care)
	21 September 2017
	Insert number of relevant DoH File on which development documentation and final approved document is attached
	QH-GDL-365-####