	Clinical Care Transition Panel, December 2013 143.2. Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel, October 2013 143.3. Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel, January 2014 143.4. Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel, November 2013 143.5. Barrett Adolescent Centre (BAC) Clinical Care Transition update, undated		Service	Service	
144.	Transition meeting file notes and updates 144.1. Email from Trevor Sadler to Bill Kingswell re Information re Barrett Adolescent Centre Stakeholder Meeting, dated 19.11.2012 144.2. Email from Lesley Dwyer to Sharon Kelly re Fwd: Agenda – Barrett Adolescent Planning Group Teleconference, dated 28.11.2012 144.3. Email from Elisabeth Hoehn to Anne Brennan and Leanne Geppert re Clinical Care Transition Panels, dated 27.09.2013 144.4. Email from Peter Blatch, Assistant Regional Director, School Performance, Department of Education and Training, to Anne Brennan re clinical care transition	Various	West Moreton Hospital and Health Service	West Moreton Hospital and Health Service	24

	panel, dated 09.10.2013 144.5. Email from Leanne Geppert to Sharon Kelly re Fwd: The Park – Bed Stats Spreadsheet 13.10.2013, dated 14.10.2013 144.6. Email from Kevin Rodgers, Principal Barrett School, to Anne Brennan re Education planning meeting with adolescents and parents, dated 18.10.2013 144.7. Email from Leanne Geppert to Anne Brennan and others re BAC consumer transition planning process, dated 05.11.2013 144.8. Email from Leanne Geppert to [redacted] re BAC consumer transition planning process, dated 08.11.2013 144.9. BAC Strategic Update/Progress, dated 20.11.2013 144.10. Transition Service Planning table, dated 27.11.2013 144.11. Attachment 1: AGENDA, Barrett Adolescent Strategy, dated 15.07.2013 144.12. Barrett Adolescent Centre Clinical Oversight Meeting, File/Meeting Note, dated 12.12.2013 144.13. Minutes: Barrett Adolescent Strategy, dated 23.07.2013 144.14. Minutes from BAC Stakeholder Meeting,				

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	28.10.2013 144.15. Barrett Adolescent Centre Consumer Meeting, File/Meeting Note, dated 18.12.2013 144.16. Barrett Adolescent Centre Transition Care Planning Meeting, dated 11.12.2013 144.17. Barrett Adolescent (BAC) Transition Service Planning, Risk Mitigation Table, November 2013 144.18. Barrett Adolescent Centre Consumer Update, 06.01.2014 144.19. Barrett Adolescent Centre (BAC) – Consumer Overviews, Briefing for Dr Bill Kingswell attending the Director-General, Department of Health and Director-General, Department of Communities Meeting, 22.01.2014 144.20. Document titled Consumer Contact, undated 144.21. File/Meeting Note re Update Barrett Adolescent Centre (BAC) and Extended Treatment & Rehabilitation (ETR) Projects, dated 08.07.2013 144.22. WMHHS File/Meeting Note re meeting on 17.10.2013 144.23. WMHHS File/Meeting Note re meeting on 05.11.2011 144.24. WMHHS File/Meeting Note re meeting on				

	06.11.2011 144.25. WMHHS File/Meeting Note re meeting on 07.04.2014 144.26. Email from Laura Johnson to Leanne Geppert re BAC Consumer Meeting 181213, dated 14.08.2013, with attached draft file note of meeting on 18.12.2013 144.27. Email from Laura Johnson to Leanne Geppert re Barrett Adolescent Centre Consumer Update 060114, dated 06.01.2014, with attached BAC consumer update – 06.01.2014 144.28. Email from Elisabeth Hoehn to Leanne Geppert re BAC Meeting 131213 – draft meeting note for your consideration, dated 16.12.2013, with attached File/Meeting Note from Barrett Adolescent Centre Clinical Oversight Meeting on 12.12.2013 144.29. Email from Laura Johnson to Elisabeth Hoehn and others re BAC Transition Care Planning Meeting Notes and Actions, dated 12.12.2013, with attachment re Barrett Adolescent Centre Transition Care Planning Meeting on 11.12.2013 – Draft Actions 144.30. Email from Laura Johnson to Leanne Geppert re BAC Transition Care Planning Meeting 111213, dated 12.12.2013, with attachment re Barrett Adolescent Centre Transition Care Planning Meeting				

	on 11.12.2013 – Draft Actions 144.31. Email from Anne Brennan to Vanessa Clayworth and others re Fwd: Barrett Adolescent Centre patient, dated 29.10.2013 144.32. Email from Leanne Geppert to Laura Johnson re Update from Clinical Consumer Transition Panel Meeting, dated 02.10.2013 144.33. Email from Vanessa Clayworth to BAC Nursing Staff re Transition Panels – Outcomes and Care Planning documents, dated 14.11.2013 with attachment Transition and Care Plan list for Nursing Staff 144.34. Email from Leanne Geppert to Anne Brennan re Update, dated 31.10.2013				
West Moreton Project Governance					
145.	Barrett Weekly update Meetings 145.1. Barrett Adolescent update Meeting (Weekly) – Agenda, undated 145.2. BAC Strategic Update/Progress, dated 02.12.2013 145.3. Barrett Adolescent Centre (BAC) Update Meeting – Draft Minutes, dated 04.12.2013 145.4. Barrett Adolescent Centre (BAC) Update Meeting –	Various	West Moreton Hospital and Health Service	West Moreton Hospital and Health Service	24

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	Draft Minutes, dated 15.01.2014 145.5. Barrett Adolescent Centre (BAC) Update Meeting – Draft Minutes, dated 18.12.2013 145.6. Barrett Adolescent Centre (BAC) Update Meeting – Draft Minutes, dated 22.01.2014 145.7. Barrett Adolescent Centre Update Meeting – Draft Minutes, dated 27.11.2013 145.8. Barrett Adolescent Centre Update Meeting – Agenda, dated 04.12.2013 145.9. Barrett Adolescent Centre Update Meeting – Agenda, dated 11.12.2013 145.10. Barrett Adolescent Centre Update Meeting – Agenda, dated 15.01.2014 145.11. Barrett Adolescent Centre Update Meeting – Agenda, dated 18.12.2013 145.12. Barrett Adolescent Centre Update Meeting – Agenda, dated 22.01.2014 145.13. Barrett Adolescent Centre Update Meeting – Agenda, dated 29.01.2014 145.14. Barrett Adolescent Centre Update Meeting (Weekly) – template minutes, undated 145.15. BAC Weekly Update Meeting – Issues				

	Register, undated (4 versions)				
146.	Board Papers 146.1. West Moreton Hospital and Health Service Executive Committee Meeting Agenda Paper, dated 16.08.2013 146.2. West Moreton Hospital and Health Service Board Committee Agenda Paper, dated 26.04.2013 146.3. West Moreton Hospital and Health Service Board Committee Agenda Paper, dated 25.01.2013 146.4. West Moreton Hospital and Health Service Board Meeting Agenda Paper, dated 29.11.2013, with attached West Moreton HHS Transitional Service Operations Overview, November 2013 146.5. West Moreton Hospital and Health Service Board Meeting Agenda Paper, dated 27.09.2013, with attached Briefing Note to Director-General, dated 09.09.2013 146.6. West Moreton Hospital and Health Service Board Meeting Agenda Paper, dated 23.08.2013 146.7. West Moreton Hospital and Health Service Board Meeting Agenda Paper, dated 20.12.2013 146.8. Expert Clinical Reference Group – Barrett Adolescent Strategy, Terms of Reference, unsigned	Various	West Moreton Hospital and Health Service	West Moreton Hospital and Health Service	24

	and undated				
147.	Project 147.1. Memorandum from Judi Krause, Divisional Director, CYMHS, Children's Health, to Dr Peter Steer, Chief Executive, Children's Health re Adolescent Extended Treatment and Rehabilitation – site visits to Victoria, dated 26.08.2013 147.2. Adolescent Extended Treatment and Rehabilitation Models – Summary of Site Visits to Victoria, 14 to 16 August 2013, prepared by Judi Krause, Divisional Director, CYMHS, Children's Health, dated 26.08.2013 147.3. Adolescent Extended Treatment and Rehabilitation (BAC) Project Handover Report January 2014 147.4. Barrett Adolescent Centre Daily Status Report No 1 – 16.12.2013 147.5. Barrett Adolescent Centre Daily Status Report No 3 – 19.12.2013 147.6. Barrett Adolescent Strategy Project Plan, November 2012 147.7. Barrett Adolescent Strategy organisational structure, dated 14.11.2012	Various	West Moreton Hospital and Health Service	West Moreton Hospital and Health Service	24

Response from Children's Health Queensland Hospital and Health Service					
148.	Letter to Kristi Geddes, Minter Ellison, from Dr Peter Steer, Health Service Chief Executive, Children's Health Queensland Hospital and Health Service re Health Service Investigation – Barrett Adolescent Centre	25.08.2014	Dr Peter Steer, Health Service Chief Executive, Children's Health Queensland Hospital and Health Service	Children's Health Queensland Hospital and Health Service	25
149.	Health Service Investigation – Barrett Adolescent Centre, CHQ Document Register	28.08.2014	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
Board Papers					
150.	Redacted agenda for Children's Health Queensland Hospital and Health Board meeting	29.08.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
151.	Redacted minutes from for Children's Health Queensland Hospital and Health Board meeting	29.08.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
152.	Redacted Hospital and Health Board Briefing Note re Barrett Adolescent Centre – transfer of governance to Children's Health Queensland	29.08.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
153.	Redacted agenda for Children's Health Queensland Hospital and Health Board meeting	31.10.2013	Children's Health Queensland	Children's Health Queensland Hospital	25

				and Health Service		
154.	Redacted minutes from for Children's Health Queensland Hospital and Health Board meeting	31.10.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25	
155.	Redacted document including Barrett Adolescent Centre Consumer Status	Undated	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25	
156.	Redacted Hospital and Health Board Briefing Note re Statewide Adolescent Extended Treatment and Rehabilitation Initiative Update	31.10.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25	
157.	Redacted Children's Health Queensland Board Meeting Agenda	28.11.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25	
158.	Redacted Minutes of the Children's Health Queensland Hospital and Health Board Meeting	28.11.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25	
159.	Redacted Children's Health Queensland Hospital and Health Service Board Paper re Statewide Adolescent Extended Treatment and Rehabilitation Initiative Update	November 2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25	
160.	Redacted Children's Health Queensland Board Meeting Agenda	30.01.2014	Children's Health Queensland	Children's Health Queensland Hospital	25	

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161.	Redacted Minutes of the Children's Health Queensland Hospital and Health Board Meeting	30.01.2014	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
162.	Redacted Children's Health Queensland Hospital and Health Service Board Paper re Adolescent Mental Health Extended Treatment Initiative	January 2014	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
CE Oversight Committee					
163.	Redacted meeting agenda – Chief Executive and Department of Health Oversight Committee	17.10.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
164.	Redacted minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	17.10.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
165.	Redacted Meeting Agenda – Chief Executive and Department of Health Oversight Committee	15.11.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
166.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy – Oversight Committee	15.11.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
167.	Redacted Meeting Agenda – Chief Executive and	22.01.2014	Children's Health	Children's Health Queensland Hospital	25

	Department of Health Oversight Committee		Queensland	and Health Service		
168.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy – Oversight Committee	22.01.2014	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25	
Steering Committee						
169.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	09.09.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25	
170.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	09.09.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25	
171.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	23.09.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25	
172.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	23.09.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25	
173.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	09.10.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25	
174.	Redacted Minutes – State-wide Adolescent Extended	09.10.2013	Steering Committee	Children's Health Queensland Hospital	25	

	Treatment and Rehabilitation Implementation Strategy			and Health Service	
175.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	21.10.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
176.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	21.10.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
177.	Statewide Adolescent Extended Treatment and Rehabilitation Initiative Update Brief	Undated	Steering Committee	Children's Health Queensland Hospital and Health Service	25
178.	West Moreton Hospital and Health Service Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel	October 2013	WMHHS BAC Clinical Care Transition Panel	Children's Health Queensland Hospital and Health Service	25
179.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	04.11.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
180.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	04.11.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
181.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation	18.11.2013	Steering Committee	Children's Health Queensland Hospital	25

	Strategy			and Health Service	
182.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	18.11.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
183.	West Moreton Hospital and Health Service Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel	November 2013	WMHHS BAC Clinical Care Transition Panel	Children's Health Queensland Hospital and Health Service	25
184.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	02.12.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
185.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	02.12.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
186.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	16.12.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
187.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	16.12.2013	Steering Committee	Children's Health Queensland Hospital and Health Service	25
188.	Project Status Report – Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	December 2013	Steering Committee	Children's Health Queensland Hospital	25

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				and Health Service	
189.	West Moreton Hospital and Health Service Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel	December 2013	WMHHS BAC Clinical Care Transition Panel	Children's Health Queensland Hospital and Health Service	25
190.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	13.01.2014	Steering Committee	Children's Health Queensland Hospital and Health Service	25
191.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	13.01.2014	Steering Committee	Children's Health Queensland Hospital and Health Service	25
192.	West Moreton Hospital and Health Service Status Report – Barrett Adolescent Centre (BAC) Clinical Care Transition Panel	January 2014	WMHHS BAC Clinical Care Transition Panel	Children's Health Queensland Hospital and Health Service	25
193.	Redacted Meeting Agenda – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	28.01.2014	Steering Committee	Children's Health Queensland Hospital and Health Service	25
194.	Redacted Minutes – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	28.01.2014	Steering Committee	Children's Health Queensland Hospital and Health Service	25
Young People's Extended Treatment and Rehabilitation Initiative (YPETRI)					
195.	Redacted meeting agenda – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI)	12.12.2013	YPETRI Governance	Children's Health Queensland Hospital	25

	Governance Committee		Committee	and Health Service	
196.	Redacted meeting agenda – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	19.12.2013	YPETRI Governance Committee	Children's Health Queensland Hospital and Health Service	25
197.	Redacted meeting agenda – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	09.01.2014	YPETRI Governance Committee	Children's Health Queensland Hospital and Health Service	25
198.	Redacted meeting agenda – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	06.02.2014	YPETRI Governance Committee	Children's Health Queensland Hospital and Health Service	25
199.	Minutes – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	04.12.2013	YPETRI Governance Committee	Children's Health Queensland Hospital and Health Service	25
200.	Minutes – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	12.12.2013	YPETRI Governance Committee	Children's Health Queensland Hospital and Health Service	25
201.	Minutes – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	19.12.2013	YPETRI Governance Committee	Children's Health Queensland Hospital and Health Service	25
202.	Minutes – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	09.01.2014	YPETRI Governance Committee	Children's Health Queensland Hospital	25

				and Health Service	
203.	Minutes – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	06.02.2014	YPETRI Governance Committee	Children's Health Queensland Hospital and Health Service	25
Clinical Care Transition Panel					
204.	West Moreton Hospital and Health Service Barrett Adolescent Centre Clinical Oversight Meeting – File/Meeting Note	12.12.2013	Barrett Adolescent Centre Clinical Oversight Committee	Children's Health Queensland Hospital and Health Service	25
205.	West Moreton Hospital and Health Service Barrett Adolescent Centre Clinical Oversight Meeting – File/Meeting Note	18.12.2013	Barrett Adolescent Centre Clinical Oversight Committee	Children's Health Queensland Hospital and Health Service	25
206.	Memorandum from Dr Terry Stedman, A/Executive Director, Mental Health Alcohol and Other Drugs Branch to	10.01.2014	Dr Terry Stedman, A/Executive Director, Mental Health Alcohol and Other Drugs Branch	Children's Health Queensland Hospital and Health Service	25
207.		14.01.2014		Children's Health Queensland Hospital and Health Service	25

208.	Email from Leanne Geppert to Ingrid Adamson	30.01.2014	Dr Leanne Geppert, A/Director of Strategy, Mental Health & Specialised Services, WMHHS	Children's Health Queensland Hospital and Health Service	25
209.	Email from Ingrid Adamson, Project Manager, Children's Health Queensland to	03.02.2014	Ingrid Adamson, Project Manager, Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
210.	Barrett Adolescent Centre Consumers Review	03.03.2014	Dr Anne Brennan, A/Clinical Director	Children's Health Queensland Hospital and Health Service	25
211.	Email from Leanne Geppert to	04.03.2014	Dr Leanne Geppert, A/Director of Strategy, Mental Health & Specialised Services, WMHHS	Children's Health Queensland Hospital and Health Service	25
212.		25.02.2014	Children's Health Queensland	Children's Health Queensland Hospital	25

				and Health Service	
213.	Email from Ingrid Adamson, Project Manager, Children's Health Queensland to Judi Krause and others	05.03.2014	Ingrid Adamson, Project Manager, Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
214.	BAC Holiday Program – Week 1 Dec 16th – 19th	Undated	West Moreton Hospital and Health Service	Children's Health Queensland Hospital and Health Service	25
215.	BAC Holiday Program – Week 2 Dec 23rd – 24th	Undated	West Moreton Hospital and Health Service	Children's Health Queensland Hospital and Health Service	25
216.	WM HHS Transitional Service Options Overview	November 2013	West Moreton Hospital and Health Service	Children's Health Queensland Hospital and Health Service	25
217.	WM HHS Transitional Service Options Plan	November 2013	West Moreton Hospital and Health Service	Children's Health Queensland Hospital and Health Service	25
Presentation to parents					
218.	Proposed Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care	11.12.2013	Assoc. Prof. Stephen Stathis, Clinical Director CYMHS	Children's Health Queensland Hospital and Health Service	25

219.	Barrett Adolescent Parent Session	11.12.2013	West Moreton Hospital and Health Service	Children's Health Queensland Hospital and Health Service	25
Project Plan					
220.	Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy – Steering Committee Action Plan	29.08.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
221.	Barrett Adolescent Strategy Expert Clinical Reference Group – Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)	08.05.2013	Barrett Adolescent Strategy Expert Clinical Reference Group	Children's Health Queensland Hospital and Health Service	25
222.	Project Plan – Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy	October 2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
223.	Redacted and untitled Project Plan document	Undated	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
Terms of Reference					
224.	Committee membership lists	Undated	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
225.	Terms of Reference – Chief Executive and Department of	17.10.2013	Children's Health	Children's Health	25

	Health Oversight Committee		Queensland	Queensland Hospital and Health Service	
226.	Terms of Reference – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee	23.09.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
227.	Terms of Reference – Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Service Options Implementation Working Group	23.09.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
228.	Terms of Reference – Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Barrett Adolescent Centre Consumer Transition Panel	23.09.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
229.	Email from Ingrid Adamson, Project Manager – SW AETRS, Children's Health Queensland, to SW AETR Working Group 2 BAC Transition re Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy – BAC Consumer Transition Panel	27.09.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
230.	Email from Ingrid Adamson, Project Manager – SW AETRS, Children's Health Queensland, to Alan Fletcher and others re Financial and Workforce Planning Working Group – Adolescent Mental Health Initiative	21.11.2013	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
231.	Draft Terms of Reference – Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Financial and	24.09.2013	Children's Health Queensland	Children's Health Queensland Hospital	25

	Workforce Planning Transition Working Group			and Health Service	
232.	Terms of Reference – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee	13.03.2014	Children's Health Queensland	Children's Health Queensland Hospital and Health Service	25
Records from					
233.	Email from to Kristi Geddes, Minter Ellison re Health Service Investigation – Barrett Adolescent Psychiatric Centre	29.08.2014		Hospital and Health Service	26
234.	Records from Life Without Barriers for P	Various	Hospital and Health Service	Hospital and Health Service	26
235.	Records from Adolescent Inpatient Unit and Day Service for P	Various	Hospital and Health Service	Hospital and Health Service	26
236.	Records from The Hospital, including Admissions 1, 2 and 3	Various	Hospital and Health Service	Hospital and Health Service	26
Records from Hospital and Health Service					
237.	Letter from to Kristi Geddes, Minter Ellison re Health Service Investigation – Barrett Adolescent	18.09.2014		Hospital and Health Service	27

	Psychiatric Centre				
238.	Transition Plan: 2014	2014	Hospital and Health Service	Hospital and Health Service	27
239.	Model of Service – Queensland Public Mental Health Services	Undated	Queensland Government	Hospital and Health Service	27
240.	Metal Health – The Hospital Guideline re – Guidelines for referral	05.05.2014	Hospital and Health Service	Hospital and Health Service	27
241.	Metal Health – The Hospital, Residents Guide to the	22.07.2014	Hospital and Health Service	Hospital and Health Service	27
242.	Hospital Records –	Various	Hospital and Health Service	Hospital and Health Service	27 and 28
Records from Hospital and Health Service					
243.	Letter from Hospital and Health Service, to Kristi Geddes, Minter Ellison	19.09.2014	Hospital and Health Service	Hospital and Health Service	29

244.	List of Barrett Adolescent Centre Inpatients and Day Patients as at 6 August 2013	Undated	West Moreton Hospital and Health Service	Hospital and Health Service	29
245.	Email from re Plan for – need to confirm a date for medication review with you	18.09.2014	Health Service	Hospital and Health Service	29
246.	Progress Note	07.03.2014	Health Service	Hospital and Health Service	29
247.	Progress Note	20.12.2013	Health Service	Hospital and Health Service	29
248.	Records for 248.1. CIMHA Records 248.2. Further CIMHA Records 248.3. Mental Health Records 248.4. General Records	Various	Hospital and Health Service	Hospital and Health Service	29

249.	Records for [redacted] 249.1. CIMHA records 249.2. General records	Various	[redacted] Hospital and Health Service	[redacted] Hospital and Health Service	30
Further documents from West Moreton Hospital and Health Service					
250.	Letter from Sharon Kelly, Executive Director Mental Health and Specialised Services, to Kristi Geddes, Minter Ellison re Health Service Investigation – Barrett Adolescent Centre	19.09.2014	Sharon Kelly, Executive Director Mental Health and Specialised Services	West Moreton Hospital and Health Service	31
251.	Case Coordinator's Role for Barrett Adolescent Centre	Unknown	Barrett Adolescent Centre	West Moreton Hospital and Health Service	31
252.	West Moreton Hospital and Health Service Mental Health and Specialised Services, The Park – Centre for Mental Health, Care Planning Package – Tool Kit (Adult Services)	August 2013	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
253.	The Park Centre for Mental Health – Individual Care Plan Checklist: Adolescent	April 2010	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
254.	Extract from titled The Barrett Adolescent Centre – Information for Teenagers	08.09.2006	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
255.	Extract from document titled The Barrett Adolescent Centre	08.09.2006	West Moreton	West Moreton	31

	– Information for Parents and Carers		Hospital and Health Services	Hospital and Health Service	
256.	Untitled document summarising purpose and requirements of the Consumer Integrated Mental Health Application (CIMHA)	Undated	Unknown	West Moreton Hospital and Health Service	31
257.	Queensland Health Procedure – Inter-district Transfer of Mental Health Consumers within Southern Queensland Health Service Districts, Division of Mental Health, Darling Downs – West Moreton Health Service District	08.11.2010	Darling Downs – West Moreton Health Service District	West Moreton Hospital and Health Service	31
258.	West Moreton Hospital and Health Service Procedure, Mental Health Divisional – Inter Hospital and Health Service Transition of Care of Mental Health Consumers from one Hospital and Health Service to another	13.05.2014	West Moreton Hospital and Health Service	West Moreton Hospital and Health Service	31
259.	Further extract from document titled The Barrett Adolescent Centre – Information for Parents and Carers	08.09.2006	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
260.	Role description for Nurse Unit Manager, Barrett Adolescent Unit, The Park Centre for Mental Health	October 2012	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
261.	Role description for Clinical Nurse Consultant, Medium Secure/Dual Diagnosis, The Park – Centre for Mental Health	Undated	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31

262.	West Moreton Hospital and Health Service – BAC Staff Communique 1	03.10.2013	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
Further documents from Hospital and Health Service					
263.	Letter from and Health Service, to Kristi Geddes, Minter Ellison	19.09.2014	Hospital and Health Service	Hospital and Health Service	31
264.	Records held by re	Various		Hospital and Health Service	31
265.	CYMHS Access Manual	Undated		Hospital and Health Service	31
266.	Paediatrics Pre-referral Guidelines – Child and Youth Mental Health Services (CYMHS), Children's Health Services	Undated		Hospital and Health Service	31
Documents provided by DSQ Ipswich					
267.	Email from Tammy Myles, A/Regional Manager, Disability and Community Services, Department of Communities, to	15.09.2014			31

	Kristi Geddes, Minter Ellison re [redacted] Intake Policy and Procedures		[redacted]		
268.	[redacted]	November 2011	[redacted]	[redacted]	31
269.	[redacted]	July 2011	[redacted]	[redacted]	31
Documents provided by [redacted]					
270.	Letter from Tess Stewart, Service Manager, Aftercare – Headspace Ipswich to Whom It May Concern re Health Service Investigation – Barrett Adolescent Psychiatric Centre	19.09.2014	[redacted]	[redacted]	31
271.	Records held by [redacted] re [redacted]	Various	Headspace Ipswich	[redacted]	31
272.	Unapproved version of [redacted] Clinical Practice Manual	January 2013	[redacted]	[redacted]	31
Other material considered					
273.					

Appendix B – Schedule of Interviews

Monday 13 October 2014		
9:15am	RN Mara Kochardy	Care coordinator for
10:00am	RN Moira Macleod	Care coordinator for
11:00am	RN Brenton Page	Care coordinator for
11:45am	RN Matthew Beswick	Care coordinator for Attending with Judy Simpson from QNU
1:00pm	RN Peta-Louise Yorke	Care coordinator for
1:45pm	CN Susan Daniel	Care coordinator for
2:45pm	Dr Anne Brennan	Clinical Director from September 2013 Attending with Harry McCay from Avant
Tuesday 14 October 2014		
9:00am	RN Rosangela Richardson	Care coordinator for
9:45am	RN Victoria Young	Care coordinator for Attending with QNU representative
10:45am	Megan Hayes	OT, active role in transition planning Attending with Lisa Harris from Coors Chambers Westgarth Lawyers (in instruction from WMHHS)
11:45am	Dr Stephen Stathis	Director Children's Health Queensland (Telephone interview)
1:30pm	Dr Trevor Sadler	Clinical Director until September 2013 Attending with David Watt from K&L Gates Lawyers (on instruction from Avant)

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Client profiles and transition evidence summary

Transition documentation pertaining to the [redacted] patients and provided to the investigators was reviewed and the following information was also corroborated at interview by BAC staff.

Appendix C ~~Table 1:~~ Transition Pplanning Eevidence Checklist

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Transfer of Care Principles (Qld Health Procedure)*						
Completion and transfer of documentation including:						
MH Act status						
Referral forms (including MHA2000 docs) completed	N/A	✓	✓	N/A	N/A	✓
Transfer of ITO complete	✓	✓	✓	✓	✓	✓
Assessment including forensic History and Risk Assessment and management plan	✓	✓	✓	✓	✓	✓
Outcome Measures	✓	✓	✓	✓	✓	✓
Recovery Plan	✓	✓	✓	✓	✓	✓
End of episode/ Discharge summary	✓	✓	✓	✓	✓	✓
Documents forwarded 3 days prior	✓	✓	✓	✓ at time	✓ at time	✓
Documented appointments	✓	✓	✓	✓	✓	✓
Family/carers notified and/or consulted	✓	✓	✓	✓	✓	✓
Receiving PSP face to face contact within 7 days	N/A	✓	✓	N/A	N/A	✓
Receiving District/mental health service						
Transition planning reflects evidence of:						
Assessment of client future service needs	✓	✓	✓	✓	✓	✓
Direct consumer assessment and consultation	✓	✓	✓	✓	✓	✓
Review of consumer medical charts	✓	✓	✓	✓	✓	✓
Contact with referring agency and local mental health service	✓	✓	✓	✓	✓	✓
Clinical need and Risk taken into account	✓	✓	✓	✓	✓	✓
Length of stay of client was considered	✓	✓	✓	✓	✓	✓
Age of client was considered	✓	✓	✓	✓	✓	✓
Demographics were considered	✓	✓	✓	✓	✓	✓
Family engagement considered/ Contact was made with family	✓	✓	✓	✓	✓	✓
Additional considerations (unrelated to the Policy):						
Funding was sourced to provide comprehensive care						
Additional supports sourced eg: housing and disability supports						

Transfer of Care Principles (Qld Health Procedure)*						
Completion and transfer of documentation including:						
MH Act status						
Referral forms (including MHA2000 docs) completed	N/A	✓	✓	N/A	N/A	✓
Transfer of ITO complete	✓	✓	✓	✓	✓	✓
Assessment including forensic History and Risk Assessment and management plan	✓	✓	✓	✓	✓	✓
Outcome Measures	✓	✓	✓	✓	✓	✓
Recovery Plan	✓	✓	✓	✓	✓	✓
End of episode/ Discharge summary	✓	✓	✓	✓	✓	✓
Documents forwarded 3 days prior	✓	✓	✓	✓ at time	✓ at time	✓
Documented appointments	✓	✓	✓	✓	✓	✓
Family/carers notified and/or consulted	✓	✓	✓	✓	✓	✓
Receiving PSP face to face contact within 7 days	N/A	✓	✓	N/A	N/A	✓
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Assessment of client future service needs	✓	✓	✓	✓	✓	✓
Direct consumer assessment and consultation	✓	✓	✓	✓	✓	✓
Review of consumer medical charts	✓	✓	✓	✓	✓	✓
Contact with referring agency and local mental health service	✓	✓	✓	✓	✓	✓
Clinical need and Risk taken into account	✓	✓	✓	✓	✓	✓
Length of stay of client was considered	✓	✓	✓	✓	✓	✓
Age of client was considered	✓	✓	✓	✓	✓	✓
Demographics were considered	✓	✓	✓	✓	✓	✓
Family engagement considered/ Contact was made with family	✓	✓	✓	✓	✓	✓
Additional considerations (unrelated to the Policy):						
Funding was sourced to provide comprehensive care						
Additional supports sourced eg: housing and disability supports						

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* Reference: *Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts* (Version No. 1.0), by the Division of Mental Health, Darling Downs – West Moreton Health Service District.

Appendix D - Client Profiles and Transition Planning Evidence Summary

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SKIPPEN, Tania

From: SKIPPEN, Tania
Sent: Friday, 17 October 2014 5:06 PM
To: SKIPPEN, Tania; KOTZE, Beth
Subject: Report 20141017.docx
Attachments: Report 20141017.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Final for Friday version

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Matter:

Queensland Health
Health Service Investigation –
Barrett Adolescent Psychiatric Centre
1084936

Authors: Associate Professor Beth Kotze and Tania Skippen

Date:

Table of Contents

Expert Clinical Review Report: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre

Authorisation

This report has been prepared in accordance with the Instrument of Appointment and Terms of Reference, both dated 14th August 2014 and both authorised by Mr Ian Maynard, Director-General Queensland Health, and revised 28th August 2014.

Scope and Purpose

To provide expert clinical review and a report under section 199 of the Hospital and Health Boards Act 2011 (HHBA) for the Director-General, Queensland Health in line with the Terms of Reference.

The functions of the health service investigators were to:

1.1 Investigate the following matters relating to the management, administration and delivery of public sector health services:

1.1.1 Asses the governance model put in place within Queensland Health (including the Department of Health and West Moreton, Metro South and Children's Health Queensland Hospital and Health Services and any other relevant Hospital and Health Service) to manage and oversight the healthcare transition plans for the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014;

a) Advise if the governance model was appropriate given the nature and scope of the work required for the successful transition of the then patients to a community based model;

1.1.2 Advise if the healthcare transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families;

1.1.3 Advise if the healthcare transition plans developed for individual patients by the transitions team were appropriate and took into consideration patient care, patient support, patient safety, service quality, and advise if these healthcare transition plans were appropriate to support the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014;

1.1.4 Based on the information available to clinicians and staff between 6 August 2013 and closure of BAC in January 2014, advise if the individual healthcare transition plans for the then current inpatients and day patients of the BAC were appropriate. A detailed review of the healthcare transition

plans for patients [redacted] should be undertaken.

2.1 Make findings and recommendations in a report under section 199 of the HHBA in relation to:

2.1.1 The ways in which the management, administration or delivery of public sector health services, with particular regards to the matters identified in paragraph 1 above, can be maintained and improved: and

2.1.2 Any other matter identified during the course of the investigation.

Process

1. Extensive documentation was made available to the reviewers; refer Index of Documentation (Appendix A), including patient files, policies and miscellaneous.
2. Written statement from Dr Anne Brennan, 13/10/14.
3. Interviews were conducted face to face over 2 days being 13th and 14th October 2014.

Context

- On 6th August 2013 Minister for Health, Mr Lawrence Springborg announced the closure of the Barrett Adolescent Centre (BAC), Wacol, West Moreton Hospital and Health Service (WMHHS)[1]. A planning process to develop new service options for the population of the State was announced under the governance of Children's Health Queensland (CHQ)[2]. A governance process to manage the transition of current individual patients of BAC was developed.
- The concentrated and focussed process of managing the transition of individual patients from the care of BAC to alternative options commenced in September 2013[3] with the expectation that the service would close in January 2014.
- The process of managing the transition of individual patients was centred on individualized and comprehensive needs assessment, including mental health, health, educational/vocational, housing/accommodation needs, and care planning, extensive investigation to identify available and suitable services to provide coordinated care in community settings, iterative planning and collaboration with consumers and families and carers.
- The clinically driven process was supported by a formal governance structure comprising:

[1] Refer: letter dated 24th August 2014 from Lesley Dwyer Health Service Chief Executive West Moreton Hospital and Health Service to Dr John Allan.

[2] This process was identified as out of scope by the reviewers because it concerned strategic forward planning at the population level rather than care planning for the individual patients of BAC.

[3] Refer interview with Dr Anne Brennan.

- Clinical Care Transitional Panel:
  - Chaired by Dr Anne Brennan
  - Key members: internal to BAC: multidisciplinary senior clinicians responsible for patient care and Acting Principal of the school.
  - Reported to the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee and the West Moreton Management Committee
  - Met twice-weekly and on an ad hoc basis to focus on day to day patient care and planning for transition. An issues log was maintained and provided to the reviewers by Dr Brennan.
  - Agendas provided to reviewers (Appendix A). No formal Terms of Reference available.
- The West Moreton Management Committee[4]:
  - Chaired by A/Director of Strategy
  - Key members: range of senior clinician and management representatives from the health service, representative from CHQ and MHAOD Branch.
  - Reported to the Chief Executive WMHHS and Chief Executive and Department of Health Oversight Committee.
  - Met weekly from September 2013 until January 2014.
  - Paperwork……
- Chief Executive and Department of Health Oversight Committee:
  - Chaired by…
  - Key members: Deputy Director General Department Health, Health Service Chief Executives from key hospital and health services; Executive Director MHAOD Branch and other key representatives from CHQ.

- The clinically driven process was supported by additional and specific resourcing:
  - Project Officer appointed to support the Clinical Care Transitional Panel and the Barrett Adolescent Update Meeting.
    - Appointed …..
    - Role to schedule agenda to ensure all patients reviewed in a timely way and record keeping.

---

[4] This meeting appears to have had an alternative meeting name: Barrett Adolescent Update Meeting.

- The closure of BAC was supported by a formal communication plan in effect from September 2013 to February 2014. This was managed by the Project Officer (above). The scope included families and carers, community, staff of BAC, hospital/health services, industrial organisations etc.
- Note that three previous patients of the BAC have died in 2014 and that their deaths are currently being investigated by the Queensland Coroner.
- The published literature (Appendix B) regarding transitional care for adolescents provides guidance and principles in relation to the planning and outcomes required for this group:
    - Optimal transition may be defined as adequate transition planning, good information transfer between teams and continuity of care following transition.
    - Predictors of positive transition include individual factors such as severe mental illness and treatment and care issues such as medication and inpatient care.
    - Neurodeveleopmental disorders, personality disorders, complex needs and emotional/neurotic disorders can be associated with less favourable outcomes.
    - Other factors associated with poor outcomes include if the process is seen simply as an administrative event.
    - It is better to undertake transitional care in the context of relative stability for the young person rather than crisis.
    - Transition preparation requires adequate period of planning and preparing the young person and carer for transition. The planning needs to broad account of health and developmental transitions recognising the young person's developing maturity and changing health-seeking behaviours.
    - Models for collaboration that support transition include: shared care/joint working across services and liaison models.
    - Barriers to transitional care include: lack of alignment between referral thresholds and criteria between CAMHS/CYMHS and Adult MHS.
- The Queensland Health Procedure Document 201000447, Inter-district Transfer of Mental Health Consumers within South Queensland Service Districts, effective 8/11/10 and active at the time of the closure of BAC, provides guidance in relation to transitional care, notably including: the roles and responsibilities of transferring and receiving services; and consideration of potential shared care arrangements.
- Noting that transition is a process in which the communication and negotiations between the referring and receiving services are critical, this review was limited to review of the available documentation and interviews with key clinicians formerly from BAC. Staff of receiving services were not interviewed and limited

documentation was available from these services. Education staff were also not interviewed.

Findings

- The process of transitional planning occurred in an atmosphere of crisis with escalation of distress in a number of the adolescents and staff of BAC. There appears to have been a contagion effect amongst the adolescents and an increase in incidents. However whilst this contributed to the complexity of the situation, it does not appear to have detrimentally affected the process of transitional care planning for the patients.
- Transitional care planning was led by a small multidisciplinary team of clinicians led by the Acting Clinical Director. Their task was enormous as they were required to review and supervise current care plans, manage incidents and crises, seek out information about service options that many times was not readily available, negotiate referrals, coordinate with the education staff and manage communication with patients and their families/carers. The team was dedicated to these tasks with the day to day supervision of the young people undertaken by the Care Coordinators.
- In relation to the patient cohort, it is noted:
    - The young people were a very complex group with various combinations of developmental trauma, major psychiatric disorder and multiple comorbidities, high and fluctuating risk to self, major and pervasive functional disability, unstable accommodation options, learning disabilities, barriers to education and training, drug and alcohol misuse. In short, this was a cohort in the main characterized by high, complex and enduring clinical and support needs.
    - This would have been very significant challenge in general in organizing transitional care for such a complex group under ideal conditions. Each very complex young person required highly individualized care assessment and planning. These are not the kind of individuals who readily 'fit' with service systems because of the scope and intensity of their needs. The model of care in existence at BAC had promoted prolonged inpatient care and the closure required the rapid development of care pathways to community care.
    - The BAC team undertook an exhaustive and meticulous process of clinical review and care planning with each individual young person's best interests at the core of the process.
- The process of communication and negotiation between the clinical team and the young person and their family/carers was careful, respectful, timely and maintained. As would be expected during a time of heightened emotions and anxiety about the future, there appears to have been a level of misunderstandings

along the way but these appear to have been in each case dealt with promptly and appropriately. The misunderstandings arose, for example, in circumstances of unopened emails or unexpected emerging clinical need. There is evidence of parent information sessions, letters to parents, individual email responses to parents and phone calls to support timely communication. Fact Sheets, FAQ sheets and the Executive Review Committee recommendations which were provided to parents and made publicly available on the WMHHS website.

- The transition plans, without exception, were thorough and comprehensive. In some instances it was not possible to identify a variety of options for each care domain, but in each case at least 1 reasonable option was able to be identified matched to a particular care domain. At times there was considerable delay in settling on the final option – but this reflected the considerable work involved in identifying a range of suitable options and working through processes of negotiation with receiving agencies.
- In a number of instances the young people had disorders that did not cross the threshold to service in the community mental health system. It is noteworthy that there were examples of successful negotiations that led to services accepting the referrals by exception. For example, the reviewers did not find any example where it was not possible to organize a reasonable system of care for any 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 provided for adolescents and the culture and approach to care in adult services and 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 rate from some aspects of the care organized, the reviewers did not identify any examples where a young person was completely lost to care, nor where a core component of care was completely missing. Where , for example, did drop out of ongoing care with it would appear that did remain under the care of a case manager from and there was also contact from with a from
- 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, the detailed discussions in relation to risk management, maintaining contact post-transfer of care and joint working by staff across the agencies. These activities would be considered best-practice in transitional care and in the main appear to have been implemented. The reviewers

note however,

- There were examples where brokerage funding was very necessary and secured from health to facilitate a high quality transition.
- The reviewers 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 reviewers 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. Further the remarkable effort in enabling this process within the relatively tight time-frame should be considered an achievement.
- The reviewers confirm that:
    - The governance model put in place within Queensland Health to manage the oversight of the health care transition plans was appropriate. The reviewers noted examples of good flow in communication about transitional processes across governance groups. The reviewers noted that some documentation was incomplete/missing and there was a delay in the appointment of the Project Officer, however it is the view of the reviewers that these were minor issues and did not have a material impact on the transition of the patients.
- The reviewers 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 that supports mental health transition for vulnerable young people.

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EXHIBIT 117

TSK.900.001.01201

Policy Directive

NSW GOVERNMENT Health

Ministry of Health, NSW

http://www.health.nsw.gov.au/policies/

Transfer of Care from Mental Health Inpatient Services

Document Number	PD2012_060
Publication date	14-Nov-2012
Functional Sub group	Clinical/ Patient Services - Mental Health
Summary	This policy sets out the principles and requirements for safe transfer of a mental health consumer's care across health settings. It particularly focuses on the ongoing care needs of consumers who are returning to the community following an episode of inpatient care or who are on approved leave from an inpatient unit. The policy sets out the treating team's responsiblities in relation to advice, information sharing, and documentation to ensure continuity of care and safety are maintained during the transfer process.
Replaces Doc. No.	Discharge Planning for Adult Mental Health Inpatient Services [PD2008_005]
Author Branch	Mental Health and Drug and Alcohol Office
Branch contact	Jane Ryan
Applies to	Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Community Health Centres, Ministry of Health, Public Hospitals
Audience	Mental health clinicians - hospital and community based.
Distributed to	Public Health System, Divisions of General Practice, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres
Review date	14-Nov-2017
Policy Manual	Patient Matters
File No.	10/2497
Status	Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

NSW GOVERNMENT Health

TRANSFER OF CARE FROM MENTAL HEALTH INPATIENT SERVICES

PURPOSE

This policy replaces PD 2008_005 *Discharge Planning for Adult Mental Health Inpatient Services*. The policy has been revised and expanded to include Child and Adolescent inpatient services. This policy promotes safe and effective transition of all mental health consumers between inpatient treatment settings, and from the hospital to the community. It maps a structured process for the transfer of care that will:

- Improve consumer, family and carer, and community safety;
- Improve communication between all stakeholders;
- Improve continuity of care for consumers; and
- Facilitate better access to community mental health care, primary health care, family and community support services.

The policy and procedures set out a safe and appropriate approach to the care of mental health consumers transferring between inpatient settings, and from inpatient settings to the community. However, as in any clinical situation, there may be factors which cannot be covered by a single set of procedures. This document provides direction and guidance but it does not replace the need to exercise clinical judgement for each presentation and recognition of the current workplace environment.

MANDATORY REQUIREMENTS

This policy applies to all inpatient mental health facilities. It requires all Local Health Districts to have local guidelines/protocols in place that are based on the policy.

Local Health District implementation

Local Health Districts (LHD), the Justice and Forensic Mental Health Network, the St Vincent's Health Network and the Sydney Children's Hospital Network must have local policies and procedures in place for transfer of care that are consistent with the principles and procedures identified in this policy.

Mental Health service evaluation

LHD and Health Network mental health services must monitor and evaluate their local transfer of care practices on a regular basis.

Training and orientation

LHD / Health Network mental health services must incorporate the principles and procedures for safe and effective transfer of care planning into the induction programs for all new clinical staff.

IMPLEMENTATION

Roles and responsibilities of the NSW Ministry of Health:

- Provide advice and assistance for the implementation of this Policy.
- Monitor and review the implementation of this Policy.

Roles and responsibilities of LHD Chief Executives:

- Assign responsibility, personnel and resources to implement the principles and procedures for mental health service settings.
- Report annually on the implementation of transfer of care principles and procedures to the NSW Ministry of Health.

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NSW GOVERNMENT Health

Roles and responsibilities of the LHD Director of Mental Health:

- Facilitate development of District-wide transfer of care and leave policy and protocols that
  - Are consistent with the state-wide policy directive's principles and procedures; and
  - Include protocols for managing a consumer's transfer of care to the community outside of usual working hours, at weekends and during holiday periods.
- Develop a transfer of care checklist to ensure that all steps of the procedure are carried out.
- Educate clinical staff in the engagement of the principles and procedures for transfer of care planning.
- Ensure the principles and procedures for transfer of care planning are incorporated into orientation programs for new clinical staff.
- Ensure transfer of care practices are regularly monitored across their services and feedback on results is provided to staff.
- Report annually to the Ministry on implementation of the policy directive's requirements through the Chief Executive.

Roles and responsibilities of hospital, facility, clinical stream, unit managers and heads of departments:

- Implement the local policy for mental health transfer of care.
- Ensure that the Primary Carer, and/or family, other health care providers and community support services participate in the process of planning for transfer of care as appropriate (see Procedures).
- Evaluate compliance with the principles and procedures for transfer of care planning.
- Annually monitor and evaluate local transfer processes in line with the principles and procedures for transfer of care and report to LHD/Network Director of Mental Health.

Roles and responsibilities of all clinicians:

- Ensure their work practices are consistent with the principles and procedures for safe and effective transfer of care processes.

Key Performance Indicators

Transfer of Care as set out in this policy directive aims to address two key state targets to improve mental health outcomes:

- Reduce re–admissions within 28 days to any facility
- Increase the rate of community follow–up within 7 days from a NSW public mental health unit.

REVISION HISTORY

Version	Approved by	Amendment notes
PD2012_060	Deputy Director-General, Governance, Workforce and Corporate.	Replaces Discharge Planning for Adult Mental Health Inpatient Services (PD2008_005)

ATTACHMENT

1. Standard Principles and Procedures for Transfer of Care from Mental Health Inpatient Services.

Transfer of Care from Mental Health Inpatient Services - Standard Principles and Procedures

NSW GOVERNMENT Health
PROCEDURES

Issue date: November 2012

PD2012_060

Transfer of Care from Mental Health Inpatient Services - Standard Principles and Procedures

NSW GOVERNMENT Health
PROCEDURES

CONTENTS

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1. BACKGROUND

About this policy

For many mental health consumers, the period after leaving a mental health inpatient unit is a particularly vulnerable time. This policy sets out the principles and requirements for safe transfer of a mental health consumer's care across treatment settings. It particularly focuses on the ongoing care needs of consumers who are returning to the community following an episode of inpatient care or who are on approved leave from an inpatient unit. The policy sets out the treating team's responsibilities in relation to advice, information sharing, and documentation to ensure continuity of care and safety are maintained during the transfer process.

Transfer of care[1] is a structured, standardised process for ensuring the safe, efficient and effective transition of people with a mental illness between inpatient settings and from hospital to the community. Transfer of care is part of the continuum of care that starts with the person's admission to hospital.

Effective transfer of care planning is delivered by mental health services that are responsive to consumer needs and inter-linked with other agencies, service providers, carers and the consumer, using a collaborative approach.

The *National Standards for Mental Health Services 2010* apply to the range of mental health services, government, non-government and the private sector. A number of consumers under the care of private psychiatry or psychology services may also access public acute services when their private clinicians are not accessible in crisis situations. Therefore partnerships between public, private and non-government sectors in mental health are important.

With increased complexity of mental health presentations, there is a strong need for a multidisciplinary approach. Health professionals from all disciplines need to work closely together to develop and implement a comprehensive transfer plan.

Transfer of care to the community is to be effected in accordance with the principles and requirements of the Mental Health Act 2007, and by obtaining and complying with any order of the Mental Health Review Tribunal, such as Community Treatment Orders.

The NSW Health policy and reference manual for *Care Coordination from Admission to Transfer of Care in NSW Public Hospitals (PD2011_015)* set out standards and a framework for handling the needs of all consumers leaving hospital care which are generally applicable to the mental health inpatient care pathway. This mental health inpatient transfer of care policy expands the standards established in PD2011_015 and provides more detailed direction for clinicians working with people with mental illness to address their specific safety and care needs.

Thorough assessment and management of risks are essential elements of the transfer of care planning process for all mental health consumers.

[1] 'Transfer of care' replaces the term 'discharge' in this document to reflect a continuum of care. Where reference is made to the Mental Health Act 2007, the term 'discharge' is used to reflect the Act.

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The previous policy (PD2008_005) was written specifically for adult inpatient services. Child and Adolescent Mental Health (CAMHS) inpatient services are subspecialty programs and have different requirements from those focused on the care of adults. Similarly, Specialist Mental Health Services for Older People (SMHSOP) services are subspecialty programs and have particular requirements. There is however, some overlap between general procedures and subspecialty requirements.

The procedures support standardised development, implementation and review of local transfer of care processes. Note, this policy does not look at the models of care; instead, it specifically refers to the process involved in transfer of care from a mental health inpatient unit.

Scope of policy

This policy refers to situations where the mental health consumer's care is transferred from a mental health inpatient unit to:

1. Another inpatient service:
    - Public mental health unit
    - Private psychiatric hospital
    - General hospital ward
2. The community:
    - Community mental health service
    - Consumer in conjunction with family/carers
    - General practitioners and private mental health professionals
    - Government and non-government organisations
    - Combinations of the above.
3. Approved leave
   This policy recognises approved leave as a transfer of care situation and identifies the basic requirements for promoting safety during and following a consumer's period of leave in the community.

When Psychiatric Emergency Care Centres (PECCs) transfer consumers either to an inpatient service, or to the community, the principles and practices required under this policy apply, as far as practicable.

Although the principles and procedures set out in this policy are relevant to forensic and correctional patients, transfer of care for these patients has additional requirements that are not addressed in this policy.

Likewise, the additional requirements involved in a consumer's transfer from a mental health inpatient unit to a general hospital ward are not dealt with in this policy.

Many episodes of inpatient care involve movement between units or wards while continuing as a single episode of care and under the same team. This policy does not include points of transfer of care within the inpatient unit such as between shifts, internal units or teams, as these are covered in the *Clinical Handover – Standard Key Principles* policy (PD2009_060).

The definitions of 'discharge' and 'leave' for data reporting purposes remain unchanged as identified in the *Admitted Patient Data Dictionary* .

Main definitions

Authorised Medical Officer as defined in the Mental Health Act 2007.

Carer is a person involved in the care of the consumer but is not **only** the primary carer as defined by the Mental Health Act 2007. Other carer/s may include close family members or friends.

Consumer refers to a person under the care of a NSW LHD Mental Health Service. The term 'patient' is only used in this document when associated with legal status.

Continuity of care involves a consistent, connected and coherent approach that is responsive to the consumer's health needs and personal context.

Guardian as defined in s4.1 of the Mental Health Act 2007.

Primary carer has the same meaning as in the Mental Health Act 2007 (s71)

Transfer of care involves the transfer of professional responsibility and accountability for care of a mental health consumer to another person or professional or a combination of professionals.

Transfer of Care Plan refers to a **tailored** package of information setting out details of treatment, referrals, advice and support arrangements for the information the consumer, carers, community based health professionals and NGO support services to promote continuity of care and safety. Components of the Transfer of Care Plan package are given to the consumers and care providers as relevant to their particular role in supporting the consumers care and recovery.

Health Network/s refers to Local Health Districts, Justice Health, The Children's Hospital Network and the St Vincent's Health Network.

> Where a person has an appointed guardian, the guardian will be the primary carer.

Legislative and Policy context

The development of this policy has been informed by key aspects of NSW legislation, government policy and plans. The policy also puts into effect coronial recommendations concerning transfer of care issues and those of other formal enquiries. Revisions from the previous policy are in the context of the recommendations made by Commissioner Garling following his inquiry into acute care services in NSW public hospitals conducted in 2008.

See Attachment 6 for further details.

2. SAFE, EFFECTIVE AND EFFICIENT TRANSFER OF CARE

Continuity of care is one of the cornerstones of good clinical practice. It requires clear and agreed governance arrangements within and between services and agencies, supported by competent, confident staff with the necessary resources to work in partnership and to involve consumers and their carers appropriately at all stages in their care. The development of shared understanding and common objectives is crucial. This should involve key staff in different services together with consumers and their carers and/or guardian. Planning is required to ensure that transfer of care between services is conducted in a timely and streamlined way in order to promote optimal outcomes for the consumer.

2.1. Principles for Transfer of Care

To ensure quality, safety and efficiency, transfer of care is based on the following principles:

- Admission and transfer of care are part of a continuum of care.
- The consumer and their family/carer/guardian are at the centre of care and are partners in care.
- Collaboration between public and private mental health services, primary care, other government agencies and non-government organisations is more effective in comprehensively addressing consumers' and carers' needs.
- Clear and timely communication practices supported by efficient information technology minimises risk of harm to the consumer and others.
- Standardised and monitored transfer of care processes support continuous system-wide improvement.

2.2. Summary of Essential Actions

Essential components for safe, effective transfer of a mental health consumer's care:

- Undertake admission assessment including assessment of risks (e.g. suicide, harm to others, sexual exploitation, absconding, homelessness).
- Conduct a multidisciplinary review and identify a care coordinator.
- Estimate date for transfer.
- Communicate estimated date for return to the community to consumer, carers, and other relevant parties.
- If care planning includes periods of leave, develop and document plans and conditions for approved leave with the involvement of the consumer, those caring for the consumer whilst on leave, and where relevant, community based health and recovery support services.
- Develop and document Transfer of Care Plan package with the participation of the consumer, family/carers/guardian, community support agencies, and health professionals providing ongoing treatment.
- Book referral services with consideration of waiting times or waitlist of the receiving service.

- Prior to transfer to the community:
  - Discuss the consumer's transfer readiness and needs at a multidisciplinary team review;
  - Ensure a consultant psychiatrist review has been conducted within 24-48 of transfer;
  - Conduct risk assessments, and reconsider consumer's readiness immediately before transfer to the community;
  - Document modifications to management of risks and other changes in the Transfer of Care Plan;
  - Provide consumer with prescribed medication;
  - Provide relevant components of the Transfer of Care Plan package to the consumer and family/carer/guardian, GP, community mental health service, private health professionals and non-Government support agencies.

The Transfer of Care Plan is a package of documents that together provide comprehensive information for the consumer, family/carers community based health professionals and other service providers involved in the consumers ongoing care and support. Components of the package should be tailored to the recipient's needs. For example, information provided to another mental health professional who will be resuming the person's care may not include emergency contact details but this would be important information for the consumer or primary carer.

When developed for a consumer returning to the community, the consumer's right to privacy must be considered and any information provided to support services must be directly related to their service role. The package would be expected to set out advice such as emergency contacts, follow up appointments, support service arrangements, detection and management of possible risks and medication details. It should:

- Include the Transfer/Discharge Summary,
- Be guided by relapse prevention and recovery focused principles, and
- Take into account ongoing physical health care needs,
- Be written in plain language and where necessary include information in community languages,
- Ensure that the consumer's right to privacy is observed,
- Outline supports available for consumers and carers.

When transferring to another inpatient service, the transfer of care plan is expected to include a detailed clinical and social history, risk assessment information, relevant psychosocial information.

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2.3 Procedure for Transfer of Care to another Inpatient Service

This policy also applies in circumstances where a mental health inpatient's treatment has been completed in one setting and is being transferred to another inpatient service for ongoing care.

Local Health Districts have the responsibility for ensuring that their local policy and procedures for transfer to another inpatient service comply with the principles set out in section 2.1 above and the standards established in this policy.

It is expected that the transferring unit and receiving units meet all the requirements and criteria of the admitting service and at a minimum address:

- Documentation provided to admitting service
    - Full information on consumer's history
    - Transfer/Discharge Summary
    - Relevant reports, case summaries and materials requested as per receiving unit's admission policy
    - Recent investigations/tests and reports
    - Updated risk assessment and management plan
    - Updated care plan
    - Medication details
- Requirement to phone the other service to confirm transfer
- Documentation in the transferring unit shows that staff have informed the primary carer/relatives, the GP and other agencies involved that the consumer's care is being transferred to the other inpatient service.
- Completion of K10/HONOS
- Transfer of Care Plan documented in medical record
- Medical entry in file including follow up plan
- Ward clerk notified of discharge
- Consumer's name removed from white board
- Discharge details recorded in Admission/Discharge Register
- Treatment sheet placed in clinical file
- Valuables transported with consumer
- Copy of Transfer of Care Plan and associated information provided to admitting service at transfer
- MH-CoPES survey questionnaire given to consumer
- Transport arranged

Appendix 4 provides a sample checklist to monitor this process.

2.4 Procedure for Transfer of Care to the Community

Successful transfer of care is facilitated by good admission and pre-discharge planning with consistent senior staff support throughout the process.

The decision to transfer a consumer rests with the consultant psychiatrist in discussion with the multidisciplinary team.

Transfers from a mental health inpatient unit to another inpatient service are guided by the Principles set out in section 2.1.

Six stages for effective transfer of care to the community are detailed on the following pages. It is recognised, however, that in some situations, for example for brief acute admissions, the completion of the detailed procedure set out in these six stages may not be practicable. See section 2.4.1 for further advice.

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Six stages for effective transfer of care for mental health consumers returning to the community.

STAGE 1: Initial Planning for Transfer of Care – Inpatient Unit

- Admission assessment including comprehensive assessment of risks (e.g. suicide, harm to others, homelessness, sexual exploitation, domestic violence, D&A abuse, physical health, absconding, adherence to treatment, cultural and language issues).
- Multidisciplinary review and identify a key clinician/care coordinator responsible for ensuring all steps of the transfer of care process are completed and documented.
- Within 72 hours of admission to an **acute** unit, document an estimated date of transfer (EDT*), taking into account assessment information related to the consumer's likely needs (e.g. accommodation, support with daily living skills, support with parenting, support to reduce isolation, support with employment) and any risks at that time. For Psychiatric Emergency Care Centres (PECCs) the EDT is to be documented within 24 hours of admission.
- Notify consumer, primary carer/guardian, GP, community care coordinators and community support providers of the EDT as appropriate.
- Conduct regular reviews of EDT, adjust where appropriate. Keep consumer, primary carer, community mental health and other relevant parties informed of the progress.
- Make early referrals and seek engagement of new/next care providers in transfer planning.

** 'EDT' is equivalent to the term EDD (Estimated Day of Discharge) in current operational practices.*

STAGE 2: Planning for Transfer to the Community

- Develop a Transfer of Care Plan* with the consumer, the primary carer and, if appropriate other carers, community based health professionals and support services.
    - Detail as appropriate:
        - Medication/s frequency; dosage and side effects
        - A schedule of medical follow up appointments
        - Contact details for community mental health service and follow up arrangements
        - Signs of possible relapse and what to do
        - Emergency contact numbers
        - Consumer self management plan (including coping strategies)
        - Crisis management plan
        - Community support arrangements including referrals to other services/ programs.
- Provide a copy of the care plan to the consumer and primary carer and, as appropriate other carers and relevant portions of the transfer of care plan package to community based health professionals, and support services which identifies their roles and allows them to confirm their willingness and capacity to participate as envisaged. Provide any risk information, which service providers may need

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to consider in relation to their capacity to respond.

- Where relevant, develop a service coordination plan that clarifies the different roles and responsibilities of each community based service provider and promotes improved communication and safety, and formalises the professional responsibility of each provider towards the consumer. The consumer and primary carer should be involved in this action. Other carers should be involved as appropriate.

*The Mental Health (MH) Clinical Documentation - Care Plan module and the Consumer Wellness Plan module may be used to document components of this package.

Note: *Section 2.5 - Leave from inpatient units; Section 3 - Transfer of Care Planning for Specific Population Groups*

STAGE 3: Preparation for Transfer of Care

- Take into account legal status including Community Treatment Order (CTO), Trustee, Guardianship, or Child Protection Issues.
- Where necessary, arrange for the relevant community mental health team to make application to the Mental Health Review Tribunal (the Tribunal) for a CTO. Refer to the Tribunal's *Civil Hearing Kit* which details the application process and legal requirements of Tribunal orders.
- Contact and book appointment/s for follow-up with the appropriate health providers (including the GP, community mental health team, relevant private health practitioners).
- Ensure that timing for follow-up appointments is commensurate with the level of risk, mental health acuity and functional capacity of consumer to adhere to the care plan.
- Make referrals to relevant other service providers that clearly outline what the service is being asked to do, and ensure that the other service provider accepts the referral.
- Ensure the consumer completes the MH-OAT consumer-rated outcome measures, unless contraindicated, and the measures are reviewed by a clinician.
- Encourage and support consumer to complete and return the MH-Copes questionnaire. Explain how the questionnaire fits within the quality improvement framework of the service.
- Provide information to consumers on the community consumer worker services and other peer support programs.
- Conduct a physical health assessment and examination in accordance with PD2009_27 and GL2009_007 (and record in the MH-Clinical Documentation Physical Examination module).

Link to MH Clinical Documentation Modules

(*http://internal.health.nsw.gov.au/policy/cmh/mhoat/protocols.html*)

STAGE 4: Confirming Readiness for Transfer of Care (within 24-48 hours of transfer)

- A consultant review must be undertaken within 24-48 hours prior to transfer of care, by a consultant, either face to face or via telepsychiatry. The review is to be discussed with the primary carer and documented in the clinical record.

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- Complete HoNOS/65+/CA and K10+. If HoNOS and K10+ are inconsistent with each other, or your clinical impression, discuss with the senior clinician and the consumer and /or family/carer prior to transfer.
- Ensure medication is available for use during initial period post transfer. In addition, confirm with the consumer if a prescription for nicotine replacement therapy (NRT) is required.
- Ensure that the General Practitioner and where relevant, other health care providers
  - Have community mental health service contact details
  - Agree on follow-up action if a consumer fails to attend the initial or subsequent appointments
  - Know how to seek specialist advice concerning the consumer's ongoing care
  - In situations where the consumer will be transferred to a hospital without onsite mental health care (e.g. rural hospital), the treating team must ensure that inter-hospital transfer and admission arrangements, including referral to the local community mental health service, have been made.
- Document follow-up and support arrangements in the *Transfer/Discharge Summary* (MH-Clinical Documentation module) on, or before, the day of transfer. Where relevant include summaries from other members of the treating team. The *Transfer/Discharge Summary* must:
  - Specify the person/service responsible for ongoing treatment/actions and
  - Include clear advice about:
    - recent changes to clinical management
    - medication requirements
    - any relevant risks
    - the follow up plan
    - contact details of support services/GP involved in ongoing care and whether they were notified of transfer date
    - details of scheduled appointments.
  - Indicate whether or not a copy the MH Clinical Documentation *Transfer/Discharge Summary* module was provided to consumer and primary carer.

Note: *Section 2.4 Consumers at Risk of Harm to Self or Others*

STAGE 5: At the point of Transfer of Care

- Check medication supply and prescriptions are provided to the consumer or primary carer in accordance with *Transfer/Discharge Summary*.
- Discuss arrangements for subsequent medication and supervision of medication with consumer and primary carer or other family members/carers, with the consumer's consent.
- Ensure that consumer/or primary carer understands and signs the Transfer of Care Plan and the Consumer Wellness Plan. If the consumer is under 16 years old, ensure that both the consumer and their parents/primary carer understand the plan.
- Provide a copy of the care plan for transfer to the consumer and primary carer. In circumstances where the consumer opposes access to such information being provided to a primary carer, it may be necessary to negotiate the primary carer's access to certain information that is essential for the

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primary carer to support safe return to living in the community for the consumer and others. (For further guidance see Attachment 2: Disclosure of Information to families and carers). If the consumer is under 16 years old, provide

- their own copy of the Transfer of Care Plan or other tailored developmentally appropriate information, to the young consumer; and
- a separate copy of the Transfer of Care Plan directly to the parent and/or primary carer.

- Provide relevant information leaflets to consumer/carer.
- Provide a verbal handover to the mental health community team at the point of transfer.
- With the consumer's agreement, provide relevant information to Community Managed Organisation (CMO) involved in providing immediate support. (For further guidance see Attachment 2: Disclosure of Information to recovery support services and other community based service providers).
- Fax/Email a copy of the *Transfer/Discharge Summary* (within 12 hours) to the general practitioner and other health professionals who will provide care. Where appropriate and in line with Mental Health Clinical Documentation guidelines, attach:
  - Current *Care Plan*
  - The Transfer of Care Plan
  - Consumer Wellness Plan
  - Physical Examination module.
- Place copies of the Transfer of Care Plan and *Transfer/Discharge Summary* in consumer's file.

STAGE 6: Assertive follow-up - Community Mental Health Service

- Make direct contact with the consumer within the timeframe indicated in the Transfer of Care Plan or at a maximum within 7 days to:
  - Monitor the consumer's progress against the plan after leaving hospital; discuss problems arising and commence future management planning
  - Prompt the consumer about appointment(s) and follow-up plans.

  This contact may be face-to-face, by telephone or videoconference.

  It may also be worthwhile contacting the consumer's primary carer.
- If the consumer does not attend his/her appointment, initiate follow-up according to agreed arrangements.
- Where the consumer does not attend an appointment and there is persistent refusal to do so, discuss at a multidisciplinary team meeting whether a Community Treatment Order (CTO) should be sought from the Tribunal.

2.4.1 Short mental health inpatient stays

An inpatient stay of less than 48 hours, such as an admission to a PECC, is often associated with additional risks and problems such as inability to contact carers, inadequate access to clinical history, corroborating information and existing documentation. Transfer to the community in such situations should be reviewed by a consulting psychiatrist. LHD mental health management may

determine some specific circumstances where exceptions can be made. In addition LHD mental health services need to establish a protocol setting out the minimum requirements for transfer of care for these admissions.

2.4.2 Monitoring

Monitoring and evaluation are essential processes to promote the delivery of responsive, effective transfer of care. LHDs should develop a *transfer of care checklist* to ensure that all steps of the process are carried out as far as practicable. See Attachment 3 for a sample checklist.

Transfer of care planning and outcomes for consumers must be routinely monitored and periodically evaluated in conjunction with other mental health continuous improvement processes. See Attachment 4 for a sample of a *self assessment tool* to monitor the transfer of care process (developed by the Victorian government).

2.5 Leave from Inpatient Units

Planned leave can play an important role in a consumer's gradual return to the community. However, evidence demonstrates that during leave, mental health consumers are at an increased risk of suicide.

Decisions to grant leave should be made in the context of treatment goals and strategies in the consumer's treatment plan. Leave decisions need to take into account the risks and expected benefits of leave, the rights of the consumer, their family and carers. Risks, include, but are not limited to, risk of harm to self and others (including any child protection issues), and the likelihood and consequences of substance abuse.

LHD mental health services must re-examine leave protocols to ensure they address:

- Specific criteria and purpose for granting leave
- Development and documentation of a leave plan
- Engagement and consultation with family/carer/CMO
- Requirement for all consumers to have documented risk assessments and risk management plans which are considered and referenced in documentation of all leave decisions.
- Procedures to follow where:
    - Newly admitted persons request leave
    - Voluntary consumers seek unplanned leave and
    - Requests for leave are made after hours, at short notice, or on weekends when the treating team is not present.
- Documentation requirements for:
    - The leave plan
    - Post-leave feedback from the consumer, family/staff about any issues of concern arising during the leave
    - Mechanism for post-leave report to inform clinical reviews
    - Post-leave consumer search procedures, in accordance with local search and safety policies
    - Steps to be taken by health staff when any consumer
        - Does not return from leave as agreed
        - Is missing/absent without leave from the unit, and
        - The circumstances and procedures for when Police should be notified.
- Processes for monitoring unit leave practices.

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It is expected that each **LHD** will develop checklist/s in regard to inpatient leave from, and return to, units that take into account the nature of the unit.

Note, the additional transfer of care requirements for a mental health inpatient on leave to a general hospital ward are not set out in this policy, and must comply with the hospital's inter-ward transfer procedures.

When approved leave is taken, provide the consumer, and where appropriate, carer/s, with clear, simply written care instructions setting out medication and supervision requirements, contact details, arrangements for crisis support, restrictions on the consumer's activities and agreed responsibilities.
For short leave please see page 15.

2.5.1 Management of planned leave

Leave planning

Where possible, leave should be planned well in advance in the context of treatment goals and discussed by the treating team, in consultation with the consumer and carers (where this is relevant).

The **leave plan** will

- document
  - a statement of its purpose
  - the consumer's departure and return times
  - any special conditions (e.g. escorted, whether the consumer should avoid driving or other restrictions)
  - medication and supervision arrangements
  - contact numbers for the consumer, carer and mental health unit
  - identification of the services or persons responsible for managing risks during leave including any role for primary care services, community mental health services, or family members and/or carers
  - guidance for the consumer and the family/carer concerning measures to manage risks during leave (e.g. self harm/suicide; harm to others; domestic violence; the likelihood and consequences of substance abuse)
  - the provision of a crisis plan if difficulties arise during the leave period, and
  - written advice and information provided to family/carer prior to the leave.
- be approved in writing by the treating psychiatrist or his/her delegate.
  (Please note that under the Mental Health Act 2007, the clinician approving leave for an involuntary patient must be an authorised medical officer - AMO).
- be provided to the consumer, the carer/s (as appropriate) and relevant clinical staff.

Preparation for Leave

The consumer's mental state and risk assessments should be reviewed immediately before planned leave, and if necessary leave arrangements may be altered or cancelled.

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- Where appropriate, involve the acute community care team to ensure after hours support, flexible assertive community support and prompt intervention in crisis situations.
- Provide a comprehensive record of the short leave plan and any changes in the consumer's health care record.
- Provide details of the support available to the consumer from family/friends.
- Negotiate communication pathways with the client, the community team and any family member or friend who has accepted responsibility for the care of the person whilst on leave.
- Develop a clear agreement with the consumer stating expected time of return, and process for notification if return is delayed. Staff must be alert to the reasons a consumer may provide for changing return timing or arrangements. Consider indications of deterioration of mental state.
- Arrangements and responsibilities of leave are to be explained and agreed to by the consumer, and if relevant and appropriate, to family/carers. This will include information and instructions regarding the circumstances and contact details for the mental health unit should the staff need to be contacted.
- Where the granting of leave relies on the expectation that the consumer will be supervised by a responsible adult at all times during leave, this should clearly be communicated to both the consumer and the carer/s. If the carer is unwilling or unable to take on this responsibility, decisions regarding leave should be reviewed, and documented.
- Attention must be given to granting leave to involuntary patients who should be escorted by a staff member (or a family member/carer if appropriate). This will include information and instructions regarding risks and responsibilities of escorted leave; and the circumstances and contact details for the mental health unit should the staff need to be contacted.
- For very short periods of unescorted leave of less than an hour, for example, to go to the shop, the treating team should have a clear leave plan that follows the standards identified above. Before the consumer leaves, the clinical staff need to be assured that the person is able to understand the nature of the leave. The clinical staff also need to be satisfied that the person can do what is expected of them during leave, and be satisfied that the risks are known and can be contained within the limited nature of this leave occasion. Details of very short leave periods must be recorded in the consumer's health care record.

Short leave of less than an hour duration must follow the principles outlined above but does not require written care instructions to be given to the consumer/carer. Information should be given verbally and recorded in the health care record.

Handover process on return

It is important for health staff in the inpatient unit to be aware of any significant events during the leave that may have had an impact on the consumer's current mental state or on other matters affecting further planning for transfer to the community.

Inpatient staff must speak with the consumer and, where relevant and appropriate, with the family/carers after leave to find out about any concerns arising during leave. An assessment of the leave is to be documented in medical record and the impact of this information on management/ongoing care planning needs to be considered.

If the community mental health staff members have been involved in providing care to the consumer, a report outlining assessment and key interventions must be provided, as soon as possible, to the treating clinician or documented in the medical record on the in-patient unit.

In accordance with the LHD search protocols, and for the **safety** of the person, other consumers, and staff, the consumer should be searched for potentially dangerous items on their return.

2.5.2 Procedures for locating missing patients

LHD leave protocols must address the safety needs of both voluntary and involuntary consumers and:

- Clearly set out the procedures that mental health staff must follow if a consumer
  - Fails to return from leave as agreed, or
  - Is missing from the unit, and is considered to be at high risk of harm to self or others.
- Identify[2] steps to be taken to locate and safely return the consumer to the inpatient unit including:
  - Notifying senior nursing and medical staff (treating psychiatrist or on call psychiatrist)
  - Contacting the family/carer
  - Noting that involuntary patients who have absconded are able to be apprehended and returned to the mental health facility in accordance with the Act
  - Procedures to detain and return a voluntary patient under s19 or s22 of the Mental Health Act 2007 where the person is considered to be at high risk of harm to self or others
  - If not seeking to detain the person, guidance around notifying the police to request a welfare check
  - Completion of relevant incident reporting documentation
  - On the consumer's return to the unit
    - Re-assess his/her mental state and risk status
    - Review observation/supervision category
    - Interview the consumer to ascertain any factors that contributed to the absconding incident.

2.6 Consumers at risk of harm to self or others

2.6.1 Risk of harm to self

For mental health consumers, periods of inpatient leave, the time following return to the unit, and the first 28 days following transfer to the community are recognised as times of increased risk of possible self harm or suicide. Ongoing care planning must take into account these risks to promote a safe transition.

Prior to transfer from an inpatient unit, the suicide risk status of a person **must** be reassessed to determine whether transfer to the community (including leave) can be approved at this time. The timing of this risk assessment may be up to 48 hours prior to the transfer, but the timeframe must relate to the consumer's clinical situation. For example for overnight leave, for a person recently admitted, or one who has had a change of status, the risk assessment must be conducted within 24 hours of the transfer.

[2] Mental Health Emergency Response 2007: Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSW Police Force provides guidance

The risk assessment and the time it is conducted must be recorded in consumer's notes. If the transfer continues, this information **must** be conveyed in writing to the receiving mental health service, private health providers and any agencies to which the consumer is being referred for support services.

A proportion of mental health consumers will be at chronic risk of suicide or self harm and will need inpatient care when that risk is elevated. Once that level of risk has been reduced, further treatment in the inpatient environment may not be considered by the treating team to offer additional health or safety benefits. It is essential to ensure that the person has appropriate supports in place when they return to the community so that the risk is minimised. If the consumer is returning home or to supported accommodation, any current and ongoing risk of self harm should be conveyed to the family and service provider who is providing ongoing care, along with recommendations of how to manage the risk and access help.

For consumers who have been hospitalised for lengthy periods, the impact of their return to the community, and their ability to cope, should be assessed sensitively. Associated risks should be identified and addressed.

Consult NSW Health's Suicide Risk Assessment and Management Protocols for Mental Health Inpatient Units.

If the consumer is known to have access to a firearm, staff should consider the need to complete a *Notification to NSW Police and Firearms Registry Form* (refer to copy at Attachment 5).

2.6.2 Risk of harm to others

Prior to transfer (and leave), a further assessment of risk of harm to others, including any risk to children who are in contact with the consumer, **must** be conducted.

Based on this risk assessment and others conducted during the admission, a management plan **must** be documented in the Transfer of Care Plan and Transfer/Discharge MH-Clinical Documentation module. The consumer's readiness to return to the community at this time should be reconsidered.

CMO service providers need to be provided with information about the client that is directly related to their service role, including the nature and level of any risks.

If the consumer is known to have access to a firearm, and there is an assessed level of risk to others, staff are required to complete a *Notification to NSW Police and Firearms Registry Form* (refer to copy at Attachment 5).

NSW Health staff who suspect, on reasonable grounds, that a child or young person is at '*risk of significant harm*' from abuse or neglect must report these concerns to the Community Services' Child Protection Helpline (**13 36 27**) as required under the *Children and Young Persons (Care and Protection) Act 1998*. Refer to the following Information Bulletin – *KEEP THEM SAFE – Making a Child Protection Report (IB2010_005)* for procedures on making a report.

The *Child Protection Mandatory Reporter Guide* (MRG) is a resource to help make a decision about whether to report. The guide is available online at http://sdm.community.nsw.gov.au/mrg/app/summary.page or in hard copy through LHD/Child Wellbeing Units. You may call the Child Protection Helpline to report directly, however the decision to report should always be informed by the Mandatory Reporting Guide which defines the reporting threshold for statutory child protection reports.

For additional guidance, call your local NSW Health Child Wellbeing Unit on **1300 480 420**

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2.7 Transfer of care for specific circumstances

2.7.1 Voluntary admissions

Voluntary patients (as defined under the Mental Health Act 2007) can leave hospital at their own request at any time. LHDs should establish protocols for managing the transfer of care to the community outside of usual working hours, at weekends or during holiday periods.

There may be times when a voluntary inpatient seeks transfer of care out of hours, against medical advice, or chooses not to accept ambulatory or community follow-up for mental health treatment. In such situations, inpatient clinicians should maintain a collaborative approach in decision making, and

- Ascertain why the person wishes to leave prior to formal transfer of care.
- Request that the person discusses reasons and follow up management with the person's consultant psychiatrist or the on-call psychiatrist.
- Inform relevant senior nursing and medical staff to ensure that a review is conducted as soon as possible.
- Involve the primary carer/family members/ carers who are relevant to the clinical decision in discussion about the situation.
- Assess mental status and any safety concerns. After assessing the person, the medical officer should discuss the review with the treating psychiatrist, or on-call psychiatrist, who will decide whether the person may leave 'against medical advice'.
- Assess child protection issues and make appropriate notifications to Community Services in line with the Mandatory Reporter Guide.
- Liaise with the local community mental health service (Adult, CAMHS or SMHSOP as appropriate) to ensure assertive follow up arrangements at home within 24 hours of transfer of care.
- If the treating psychiatrist or on-call psychiatrist agrees to the unscheduled return to the community, document all action by the medical staff and clinical team in the medical record and in the MH-Clinical Documentation *Transfer/Discharge Summary.*
- If, after assessment, an authorised medical officer determines that a voluntary patient needs to be detained in the mental health facility, the involuntary detention provisions of the MHA 2007 (s10 applies). The authorised medical officer must document the reasons for the change of legal status in the medical record. The person and the primary carer must be informed.

2.7.1 Involuntary admissions

The transfer of care process for involuntary patients will include consultation with the consumer, their primary carer, relevant agencies [Mental Health Act (MHA) 2007 s78 & 79] and take into account the following procedural requirements:

Condition	Comment
Discharge by Authorised Medical Officer	Consumers must be discharged from involuntary treatment by an Authorised Medical Officer (AMO) if the person is no longer mentally disordered or a mentally ill person, and the AMO is satisfied that care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person [MHA 2007 s12(2)].
Community Treatment	Under the MHA 2007, consumers may be placed on a CTO as part of the planning for safe transfer to the community. MHA2007 ss 51-56 and s10 of the Regulations refer.

Order (CTO)	The rationale for the CTO, and the consumer's rights and responsibilities in relation to it, must be clearly explained so that can be understood by the consumer and carer. Best practice would indicate that the consumer be included in the development of the CTO care plan.
Tribunal Discharge	Under the MHA 2007, a person held involuntarily may be discharged by the Mental Health Review Tribunal (the Tribunal).
Mentally Disordered Consumers	The discharge of a consumer meeting the criteria of 'mentally disordered' under the MHA 2007 must comply with section 31. The Act also requires a daily re-assessment of any consumers detained as 'mentally disordered' are examined by an AMO at least once every 24 hours.
Guardianship	For the discharge of a consumer under the Guardianship Act 1987 notice must be given in advance to the consumer's guardian.

2.7.2 Consumers on Community Treatment Orders

A Community Treatment Order (CTO), made under the Mental Health Act (MHA) 2007 by the Mental Health Review Tribunal (the Tribunal), authorises compulsory treatment of a person in the community. A CTO can be an important component in the Transfer of Care Planning and is developed by the community mental health facility that will implement the treatment.

The following factors indicate an application for a CTO may be appropriate:

- Previous history of refusing to accept appropriate treatment leading to relapse into an active phase of mental illness,
- Severity of the acute episode and associated recovery and adjustment issues,
- Specific rehabilitation needs requiring community care coordination and support,
- Past history of poor treatment response or co-morbidity,
- Past history of poor adherence to the care plan necessitating a CTO, and
- Ongoing significant risk of harm to self or others.

Section 53 of the MHA 2007 outlines the issues which the Tribunal must consider in making a CTO. If a new CTO is to be implemented as part of the consumer's successful transition to the community, it is implemented by the community mental health facility that has developed the CTO treatment plan. The community mental health facility that has developed the CTO treatment plan must allocate a case manager to the consumer. This should occur early in the admission so that the case manager can commence working collaboratively with the consumer and inpatient team prior to transfer of care. The case manager should be involved in the CTO application hearing and be in a position to provide a report as to whether the CTO is capable of implementation, how the consumer will benefit from the order and inform the Tribunal of the efficacy of any previous orders.

3. TRANSFER OF CARE FOR SPECIFIC POPULATION GROUPS

3.1 Children and adolescents

In addition to the general principles for the transfer of care, referred to at the beginning of this document, the following principles should be kept in mind when working with children, adolescents and their families. These are:

- It is imperative that child protection requirements are considered at all stages.
- Children, adolescents and their parents/carers should have opportunities to participate in and contribute to decisions affecting their care.
- Involvement in care planning should take into account developmental stage, age, maturity and circumstances at the time including the nature and quality of parental capacity and involvement.

It is **mandatory** to involve the child or adolescent's parents or guardians in planning for the transfer of care if they are under 16 years of age and recommended above that age. In circumstances where the Minister or Director-General of Community Services has parental or care responsibility, a Community Services caseworker must participate in the process.

3.1.1 Multisystem approach to Transfer of Care Planning

Preparing for transfer of care of children and adolescent requires a multisystem approach. The goal is to reintegrate the child or adolescent with family, education and community. In developing a structured Transfer of Care Plan, the following need to be taken into consideration:

- Safety and wellbeing
- Educational needs
- Skills for life
- Parenting issues
- Family and social connectedness

School and Education

Successful re-integration to school or other learning institutions is an important component of transfer of care planning for children and adolescent. Clinicians should liaise with appropriate staff in the relevant educational institution and exchange appropriate information to guide comprehensive care and re-integration planning, in accordance with requirements of the Health Records and Information Privacy Act.

The Memorandum of Understanding between the NSW Department of Education and Training and NSW Health in relation to the School-Link Initiative supports the development and enhancement of shared care between the two agencies (PD2010_020).

3.1.2 Additional requirements when an adolescent is in an adult inpatient unit

CAMHS staff should facilitate care transitions to and from the adult inpatient unit and contribute to care planning. Adolescents admitted to an adult mental health inpatient unit will be prioritised for transfer to a local CAMHS service wherever possible. Adult units **must** have active liaison with a CAMHS team. Given the capacity issues within CAMHS, there will need to be agreed procedures set up at the local level for the management and transition of adolescents from adult units back to CAMHS developed by the Local Health Districts.

3.2 Older people

The general principles and practices identified elsewhere in this document must be followed when planning for the transfer of care for older inpatients. In addition, for older people with mental illness or severe behavioural disturbance associated with dementia or other organic brain disorder, particular consideration should be given to:

- The complex interaction of physical health and mental health problems.
- Level of physical impairment, particularly whether this presents a risk to the person's safety or ability to remain in the current residence.
- Risk of harm to self or others.
- Risk of elder abuse.
- Impact of severe behavioural or psychiatric disturbance because of dementia on, for example, the consumer's accommodation arrangements or community participation.
- Requirements for referrals to specialist care and support services such as nursing homes or Aged Care Assessment Teams.
- Role of the Guardian (for older people under guardianship) in transfer of care planning.

It is essential to consider undertaking consultation with the LHD's Specialist Mental Health Services for Older People (SMHSOP) during the consumer's admission and in relation to transfer of care planning for expert advice on the ongoing care and treatment issues for this group of consumers.

In addition, if the carer of the older person is also aged, consideration should be given to the carer's capacity to provide ongoing support.

3.3 Consumers caring for infants, children or adolescents

Prior to transfer of care, information regarding any child or children in the consumer's care previously recorded in the Assessment or Care Plan **must** be reviewed and documented in the consumer's medical record. Special attention must be made to risk factors that may impact on the consumer's capability to care for their children such as:

- Changes in accommodation or level of support
- Changes in level of functioning, and
- The impact of medications or interventions on cognitive functions.

In planning for transfer of care to the community, consideration should be given to:

- Parenting support
- The needs of the child or children in the consumer's care, and
- Assisting with referrals to early childhood services or child and family services or GP in consultation with the consumer, especially if there is an infant or toddler involved.

For further guidance consult the NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010 – 2015 (PD2010_037).
If there are continuing concerns about the safety or wellbeing of the child or young person following the transfer of care:

- Other services or agencies may need to be involved; planning for this must occur prior to transfer of care and be included in follow-up arrangements noted in the Transfer of Care Plan.

- A report to Community Services must be completed if there is a risk of significant harm (see section 2.4.2). It is recommended the consumer's nominated clinician responsible for transfer of care refers to the Mandatory Reporter Guide.

3.4 Pregnant consumers

Planning for the transfer of care for consumers who are pregnant should include the following:

- Ensure the consumer is connected with a General Practitioner and with antenatal services. Assist with booking if required.
- Due to the high risk of relapse, liaise with appropriate maternity services;(e.g. Safe Start consultation liaison staff) with the consumer's consent.
- If there are concerns that may reasonably be expected to produce a substantial and demonstrably adverse impact on the child after the child's birth, consideration should be given to making a prenatal report to Community Services Helpline (13 36 27). It is recommended the consumer's nominated clinician responsible for transfer of care refers to the Mandatory Reporter Guide (p.7).

For further guidance, consult the SAFE START Strategic Policy (PD2010_016).

3.5 Aboriginal and Torres Strait Islander People

Clinicians should be sensitive to specific historical, cultural, spiritual and social factors of Aboriginal and Torres Strait Islander people when planning for transfer of care. Many Aboriginal people have had negative contact with government services which can cause suspicion and mistrust. This may be acutely important for Aboriginal people with mental health problems and disorders. The *NSW Aboriginal Mental Health and Well Being Policy 2006-2010* (PD 2007_059) outlines the key principles for mental health service delivery to Aboriginal people.

Health staff should liaise with specialist Aboriginal health representatives in their area (e.g. Aboriginal Mental Health Workers or Aboriginal Medical Services) to ensure that transfer of care planning is commenced early and is consistent with the needs of the local Aboriginal community.

Health staff should also:

- Identify community liaison contact(s) who can engage additional support for the consumer such as extended family, elders and community members.
- Ensure actions are taken to resolve precipitating events and other life stressors.
- Refer the consumer to Aboriginal health or medical services if the consumer so chooses.
- Establish contact between consumer and Case Worker prior to transfer of care.
- Obtain funds, where available, to assist with transport and accommodation of family at the time of transfer of care.
- Ensure, where possible, that the family is present at the time of transfer of care to accompany the consumer home.

Risk of suicide is another significant factor. When transferring the care of an Aboriginal person who is at long-term risk of suicide, the clinician must to take into account the consumer's:

- Current mental state and wellbeing; and
- The nature and impact of the home/community environment and availability of support.

The consumer may be at a significantly increased level of risk on return to a troubled home or community environment. For consumers who have been hospitalised for lengthy periods, the

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impact of their return to the community, and their ability to cope, should be assessed sensitively and risks identified and addressed.

3.6 Consumers from Culturally and Linguistically Diverse Backgrounds

The transfer of care for consumers from Culturally and Linguistically Diverse Backgrounds (CALD) requires a culturally sensitive approach as outlined in the Multicultural Mental Health Plan 2008-2012 (PD2008_067). Health professionals should be aware of their own values, attitudes and beliefs. Staff should approach CALD consumers with sensitivity and respect for the social context of the consumer's problems. It is important to understand the personal meaning of the illness for the consumer, their family and their community. CALD consumers may experience increased isolation. Therefore, where appropriate, promote or connect the consumer and their family with the multicultural agencies and support groups in the community (see PD2005_483 *Non-English Speaking Backgrounds – Standard Procedures- Improved Access Area/Public Health Services*).

Consider a referral to the Transcultural Mental Health Centre early in the admission, to support mental health literacy for carers and consumers in their own first language.

The Transfer of Care Plan should take into account the following factors:

- Comprehension and proficiency in English or literacy in another language
- Barriers to accessing health services due to language difficulties and cultural expectations
- Awareness of available community services
- Stressors experienced during the process of adapting to mainstream Australian culture
- Ensure care plans for transfer document the consumer's first language and any requirement for a specific language interpreter
- Access to translated material at appropriate stages.

For further guidance, consult the Culturally & Linguistically Diverse (CALD) Carer Framework: Strategies to Meet the Needs of Carers (GL2009_018).

CALD consumers and their families should have access to interpreter services to facilitate the transfer of care process where appropriate. Consent is essential. When booking an interpreter, a consumer's name and contact telephone number is required. Three-way telephones or conference phones should be available for use with telephone interpreters. Health staff should refer to *Interpreters: Standard Procedures for working with Health Care Interpreters PD2006_053* for guidance on use of interpreters.

Where complex or unknown cultural dynamics are involved, for clarification of the diagnosis and assessment of cultural issues that should be considered in the provision of mental health care, cultural advice should be sought from the local multicultural staff within the LHD and/or NSW Transcultural Mental Health Centre.

Where the issues are related to torture and trauma it is advisable to consult with the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).

Access to translated material should be available as required.

3.7 Consumers with intellectual disabilities

NSW Health and Ageing Disability and Home Care (ADHC) offer different services to people with mental illness and intellectual disability. NSW Health provides episodic health care while ADHC

provides community support programs, and directly operates and funds non-government organisations to provide accommodation facilities for people with intellectual disability. These services are not mental health specific.

NSW Health and ADHC have developed to a Memorandum of Understanding (PD2011_001) to improve access and quality of service delivery for people with intellectual disability and mental illness. Guidelines to the MOU outline processes and procedures to support clinical practice and emphasise the collaborative approach that should be taken between the two agencies in the provision of services to consumers.

In addition to the standard procedures outlined in this document, planning for transfer of care for consumers with intellectual disability and mental illness are likely to require additional support from a range of services including mental health. It is important to:

- Include the key worker from accommodation services, disability service and/or the consumer's guardian or advocate in the transfer of care planning process.
- Transfer of care planning (including contingency and relapse response planning) needs to consider the specific needs of a consumer with intellectual disabilities, particularly in circumstances requiring readmission.
- Identify relapse prevention needs to differentiate between behaviours related to the intellectual disability and the re-emergence of mental health symptoms.
- Consider whether joint case management is necessary.

3.8 Consumers with Accommodation Needs

For mental health consumers, secure, stable, affordable housing with access to appropriate assistance, supports the person's recovery and is essential in maintaining their mental and physical health. This policy requires the development of Transfer of Care Plans that address the housing and accommodation needs of the individual and ensure that connections to support services are provided, as required. During admission to the inpatient unit, information about the person's current living arrangements, supports and risk of homelessness are to be identified.

Assessment of a consumer's housing and accommodation support needs must be part of planning for the person's return to the community. If required, referrals to a service that can assist with accommodation and accommodation support, should be completed well in advance of the consumer leaving the inpatient unit.

Mental Health Services must maintain contact details, and be familiar with the referral procedures of local agencies such as Housing NSW, *the Specialist Homeless Services program* for people who are homeless or at risk of homelessness; and *Housing and Accommodation Support Initiative (HASI)* which provides accommodation support that is linked to clinical and psychosocial rehabilitation for people with a range of levels of psychiatric disability. These agencies should be engaged in the Transfer of Care Planning where relevant.

The development of local protocols will assist in meeting the transfer of care needs of patients who are homeless.

Mental Health facilities should also refer to the supplementary policy to PD2011_015 *Care Coordination: From Admission to Transfer of Care in the Public Health System.* The supplementary policy sets out issues for consideration in the management of transfer of care for homeless people in the public health system.

4. APPENDICES

Appendix1: Implementation Checklist

Assessed by:		Date of Assessment:	
IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
1. Assign responsibility, personnel and resources to implement the principles and procedures in mental health service settings.	❑	❑	❑
	Notes:		
2. Review, LHD and unit mental health discharge/transfer of care and leave protocols to ensure they are consistent with the state-wide Policy's requirements, principles and procedures	❑	❑	❑
	Notes:		
3. Ensure local protocols include guidance on managing a consumer's transfer of care to the community outside of usual working hours, at weekends and during holiday periods.	❑	❑	❑
	Notes:		
4. Develop a 'transfer of care' checklist to ensure that all steps of the procedure are carried out.	❑	❑	❑
	Notes:		
5. Process for educating inpatient clinicians on the requirements of the Policy Directive and their responsibilities in relation to its local implementation	❑	❑	❑
	Notes:		
6. Educate clinical staff in the principles and practices for Transfer of Care Planning.	❑	❑	❑
	Notes:		
7. Develop and implement a process for monitoring compliance with the requirements and procedures for Transfer of Care Policy Directive that includes feedback to staff of compliance	❑	❑	❑
	Notes:		
8. Establish a process for annual reporting through the Chief Executive on implementation of the Policy Directive's requirements.	❑	❑	❑
	Notes:		

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Appendix 2: Disclosure of Information

Consumers should be consulted about who will be provided with their personal information and the reasons why, according to their age, maturity and safety needs. If the consumer has concerns about release of information, this should be discussed with them and their primary carer, and attempts made to resolve the concerns in the context of optimal ongoing care and the obligations under the Mental Health Act 2007 and NSW privacy legislation

There is a range of people with whom information may need to be shared to ensure a safe and effective transfer of care. They include:

- Health Providers

Under the Health Records and Information Privacy Act – relevant information may be provided to other health professionals providing care so long as the disclosure is directly related to the primary purpose for which the information was collected and the patient must have a reasonable expectation that their information will be used in such a manner. This expectation is best met by communicating this with the patient about relevant treatment and service provision. If they have any concerns about privacy, staff should ensure patients receive a copy of the Privacy Leaflet for Patients or are directed to it.

- Community Managed Organisations (CMOs)

While information exchange is important in the provision of a continuum of care, the disclosure of relevant information to recovery support, accommodation and other CMO service providers must be either for a directly related purpose (depending on the service provision) or occur where the patient consents to receiving the support service. Either way, the patient must have a reasonable expectation that their information will be used in such a manner or have consented to the service provision. This expectation is best met by discussing appropriate service provisions with the consumer. In appropriate circumstances, where there may be safety concerns for the consumer and others, relevant risk assessment information may be provided if there is a serious and imminent of harm or the information is reasonably necessary in order to allow the CMO to provide the relevant service.

- Families and Carers

While primary carers must be included in the transfer of care planning under the Mental Health Act 2007, with consent it may be good practice to involve other members of the family or carer network. A person under 18 may not exclude a parent from being given information about them (s72(3)).

In circumstances where a consumer is being discharged into the care of their family and/or carers, family and carers should be provided with relevant information to properly manage the consumer's ongoing medical care where there is consent or a reasonable expectation on the consumer's part that this will occur. This may include being given a written copy of the Transfer of Care Plan for transfer so that they can refer to information and care instructions at a later time. The copy of the plan will provide easy access to critical advice, such as information about the medication regimen and the management of suicide risk. In some circumstances, the provision of generic information about general matters relating to mental health care and treatment options to carers and family may be appropriate.

It is important that any disclosure to family or carers is directly related to the primary purpose for which the information was collected and the patient must have a reasonable expectation that their information will be used in such a manner. This expectation is best met by communicating with the consumer about relevant discharge planning. If they have any concerns about privacy make sure they have received a copy of the Privacy Leaflet for Patients.

- Role of Appointed Guardian

If a patient has a guardian, the guardian will be the patient's primary carer and therefore all the provisions of the Act relating to primary carers will apply.

If the patient under guardianship lacks capacity, then under the Health Records and Information Privacy Act, the guardian essentially stands in the shoes of the patient and all information can be provided to the guardian but only while the patient lacks capacity.

- State and Commonwealth Agencies

Appropriate information must be provided to State and Commonwealth government agencies for mandatory statutory reporting purposes, such as to report notifiable diseases or where there are mandatory requirements to do so including child protection concerns.

The law also allows for personal health information to be disclosed to other third parties in certain circumstances, for example:

- To researchers for public interest research projects as approved by a Human Research and Ethics Committee
- To law enforcement agencies, such as the Police, in order to provide information relating to a serious crime, including assault, domestic violence, child abuse
- To comply with a subpoena or search warrant if your personal information is required as evidence in court.

Please refer to the NSW Privacy Manual for guidance on these requests.

Appendix 3: Sample Transfer of Care Checklist for return to the community

TRANSFER / DISCHARGE CHECKLIST			Attach patient identification label or print using black pen		
Admission date:			MRN:		
Discharge date:		Time:	Family Name		
Primary nurse:			First Name:		
Consultant on discharge:			DOB:		
Registrar			Sex:	Male	Female
Documentation			**Date**	**Complete**	**Signature**
Transfer/Discharge Summary					
Transfer/Discharge Summary faxed to GP &/or private psychiatrist prior to the consumer's discharge					
Phone call to community mental health centre to confirm transfer (write name of person contacted)					
Relatives/carers informed of discharge by patient or staff					
Relevant written information provided to private health professionals and NGO support agencies offering community care/support					
K10/HONOS completed					
Transfer of Care Plan documented in medical record					
Medical entry in file including follow up plan					
Ward clerk notified of discharge					
Consumer's name remove from white board					
Discharge details recorded in Admission/Discharge Register					
Treatment sheet placed in clinical file					
Valuables returned to consumer					
Medication supply for 5 days given on discharge					
Transfer/Discharge Summary given to consumer/primary carer					
Copy of Transfer of Care Plan and associated information given to patient/carer on discharge					
MH-CoPES survey questionnaire given to consumer					
Transport arranged					

With credit to the former Sydney South West Area Mental Health Service

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Appendix 4: Sample Transfer of Care Checklist for transfer to other inpatient services *(public mental health unit, private psychiatric hospital, general wards)*

TRANSFER / DISCHARGE CHECKLIST		Attach patient identification label or print using black pen		
Admission date:		MRN:		
Discharge date:	Time:	Family Name		
Primary nurse:		First Name:		
Consultant on discharge:		DoB:		Sex: M / F
Registrar on discharge:				

Action	Date	Complete √	Signature
Transfer/Discharge Summary			
Documentation provided to admitting service: • Full information on consumer's history			
• Transfer/Discharge Summary			
• Relevant reports, case summaries and materials requested as per receiving unit's admission policy			
• Recent investigations/tests and reports			
• Updated risk assessment and management plan			
• Updated care plan			
• Medication details			
Phone call to other inpatient service to confirm transfer (write name of person contacted)			
Staff have informed: • Primary carer/relatives			
• GP			
• other agencies involved			
K10/HONOS completed			
Transfer of Care Plan documented in medical record			
Medical entry in file including follow up plan			
Ward clerk notified of discharge			
Consumer's name removed from white board			
Discharge details recorded in Admission/ Discharge Register			
Treatment sheet placed in clinical file			
Valuables transported with consumer			
Copy of Transfer of Care Plan and associated information provided to admitting service on discharge			
MH-CoPES survey questionnaire given to consumer			
Transport arranged			

Appendix 5: Self Assessment Tool for Monitoring Transfer of Care

The following indicators are provided to assist services in the internal quality monitoring of practices, and were adapted from the *Chief Psychiatrist's Guideline: Discharge Planning for Adult Community Mental Health Services* (Victorian Government 2002). The indicators focus on requirements for transfer of care when the consumer is returning to the community following an episode of inpatient care.

INDICATOR	Yes/No
The service has documented policies and procedures for transfer of care to guide staff in day to day practice.	
The clinical record shows evidence that planning for transfer of care commenced on the person's admission to the inpatient unit.	
There is evidence that the Transfer of Care Plan was developed in collaboration with the consumer, and where relevant, primary carer, other carers, external clinicians and support agencies.	
There is evidence that the Transfer of Care Plan takes into account ongoing physical health needs.	
There is evidence that the Transfer of Care Plan takes into account the need for support services (e.g. support with accommodation, daily living skills; parenting; education or employment; to reduce social isolation)	
The clinical record reflects that a comprehensive clinical review and consultation with the consumer (and carers unless otherwise indicated) was undertaken prior to transfer of care.	
There is evidence that the decision to transfer care was reviewed by the consultant psychiatrist 24-48 hours prior to the physical movement of the consumer and that the decision was supported by a comprehensive risk assessment.	
The service ensures that plans for transfer of care have been communicated to and agreed by the: - receiving service - consumer and - primary carer /guardian In advance of the physical movement of the consumer.	
Necessary follow up has been undertaken within a reasonable time for the consumer's condition.	
Mental Health Clinical Documentation *Transfer/Discharge Summary* was completed and placed on the file and copies forwarded to relevant parties within 12 hours.	
The consumer, carers (unless otherwise indicated) and any relevant service provider was - advised on how to re-access the service if necessary in the future, and - Provided with emergency contact numbers in writing and in an appropriate community language.	
The inpatient unit provides written information to consumers, carers and relevant service providers involved in ongoing care, on - strategies to prevent relapse, - identification and management of early warning signs and - when and how to contact the mental health service	
A process exists to promote re-engagement with consumers who are unable to maintain follow-up arrangements.	

Appendix 6: Notification to NSW Police and Firearms Registry Form

NOTIFICATION TO NSW POLICE AND THE FIREARMS REGISTRY
PURSUANT TO SECTION 79 OF THE FIREARMS ACT 1996

s79 of the Firearms Act 1996 provides for the notification to the NSW Police Commissioner by certain health professionals if they are of the opinion that a person to whom they have been providing professional services may pose a threat to their own or public safety if in possession of a firearm. In this instance, health professional means a Medical Practitioner, Registered/Enrolled Nurse, Registered Psychologist, Counsellor or Social Worker.

A particular circumstance involves high risk mental health patients known to have access to firearms. The Director-General, NSW Health, has written to Area Health Services to ask that in these cases health practitioners advise police as soon as practicable before the patient is discharged.

s79 protects the clinician from criminal or civil action in respect of breaching privacy. Nonetheless clinicians should inform patients that if the clinician becomes aware the patient has access to a firearm the police may be informed.

Process for notifying NSW Police of risk concerns:

1. **Ring Local Area Command Duty Officer to discuss the matter.**
2. **Fax this completed form to Local Area Command Duty Officer.**
3. **Fax this completed form to NSW Firearms Registry: 02 6670 8550**
   Attention: Manager Review and Assessment NSW Firearms Registry.

Patient's Family Name:	Given Name(s):	Date of Birth:
Residential Address		Telephone
Where is the patient currently located (eg inpatient, emergency department, residential)?		
If an inpatient address to which the patient will be discharged?	Anticipated date and time of discharge? *(to ensure safety issues can be addressed at least 6hrs notice must be provided to police)* Date: / / Time:	
Description of circumstances which lead you to believe that the person may pose a threat if in possession of a firearm *(include: relevant conversation, circumstances, observations, firearm type, effect of medical condition or treatment/medication on person's capacity etc. Use over page if more space is needed)*		
Does the person have access to their own firearm? Yes: ☐ No: ☐ Not known: ☐		
Does the person have access to other firearms? (eg spouse, other relatives, friends, neighbour) Yes ☐ No ☐ Unknown ☐ Name of person and location of firearm:		
Details of person submitting this report: Medical Practitioner ☐ Registered/Enrolled Nurse ☐ Registered Psychologist ☐ Counsellor ☐ Social Worker ☐ Contact Telephone: _____ Ext: _____ Mobile: _____ ContactAddress: _____ Name: _____ Signature: _____ Date: _____		

Note: Further details may be required by police to support legal process or legal action needed to protect persons.
The information contained herein is confidential and any action by a practitioner does not give rise to any criminal or civil action of remedy (or breach privacy laws). If you have any enquiries, contact the NSW Firearms Register, Manager Review and Assessment on 1300 362 562, or the Duty Officer at your nearest Local Area Command.

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Appendix 7: Legislation and Policy Context Details

ACTS

Mental Health Act 2007 (makes direct reference to discharge and other planning)
Children and Young Persons (Care and Protection) Act 1998 (revised 2010)
Guardianship Act 1987
Disability Services Act 1993
Health Records and Information Privacy Act 2002

POLICY

Care Coordination from Admission to Transfer of Care in NSW Public Hospitals www.health.nsw.gov.au/policies/pd/2011/PD2011_015.html See also the Reference Manual and Staff Booklet, and the supplementary guideline to PD2011_015 concerning the management of transfer of care for homeless people in the public health system

Chief Psychiatrist's Guideline: Discharge Planning for Adult Community Mental Health Services (Victorian Government 2002)
http://www.health.vic.gov.au/mentalhealth/cpg/discharge_planning.pdf

Child Protection Mandatory Reporter Guide (MRG)
http://sdm.community.nsw.gov.au/mrg/app/summary.page

Clinical Handover–Standard Key Principles
http://www.health.nsw.gov.au/policies/pd/2009/pdf/PD2009_060.pdf

Culturally & Linguistically Diverse (CALD) Carer Framework: Strategies to Meet the Needs of Carers http://www.health.nsw.gov.au/policies/gl/2009/GL2009_018.html

Information Bulletin – KEEP THEM SAFE – Making a Child Protection Report (IB2010_005)
www.health.nsw.gov.au/policies/ib/2010/IB2010_005.html

Memorandum of Understanding between the NSW Department of Education and Training and NSW Health in relation to the School-Link Initiative
http://www.health.nsw.gov.au/resources/mhdao/pdf/SLMoUIntranetInternetrequestTABB.PDF

Mental Health Clinical Documentation Modules
http://internal.health.nsw.gov.au/policy/cmh/mhoat/protocols.html

Mental Health Emergency Response 2007: Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSW Police Force
http://www.health.nsw.gov.au/pubs/2007/mou_mentalhealth.html

Multicultural Mental Health Plan 2008-2012
http://www.health.nsw.gov.au/policies/pd/2008/PD2008_067.html

Non-English Speaking Backgrounds – Standard Procedures- Improved Access Area/Public Health Services http://www.health.nsw.gov.au/policies/pd/2005/PD2005_483.html

NSW Aboriginal Mental Health and Well Being Policy 2006-2010
http://www.health.nsw.gov.au/policies/pd/2007/PD2007_059.html

NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010 – 2015 www.health.nsw.gov.au/policies/pd/2010/PD2010_037.html

Privacy Manual – NSW Health
http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_593.pdf

Provision of Services to People with an Intellectual Disability & Mental Illness - MOU & Guidelines
www.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_001.pdf

SAFE START Strategic Policy http://www.health.nsw.gov.au/policies/pd/2010/PD2010_016.html

Suicide Risk Assessment and Management Protocols for Mental Health Inpatient Units.
http://www.health.nsw.gov.au/pubs/2004/inpatient_unit.html

PLANS

NSW State Plan 202 identifies improving mental health outcomes as a priority with the following targets:

- Reduce re–admissions within 28 days to any facility
- Increase the rate of community follow–up within 7 days from a NSW public mental health unit

Caring Together: The Health Action Plan (2009) for NSW response to the recommendations made by Commissioner Garling following his Inquiry into Acute Care Services in NSW public hospitals. Specific recommendations relating to transfer of care include:

- 58 – refers to compliance with the NSW Health Policy on the mandatory provision of transfer of care summaries to a general practitioner
- 61 – refers to clinically appropriate information to be provided to the patient or their carer on transfer of care
- 97 – refers to Estimated Date of Discharge (EDD) allocated at the earliest possible opportunity and in a way that is consistent with good patient care
- 105 – refers to availability of community health services to facilitate transfer of care and improve the efficiency of the acute care system.

NSW Homelessness Action Plan 2009-2014 adopts a policy of 'no exits into homelessness' for people being discharged from health facilities. This policy requires the development of transfer plans that address the housing and accommodation needs of the individual and ensure that connections to support services are provided, when required. Types of homelessness identified:

- Primary homelessness: when a person lives on the street, sleeps in parks, squats in derelict buildings, or uses cars or railway carriages for temporary shelter.
- Secondary homelessness: describes people who move frequently from one form of temporary shelter to another. Secondary homelessness applies to people using emergency accommodation, youth refuges or women's refuges, people residing temporarily with relatives or with friends (because they have no accommodation of their own), and people using boarding houses on an occasional or intermittent basis (up to 12 weeks).
- Tertiary homelessness: describes people living in premises where they don't have the security of a lease guaranteeing accommodation, or access to basic private facilities (such as a private bathroom, kitchen or living space). It can include people living in boarding houses on a medium to long-term basis (more than 13 weeks) or in caravan parks.

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Queensland Health

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Procedure

Document ID DDWMProc201000447

Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts Division of Mental Health Darling Downs – West Moreton Health Service District

Custodian/Review Officer:
Executive Director Mental Health

Version No: 1

Applicable To:
Division of Mental Health Staff

Approval Date: 08/11/2010

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Executive Director Mental Health

Approving Officer:
Shirley Wigan
Executive Director Mental Health

Signature:

Supersedes: N/A

Key Words: mental health, transfer, interdistrict, facilities

Accreditation References:
National Mental Health Standards, EQuIP criteria and standards

EQuIP 5 – 1.1, 6.1, 1.10
NSMHS 2010 – 6.1, 6.3, 10.5 e

1 Purpose

This procedure describes the processes for by which mental health consumers of South Queensland Health Service Districts receive an efficient, consumer focused transition of care between mental health services.

2 Scope

It is well established that mental health consumers are at an increased risk of harm during periods of transition. *South Queensland Health Service Districts* are committed to an agreed procedure to ensure the comprehensive management of consumer transition between mental health services. This procedure clarifies and standardises the roles, expectations and responsibilities of transferring and receiving services in the management of mental health consumer transitions between services.

PRINCIPLES

During the transfer of care of mental health consumers between services:

- The cultural needs of the consumer and their carers will be acknowledged and respected (See APPENDIX A).
- Mental health services will work collaboratively to ensure a consumer focused transition of care.
- The transfer process, including the time it takes to complete, will be consistent with consumers' recovery / care / treatment plans e.g. efforts made to support the consumer's ongoing access to their care network if they are from a rural and remote area and are transferred out of area.
- Some transfers of consumer care may require a shared care arrangement for a period of time.
- If a clinical difference of opinion occurs regarding the ongoing management of a consumer transferring between districts, the consultant of the receiving service has the final decision and responsibility for the ongoing care.
- Allowances may be made for consumers who are mental health service employees.

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3 Procedure:

Note regarding the transfer of clinical information:

The steps required to transfer consumers between services will vary dependent upon the service type the consumer is transferring from and to. For transfers of consumers between all service types, the following (most recent) information is required (when it exists):

- Consumer demographic information form (demographic information generated from CIMHA is also acceptable)
- Consumer intake form
- Consumer assessment form with associated assessment modules attached (for initial assessments: particularly the Family Developmental History and Social Assessment)
- Recovery Plan (Note: the recovery plan has 3 sections: 1) recovery plan – consumer focused; 2) individual care / treatment plan – service / duty of care focused; 3) relapse prevention plan).
  An *individual care / treatment plan* generated from the care planning module in CIMHA is also acceptable.
- Consumer End of Episode/ Discharge Summary

Clinical documentation should be recorded on the Queensland Health Mental Health standardised suites of clinical documentation forms. Notes written by non MH staff (e.g. ED clinicians) may be recorded in other formats.

In the event that these forms have never been completed by the transferring service, the Consumer End of Episode/Discharge Summary is mandatory from inpatient service providers, the intake / assessment information is mandatory from ACT / ED services and the Consumer End of Episode / Discharge summary is a minimum requirement from Community Service Providers (including MIT services). These forms therefore **must** be completed by the transferring service prior to transfer unless exceptional circumstances exist (e.g. emergency transfer from rural ED where no after hours mental health staff to complete standard suite of documents)
Documentation in these circumstances must include:

- Risk Screen (if not recorded on intake or assessment form)
- Medical Officer R/V notes if initial MH assessment has not been completed
- MHA 2000 documentation (if applicable)
- Medical Assessment & Clearance

When possible, the transferring service should forward clinical documentation to the receiving service at least 3 days prior to the transfer of clinical care of the consumer.

Clinical information may be transferred via email or facsimile. The transferring service must ensure the information has been received by the receiving service and must document in the consumer's medical record that this has occurred.

Note regarding mandatory steps for any transfer of consumer care:

- The receiving service contact details and follow up appointment details must be noted in the consumer's transferring service medical record prior to transfer.
- Unless a consumer does not grant permission for mental health service providers to contact their carers and / or families, prior to the transfer of a consumer's care, the transferring service Principal Service Provider (PSP) or equivalent, must notify (at

the minimum) and preferably consult with the consumer's carers and family regarding the pending transfer of care.

1. Transfer of Community Voluntary Mental Health Consumers

1.1 Consumers choosing not to engage with the Community MHS within their destination District

1.1.1 The transferring service will contact the receiving service to advise of: the consumer's relocation to the receiving district; and, the CIMHA reference number (when available), for information only.

1.1.2 The transferring service will document contact with receiving service in the consumer's medical record prior to case closure.

1.2 Consumers choosing to engage with private sector support services in their destination District

1.2.1 With consumer consent the clinical information above will be provided to relevant mental health service provider/s e.g. GPs, private psychiatrists, NGO's. The transferring service will document contact with the follow up care providers in the consumer's medical record prior to case closure.

1.2.2 The Principal Service Provider (PSP) from the transferring service will contact the consumer, following their relocation, to confirm and document that they have engaged with clinical / support services in their destination district.

1.2.3 If the consumer has not engaged with clinical / support services as planned, the transferring service PSP will determine if further action is required. If the consumer requires follow up from Queensland Health Services, refer to procedure 1.2 for voluntary consumers and 2.0 for involuntary consumers.

1.3 Consumers choosing to engage with the Community MHS in their destination District

1.3.1 The transferring service will contact the receiving service via their intake officer/team leader (rural services), and will forward the information noted above (Page 2).

1.3.2 The receiving service intake officer/team leader (rural services) will facilitate the intake process to determine the follow up care which will provided in accordance with local processes (including dissemination of clinical handover information).

1.3.3 For cases where the consumer is accepted for follow up into a community team (including ACT and MITT) the receiving service follow up team will facilitate principal service provider (PSP) face to face contact with the consumer as soon as is required as determined by clinical need, but no later than 14 days. If any consumer has to wait for face to face contact with the receiving service for longer than is clinically acceptable, the transferring service will continue to provide care during the transition period (for up to 14 days, as negotiated between the transferring and receiving services). If it is geographically impractical for the transferring service to provide face to face transition care once the consumer moves into their destination district, the transferring service will maintain telephone or video link transition care as an alternative until the consumer attends their first appointment with the receiving service.

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Note: When a consumer is transferred between services following an inpatient episode of care, face to face contact is mandatory within 7 days of discharge from the inpatient unit.

2. Transfer of care for involuntary mental health consumers

2.1 Transfer of care of involuntary consumers under the MHA2000, who are not forensic consumers

2.1.2 The procedure for transfer of care of involuntary consumers under the MHA2000, who are not forensic consumers, is the same as for voluntary consumers above, with the exceptions that:

- The appropriate MHA2000 documentation must be transferred. This includes the treatment plan (all consumers) and making contact with the receiving districts MH Act Coordinator to advise of transfer and legal status.
- The consumer's forensic history must be forwarded by the transferring service with the other clinical information required.
- In the event that the transferring service is providing transition care for up to 14 days, if the consumer breaches the conditions of their treatment plan (e.g. is non compliant with medication), the transferring service will manage this clinical issue during the transition period. If the transferring service requires access to local networks (e.g. emergency services) they may make contact with the receiving service for this information.

2.2 Transfer of an involuntary consumer from an inpatient service to a community service

2.2.1 For inter-district transfer of an involuntary consumer from an inpatient service to a community service, the following requirements also apply:

- Consultant to consultant liaison/team leader (rural services) contact is required prior to discharge from the transferring service.
- If a case manager in the receiving service is not allocated at the time of transfer, the interim PSP is the team leader of the receiving service community team.
- The Nurse Unit Manager of the transferring service is responsible for liaising with the case manager/ team leader of the rural team prior to the consumer transfer, for rural discharges.

2.3 Mental Health Act Administrator (MHAA)

- When receiving notification of a transfer of an ITO via CIMHA email facility, the receiving service MHAA will confer with the Team Leader of the relevant team to establish if the transfer process has been completed and the consumer has been accepted to the service.
- When the referral has been accepted the receiving service PSP (usually a case manager) will notify the transferring service team and the receiving service MHAA so transfer of the ITO can be arranged.
- If the transfer is not complete, the receiving service MHAA must inform the transferring service that the ITO is to remain with them until the process is completed.
- If the consumer has been accepted to the receiving service, the ITO must be accepted by the receiving service MHAA.

3. Transfer of care for forensic mental health consumers

3.1 Procedure for forensic consumer under the MHA2000

3.1.1 The procedure for transfer of care of forensic consumers under the MHA2000 is the same as for involuntary consumers above, with the exceptions that:

- The District Forensic Liaison Officers (DFLO) from the transferring and receiving services will be in contact with one another throughout the transfer process.
- The DFLO from the transferring service will facilitate the transfer from the transferring service end (and therefore will be the person who will be making contact with the receiving service).
- The DFLO from the transferring service may continue to share care / liaise with the receiving service DFLO regarding the consumer's care for up to 3 months (as negotiated between the transferring and receiving services dependent upon clinical need). It may be necessary to negotiate a shared care transition plan which includes risk management. The transition plan will provide guidelines to manage issues of non compliance and indicate who is responsible for managing the consumer should a psychiatric emergency arise. The intention of the transition plan is to ensure: consistency and continuity of care; and that the consumer is suitably monitored and is unable to avoid follow up as a result of not attending appointments, or being absent without leave or frequently moving address. The duration of the transition plan should be for a maximum period of three months and should be ended as soon as the receiving service is clinically confident that they have sufficient understanding of the consumer to no longer require transferring service support.
- The State-wide Director of Mental Health (DOMH) must authorise (via written authorisation) the transfer of forensic consumers from one Authorised Mental Health Service (AMHS) to another AMHS. The transferring AMHS will commence completion of the *Request for Transfer – classified/forensic/court order patient* form (an authorised Doctor only can complete some sections of this form). This form is then provided to the new AMHS for their completion. On final completion, the form is faxed to the DOMH.
- The DOMH must be satisfied that appropriate follow-up arrangements are in place for the consumer and that the transfer has been accepted by the Clinical Director/Administrator (or equivalent in rural areas) of the receiving service. This includes allocation of an authorised psychiatrist to the consumer prior to the transfer of the order.
- Until the DOMH transfers the order to the new AMHS the transferring AMHS remains responsible for the consumer's treatment as prescribed in the treatment plan, including taking appropriate actions when the consumer is non-compliant with the treatment plan. This will occur with assistance from the receiving service to access local networks if required in geographically isolated areas.
- Additional information which must be forwarded by the transferring service to the receiving service for transfer of forensic consumers includes: last MHRT report – attached treatment plan and LCT provisions; and, summary of forensic issues/outstanding matters (Summary page – Query IPS – CIMHA).
- The receiving service may request extra documentation from the transferring service to assist with development of follow up care plans. This may include:
- Medico legal Reports (238 Report, current LCT plan and conditions).
- Crisis Management Plan.
- Relevant Clinical Reports (e.g. Forensic Order Report, CFOS assessment).
- Recent progress notes.

3.2 Transfer of care for 'Special Notification of Forensic Patients" (SNFP) mental health consumers

3.2.1 The procedure for transfer of care of SNFP consumers under the MHA2000 is the same as for forensic consumers above, with the exceptions that:

- The Clinical Director (or equivalent) of the transferring service will contact the Clinical Director (or equivalent) of the receiving service to inform them of and discuss the pending transfer.

3.3 Transfer of care for Involuntary/Forensic consumers on short term travel

Note: The MHA2000 Resource Guide, Chapter 8 "moving and transfer" does not specifically address the issue of holiday or interim care delivery for persons under the MHA2000 who are holidaying within Queensland away form their treating district. Interstate travel is addressed. Consideration of the consumers' rights must be made when determining appropriate management of this issue.

Key issues to address will include but are not limited to:

- Length of planned holiday period
- Distance between holiday and home district
- Conditions of leave
- Medication prescription and administration
- Treatment required
- Social supports required

According to *Forensic Patient Management Policy and Procedures*, (Queensland Forensic Mental Health Service), in addition to permanent transfer, Forensic Order movements may be: short term (a couple of nights, for example a holiday); and, regular short terms (for example, visiting relatives in another District). Regardless of the time length for Forensic Order movement, the following minimum level of information should be provided to the receiving DFLO and District:

- Request for transfer: Classified/Forensic/Court order patient.
- Written Authorisation from Director of Mental Health (DMH).
- Standardised suite of forms – Consumer Demographics, Copy of Consumer Intake, Consumer Assessment, and Drug Assessment.
- Summary Page – Query IPS (CIMHA).

4. Transfer of Consumers to a MHS Inpatient Unit

4.1 Consumers presenting to the Emergency Department who require inpatient admission and reside in another District

4.1.1 Consumers should be treated as close to their home as practicable, to minimise disruption to social networks and functioning.

4.1.2 All consumers presenting to the Emergency Department will be assessed regardless of their district of origin.

4.1.3 Following the decision that admission is required, the assessing district will contact the consumer's district of origin and notify them of the consumer's presentation and their status.

4.1.4 Pending bed availability and not withstanding any other agreement between districts, the consumer's district of origin will receive the referral and accept the consumer within a two hour period (between 0800 hrs and 2300hrs). Transport arrangements are the responsibility of the transferring district. Ideally, within the SQHSD

metropolitan area, districts will facilitate the acceptance of transfers from 0800hrs to 2000hrs. These transfers should be planned to be completed prior to 2300hrs.

4.1.5 If there is no bed available at the consumer's district of origin or a safe transfer is not possible at the time, the consumer should be admitted to an appropriate ward and treatment commenced until such time as a bed in the consumer's district of origin becomes available.

The transfer of clinical documentation is to be recorded in the consumer's medical record as noted above (Page 2).

4.2 Consumers presenting to a rural service Emergency Department who require inpatient admission

Note: In 2009, all rural services in South Queensland are part of a District with inpatient beds. However, the service with the inpatient beds may be some distance from the rural service needing to admit a consumer. In the first instance, a rural service should always try and admit consumers to their own district (this is an intra rather than inter district transfer). In circumstances where a rural service is unable to admit consumers to a bed in their own district, a bed in another District receiving service will need to be found and the following applies:

4.2.1 Following the decision that admission is required, the assessing district will contact the receiving district, through the receiving Acute Care Team and notify them of the consumer's presentation, their status and need for admission. The receiving service will make contact with the relevant psychiatrist to confirm and support admission to the inpatient unit. All relevant paperwork related to an involuntary admission (e.g. recommendation and request for an assessment forms and request for police escort) with be completed by the on site medical officer and mental health worker (during business hours).

4.2.2 Pending bed availability, the receiving district will receive the required material for admission and accept the consumer within a two hour period (between 0800hrs and 2300hrs). Transport arrangements are the responsibility of the transferring district. Within rural areas transfers should ideally occur during business hours. The above hours are to be seen as flexible and able to be negotiated between services taking into account the needs of the consumer, the availability of human resources and the ability of the transferring service to maintain the safety of the consumer and staff in the facility prior to transfer.

If for any reason, the rural transferring service is not able to affect the transfer immediately, the "home" mental health service should put in place strategies to assist in maintaining the consumer safely until the transfer can occur. These strategies would include but not be limited to:-

- Access to a Psychiatric Registrar or Consultant for advice and support
- Video-link assessment or review if required
- Advice and support about the most appropriate transfer mode

4.2.3 If there is no bed available at the receiving district or at other suitable facilities (relevant to CYMHS consumers only) or a safe transfer is not possible at the time and the transferring facility has the capacity to ensure the safety of the consumer and staff, the consumer should be admitted to an appropriate hospital ward and treatment commenced, with consultation from the "home" inpatient psychiatrist until such time as a bed in the receiving inpatient unit becomes available.

4.3 Consumers who present or are presented to an Emergency Department and are on an Authority to Return to another District

4.3.1 Consumers that are brought to the Emergency Department on an Authority to Return from another Authorised Mental Health Service are to be assessed upon their presentation.

4.3.2 It is expected that the service who has issued the Authority to Return document will make available all information to facilitate this assessment.

4.3.3 If, following assessment the consumer requires admission, refer to section 4.1.

4.4 Temporary transferring of inpatient care to another District during bed shortage

4.4.1 MHSs within the SQHSD have agreed to provide for the temporary care of consumers from other districts when these districts are experiencing bed shortages. Prior to this occurring, the local MHS should make every attempt to manage the consumers in their local district. Other options to be considered are:

- Assertive community treatment
- 'Outlying' appropriate consumers to a medical bed with specialist mental health support in order to make an acute MH bed available
- Overnight management of the consumer in the Emergency Department, with specialist mental health support.

4.4.2 The following process is to occur to facilitate all inter-district transfers due to local bed availability shortages:

- The delegated MHS Bed Manager from the transferring district will make contact with each delegated MHS Bed Manager within SQHSD to assess availability of beds.
- Pending bed availability the receiving district will receive the referral and accept the person within a two hour period.
- Documentation to accompany the transfer is as above (section 4.1.5).

4.4.3 Inter-district transfers due to bed availability should occur within business hours whenever possible. Transfers outside of business hours are at the discretion of the Consultant on call and must take in to account the availability of medical and nursing staff to safely facilitate the transfer in both transferring and receiving services.

4.4.4 It is preferable that a consumer requiring inpatient care within a High Dependency area NOT be transferred to another district, due to the:

- Acute nature of their mental state.
- Likelihood of requiring high doses of medication which may compromise their physical health status.
- Identified benefit of having ready access to their usual treating team.

4.4.5 The return of persons that have been transferred to another district is to be negotiated between the transferring and receiving services. Factors to be considered should include the consumer's clinical needs, the consumer's choice and the consumer's discharge address. The number of transfers for each consumer should be minimised as much as possible.

4 Supporting Documents

- See References

5 Definition of terms

Term	Definition	Source	See also
Queensland Private Health Care Sector:	Health Care services which are not Queensland Health provided:	South Queensland Health Service Districts	Nil
SQHSD:	South Queensland Health Service Districts.	South Queensland Health Service Districts	Nil
DOMH:	Director of Mental Health	South Queensland Health Service Districts	Nil
MHS	Mental Health Service	South Queensland Health Service Districts	Nil
SNFP	Special Notification Forensic Persons	South Queensland Health Service Districts	Nil
MHA:	Mental Health Act 2000	South Queensland Health Service Districts	Nil
CIMHA	Consumer Integrated Mental Health Application	South Queensland Health Service Districts	Nil