2.3.2.1 Service Element - Step Up/Step Down - Youth (Residential)

Attribute	Details
Status	Not gazetted, although people may be subject to community treatment orders and forensic orders.
Services Delivered	The aim of the service is prevent further deterioration of a person's mental state and associated disability and so reduce the likelihood of admission to an acute inpatient unit (step up). The service also aims to enable early discharge from acute care through the provision of an intensive safe and supportive residential community residential program (step-down). The service aims to provide short term transitional recovery oriented care and support to minimise the trauma and impact of a first episode or relapse of a mental illness. The service takes an integrated approach to clinical recovery and psychosocial interventions with a focus on stabilisation and management of illness, engagement or reengagement in positive and supportive social, family, educational and vocational connections.
Key Distinguishing Features	Services are located in the community, and delivered in a community residential environment. They are delivered as partnerships and/or collaborations between clinical services and the community support sector. There is a strong focus on early and active engagement of family/friend/support person or carer in a young person friendly environment. Services operate as a component of a district or area integrated mental health system.
Service specifications and other useful descriptors to illustrate service elements.	
Target Age:	Youth (12-17) or (16-24)
Diagnostic Profile	People who meet the criteria for admission to an area mental health service inpatient unit but whose level of risk is such that they can be safely supported in a less restrictive environment than an acute inpatient unit.
Average unit size	14 beds
Hours	24 hours / 7 days
Suggested Modelling Attributes	
% Occupancy	85%
Average LOS	21 days
Annual readmission rate	10%
Indicative staffing FTE/Bed	1.37 FTE per bed
Sources	• Youth prevention and recovery care (Y-PARC) framework and operational guidelines. Victorian Government 2010. Primary source. • Statewide Youth Sub-Acute Unit: An Integrated Service Approach. Government of South Australia. April 2012. • Presentation for NMHSPF EWG, Models of Residential Services, Dr Gerry Naughtin, Mind Australia.

Service Element – Step Up/Step Down – Youth – Staffing Profile

Step Up/Step Down – Youth (Residential)

SCHEME	STAFF CATEGORY	FTE	FTE/Bed	Hours/ day	Hrs/ Bed avail avge	Hours annual	FTE scalar	Wghtd avge salry	Cost	Hours/day /person	Overheads %
NMHSPF	TOTAL	19.24	1.37	89.83	6.42	32,787	1,704	$75,136	$1,445,485	7.5	25%
NMHSPF	Vocationally Qualified	5.09	0.58	38.00	2.71	13,870	1,715	$53,660	$433,869	3.2	25%
NMSPF	Peer Worker	1.85	0.13	8.69	0.62	3,170	1,715	$54,844	$101,358	0.7	25%
NMHSPF	Tertiary Qualified	8.18	0.58	37.71	2.69	13,766	1,682	$90,391	$739,625	3.2	25%
NMHSPF	Medical	1.12	0.08	5.43	0.39	1,981	1,766	$152,055	$170,633	0.5	25%

NMHR	TOTAL	FTE	FTE/Bed	Hours/ day	Hours/ ABD	Hrs annual	FTE scalar	Salary **	Cost		O'heads %
NMHR	Total Medical	1.12	0.08	5.43	0.39	1,981	1,766		$170,633	0.5	25%
NMHR	Psychiatrist	0.53	0.04	2.57	0.18	939	1,766	$186,972	$99,387	0.2	25%
NMHR	Registrar	0.59	0.04	2.86	0.20	1,043	1,766	$120,630	$71,246	0.2	25%
NMHR	Junior Medical Officer	0.00	0.00	0.00	0.00	-	-	$150,763	$0	-	25%
NMHR	Other Medical Specialis	0.00	0.00	0.00	0.00	-	-	$186,972	$0	-	25%
NMHR	Total Nursing	3.56	0.25	16.00	1.14	5,840	1,639		$365,746	1.3	25%
NMHR	Registered Nurse	3.56	0.25	16.00	1.14	5,840	1,639	$102,673	$365,746	1.3	25%
NMHR	Nurse Practitioner	0.00	0.00	0.00	0.00	-	-	$150,196	$0	-	25%
NMHR	Enrolled Nurse	0.00	0.00	0.00	0.00	-	-	$74,547	$0	-	25%
NMHR	Total Allied Health	4.62	0.33	21.71	1.55	7,926	1,715		$373,879	1.6	25%
NMHR	Psychologist	1.16	0.08	5.43	0.39	1,981	1,715	$89,058	$102,868	0.5	25%
NMHR	Social Worker	1.16	0.08	5.43	0.39	1,981	1,715	$89,058	$102,868	0.5	25%
NMHR	Occupational Therapist	1.16	0.08	5.43	0.39	1,981	1,715	$89,058	$102,868	0.5	25%
NMHR	Other TQ (eg pharmacis	1.16	0.08	5.43	0.39	1,981	1,715	$56,511	$65,275	0.5	25%
NMHR	VQ and Peer Workers	9.93	0.71	46.69	3.33	17,040	1,715		$535,227	3.9	25%
NMHR	Consumer Peer Worker	0.92	0.07	4.34	0.31	1,585	1,715	$54,844	$50,679	0.4	25%
NMHR	Carer Peer Worker	0.92	0.07	4.34	0.31	1,585	1,715	$54,844	$50,679	0.4	25%
NMHR	VQMH Worker	8.09	0.58	38.00	2.71	13,870	1,715	$53,660	$433,869	3.2	25%
NMHR	VQ Other	0.00	0.00	0.00	0.00	-	-	$55,105	$0	-	25%

Annual Cost Salaries	$1,445,485
* Including Overheads 25%	$1,806,856
Average Daily Available Bed Day C	$354
Average Cost per Patient per annu	$12,813

Bed Based Service Parameters	
Beds	14
Availability	100%
Average Available Beds	14
ABD/Bed/Year	365
Occupancy	85%
OBD/Bed Year	310.3
ALOS (days)	28
Admissions/Bed/Year	11.05
Annual Readmit Rate	10%
Patients/Bed/Year	10.07

Calculator		
Number of standardised admissions per annum multiplied by target population		5245
Beds Required		473
Cost		$61,092,423
Staffing		
NMHR	Total Medical	37.9
NMHR	Psychiatrist	18.0
NMHR	Registrar	20.0
NMHR	Junior Medical Officer	0.0
NMHR	Other Specialist	0.0
NMHR	Total Nursing	120.4
NMHR	Registered Nurse	120.4
NMHR	Nurse Practitioner	0.0
NMHR	Enrolled Nurse	0.0
NMHR	Total Allied Health	156.2
NMHR	Psychologists	39.1
NMHR	Social Workers	39.1
NMHR	Occupational Therapists	39.1
NMHR	Other	39.1
NMHR	VQ and Peer Workers	335.9
NMHR	Consumer Peer Worker	31.2
NMHR	Carer Peer Worker	31.2
NMHR	VQMH Worker	273.4
NMHR	VQ Other	0.0
Total		650.5

Adolescent Extended Treatment and Rehabilitation Models
Summary of Site Visit to NSW

Date: Visits conducted from 23rd October 2013

Purpose: To review alternative models of Adolescent Rehabilitation and Extended Treatment

Reviewers:

- Dr Stephen Stathis, Clinical Director, Children's Health Queensland (CHQ) Child and Youth Mental Health Services (CYMHS)
- Ms Judi Krause, Divisional Director, CHQ CYMHS
- Ingrid Adamson, Project Manager, Statewide Adolescent Extended Treatment and Rehabilitation Initiative (SW AETR), CHQ Office of Strategy Management

Sites visited:

- Rivendell, Concorde Mental Health Services, Western Sydney
- Walker Unit, Concorde Mental Health Services, Western Sydney

BACKGROUND

The site visits was precipitated by the announcement that the Barrett Adolescent Centre (BAC), a fifteen bed inpatient adolescent extended treatment and rehabilitation facility based at The Park, Wacol, would be closing in late December 2013. An Expert Clinical Reference Group (ECRG) had identified a range of recommendations across the continuum of extended treatment and rehabilitation spectrum to best meet the diverse needs of this cohort.

Characteristics of Adolescents requiring extended treatment and rehabilitation:

- severe and complex mental illness
- impaired development secondary to their mental illness
- persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including CYMHS community clinics, Evolve, day programs and acute inpatient child and youth mental health services
- will benefit from a range of clinical interventions

Severe and complex mental illness in adolescents occurs in a number of disorders. Many adolescents present with a complex array of co-morbidities as outlined below:

- Persistent depression, usually in the context of childhood abuse. These individuals frequently have concomitant symptoms of trauma, e.g. PTSD, dissociation, recurrent self-harm and dissociative hallucinoses.
- Adolescents diagnosed with a range of disorders associated with prolonged inability to attend school in spite of active community interventions. These disorders include Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder and Oppositional Defiant Disorder. It does not include individuals with truancy secondary to Conduct Disorder.
- Complex post-traumatic stress disorder. These individuals can present with severe challenging behaviour including persistent deliberate self-harm and suicidal behaviour resistant to treatment within other levels of the service system.
- Persistent psychosis non responsive to integrated clinical management (including community-based care) at a level 4/5 service.

- Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder.

Concorde Mental Health Services, Western Sydney
Met with Dr. Phillip Hazell, Clinical Director, Rivendell. Phillip was also a representative on the ECRG. Both Rivendell and the Walker Unit are part of the Concord Centre for Mental Health, the Walker unit is located on the grounds of Concord Hospital and Rivendell is located on adjacent land, which has been donated to the NSW Government.

NSW does not have any dedicated acute inpatient beds for paediatrics, nor are there many therapeutic residential units. There is a High Dependency Unit in Concorde Hospital and a therapeutic residential unit in Campbelltown, called Sherwood house, which has inreach from Child and Adolescent Mental Health Services (CAMHS).

The Walker Unit and Rivendell are two inpatient facilities along a spectrum of care, with the Walker Unit treating for more severe mental health problems than Rivendell. The target age group for these units is 12 to 18 years of age (or high school equivalent). Both facilities can manage dual diagnosis although they don't deal with alcohol and other drugs often. They work with a substantial number of autistic children with comorbidities. The Walker Unit tends to deal with unusual and bizarre conditions that require a secure facility.

There is limited day program capacity in NSW with only three units available in Wollongong, Rivendell and Redbank. However, NSW has a strong state-wide consultation liaison service, which provides support to young people in non-mental health wards at hospitals, as the first tier of service. This is supported by community CAMHS teams in most areas, although there are capacity issues with case load. Community CAMHS is predominantly a centre-based service usually not having resources to conduct home visits. They had 1,800 CAMHS admissions in 2011.

Early management and care at the local health district reduces the wait list into Rivendell and the Walker Unit.

They have established a Statewide Tribunal to review difficult cases and have found that in most instances the young person does not end up in the Walker Unit, but rather receives alternative treatment and care.

NSW also has residential services, typically comprising small group homes of 4 to 6 adolescents serviced by out-of-home care providers. These services tend to be linked to the state child protection services.

Phillip advised that if NSW were to expand their service offering, they would invest in IMYOS services as this would serve their consumers better than, say, more acute units. This lack of assertive outreach has been identified as a service gap in NSW as has the lack of step up and step down and residential facilities for adolescent rehabilitation and extended treatment.

Rivendell
Rivendell is a bed-based inpatient unit operating five days per week for young people, who require day program / residential-based care and who can be discharged home on weekends or have alternative care arrangements (relatives, etc.).

It is a 24 bed unit however they usually only accommodate up to 15 adolescents due to staffing and funding capacity. They have residential placements but these are not therapeutic, nor are they a foster or institutional care arrangement. Rivendell was described as more like a boarding school. It is based on voluntary attendance and does not utilise restraint or seclusion practices.

They typically have 24 adolescents in their programs including those who are attending the day program Programs can cater for up to 30 adolescents with a maximum of 6 students per class.

Rivendell can be used as a step down option from the Walker Unit, especially in regard to schooling.

The unit receives inreach from CAMHS and provides a CAMHS service for outpatients, who are within the Concorde Centre for Mental Health local health district geographical catchment.

It was noted that the parents are very motivated and engaged, and will collect their children for the weekend, with some regional families renting nearby units. For children without homes to return, they are accommodated in a refuge for the weekend. This did not appear to be a common occurrence.

Rivendell offers two programs:

1. Lawson Program for school refusal, anxiety, depression and obsessional behaviours – there is high demand for this program and the waitlist is up to 6 months
2. Yaralla Program for psychotic and autism spectrum – there is usually no waitlist for this program

The programs link with distance education and many students don't return to mainstream schooling seeking vocational options instead. Those adolescents that do fully complete a program have almost 100% success rate of returning to mainstream schooling.

A comprehensive, multi-disciplinary assessment is conducted by two clinicians using a range of measures both nationally endorsed and others. Assessment will be conducted within the family home, where possible. The Admission Planning Meeting determines whether an adolescent should go on the wait list.

Twenty-five percent of adolescents are within Rivendell's catchment and the remaining seventy-five percent are managed by local health districts until they can be accommodated by Rivendell. Rivendell accommodates people from across NSW regions and the ACT. Geography will typically determine if an adolescent will stay overnight or attend the day program.

Average length of stay is two school terms (up to 6 months). Some young people stay much longer and go home over the school holidays. Other adolescents move between overnight stays, the Day Program, or step down from the Walker Unit.

Rivendell operates on the principle of a recovery model within the continuum of adolescent extended treatment and rehabilitation.

Staffing Mix:
10 FTEs; registered nurses rostered Monday to Friday (4 in AM, 3 in PM, 2 overnight) – nurses work with inpatient adolescents only (not outpatients nor case management). Outpatients are referred to CAMHS.
Allied Health – 3 FTE psychologists; 3 FTE social workers; case manager; individual and family therapy. There are also registrars divided across inpatient and outpatient

They provide workforce development and training around de-escalation practices.

Education Services
School is classified as a special school and encompasses vocational education. It has 11 teachers and they also travel to acute units, when required. Phillip recommended not linking clinical treatment to education treatment.

A lot of work is invested into discharge planning, including referral to the adult mental health service or transition to private practice.

Rivendell is used for youth camps during school holidays, typically run by community outreach organisations.

Walker Unit
The Walker Unit provides extended treatment and rehabilitation services in a secure unit. There is no documented model of service – it is still in development. The unit has been in operation for over two years now.

They treat resistant young people who are unable to be integrated back into the community at this stage, and it is not suitable for them to remain in acute inpatient. Diagnostic profile includes unrelenting self-harm, psychosis, bipolar, borderline IQ, learning difficulties, developmental delays and borderline personality disorders. Will treat young people with substance issues co-morbidity – will detox. Exclusion: eating disorders. Majority of young people are under the Mental Health Act.

Adolescents come from across NSW, including from regional centres

Referral is through CAMHS acute services, usually acute inpatient units, and rarely community referrals. There are no formal referral forms.

All referrals have comprehensive assessment by two clinicians, who will often visit the home of the family, even if out of the district. They are finding this a resource-intensive model and are looking at reviewing it. They also utilise telehealth as well.

A range of measures are utilised for assessment, including CBCL, CSD depression measures and YSR's as well as national CAMHS outcome measures (CGAS, HONONSA, FIHS, SDQ).

There are three points of family involvement: on admission; at a mid-point in treatment for family therapy; and in the lead up to discharge
They are working up to the capacity to have families stay for short periods of time.

Recovery planning commences at admission – Health Service districts are kept engaged with varying levels of success – especially with difficult-to-transition young people requiring adult mental health care.

They have a multidisciplinary team approach with a consultant psychiatrist having single point of accountability for clinical outcomes.
It operates 24 x 7 – they have no overnight leave policy (for ABF purposes).
There are daily ward programs and individual therapy. Onsite schooling is provided and targeted at individual assessment level. Education services are also provided by the Rivendell School.
There are bi-weekly ward reviews.

Average length of stay is up to 6 months with some outliers up to 2 years.

The unit has some linkages with Coral Tree and Redbank House (family admission) but usually for much less severe cases.

Most families provide their own accommodation in Sydney to accommodate the weekday admission model. The Walker Unit is exploring how to involve families more and have an option to admit families for intensive work, although this has not happened as yet.

ALIGNMENT OF THE NSW UNITS TO THE ECRG RECOMMENDATIONS
The Expert Clinical Reference Group (ECRG) developed a service element document which proposed four tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation:

- Tier 1 – Public Community Child and Youth Mental Health Services (existing)
- Tier 2a – Adolescent Day Program Services (existing and new)
- Tier 2b – Adolescent Community Residential Service/s (new)
- Tier 3 – State-wide Adolescent Inpatient Extended Treatment and Rehabilitation

Service (new)
Rivendell service complements Tier 2 and potentially Tier 2b.

The Walker Unit would complement Tier 3 by providing a subacute, contemporary, bed-based model of care.

Melissa Gasser

From: Stephen Stathis
Sent: Thursday, 4 December 2014 5:26 PM
To: Ingrid Adamson; Judi Krause
Subject: FW: BAC meeting follow up

Importance: High

FYI

They want it tomorrow. Oh the joy.

SS

From: Stephen Stathis
Sent: Thursday, 4 December 2014 4:31 PM
To: Scott Davies; Cathie Schnitzerling
Cc: Bill Kingswell
Subject: RE: BAC meeting follow up
Importance: High

Thanks Scott

With all the commitments around LCCH, I unfortunately won't be able to get this letter to you by 1200 tomorrow. I'd rather Bill review the letter before it is signed off by the DG, as he is technically the only one who can 'direct' adolescent units to take over 18s and I don't want Bill or the DG to be put into an awkward position (the letter will certainly be table on the Save the Barrett web site).

Some other thoughts for the DG's consideration. Re:

1. To the best of my knowledge all these ex-Barrett patients are receiving some type of mental health support. Many declined CYMHS services, which is the publically funded multidisciplinary approach. I'd be hesitant to write in a letter that public funds be spent supporting these YP outside the current CYMHS system. Furthermore, we have no jurisdiction over patients within the private system. I understand that many of the parents expressed concerns that the YP required more than the 10-12 subsidised sessions available under ATAPS/Better Access. However, this is a systemic issue and funded federally. Other than parents paying for private care, there are few other options other than CYMHS, which many of these parents do not wish to engage with.
2. Support for parents. Unsure what is preventing the parents presenting to their GP requesting mental health support via the recognised pathways (ATAPS, Better Access programs etc.) Not sure if they are wanting funded group programs. I would not recommend this.
3. Concession re 18 year olds. See comments above.
4. Consultative process. This was mainly around moving adolescents with severe, longstanding and complex mental health problems from the adolescent into the adult/youth system. Interestingly, the Statewide Mental Health Alcohol and Other Drugs Clinical Network is meeting tomorrow from 0930-1130. I sit on the network as the rep for C&A mental health. The recent Barrett Report is to be tabled tomorrow at the Network for discussion. The Report noted that "the BAC process demonstrates positive learnings in relation to good quality transitional planning". The Report then recommended that "these learnings be considered for distillation into the development of a state policy (or review of the current transfer of care policy) that supports mental health transition for vulnerable young people". Interestingly, earlier this year the Network considered supporting a project to examine the transitional care of young people from the adolescent to adult system. The recommendations of the Barrett Report is timely. Should this project be endorsed by the Network, it could then be included in the DG's letter i.e. the need for consultation about improving the continuum of mental health care from the adolescent to adult system. Hence also why I would be reluctant to draft a letter before the 1200 deadline, given the Network meeting tomorrow. The Barrett families could then be consulted in this project.

Bill, I'd be interested in your thoughts.

I'll try to get a draft to the DG by COB Friday.

Cheers

Stephen

From: Scott Davies
Sent: Thursday, 4 December 2014 8:59 AM
To: Stephen Stathis; Cathie Schnitzerling
Cc: Bill Kingswell
Subject: BAC meeting follow up

G'day Stephen and Cathie,

I have got hold of Ian's notes from last weeks meeting – as you will see on page 2, he is seeking a letter back to families that covers four points:

1. Multidisciplinary support OT etc. how can this support be provided. Review of each patients care requirement and immediate action.
2. Support for parents – access to
3. Concession for 18 yo to be admitted to an adolescent ward – can this be given?
4. Consultation (not on a T3) / community engagement – wanting a collaborative process

Grateful if you can please draft a response for Ian's signature by 1200 tomorrow.

Thanks,
SD

Scott Davies
Senior Director
Office of the Director-General | Department of Health
Level 19, 147 Charlotte Street, Brisbane QLD 4000
(07) [redacted]

Queensland Government

Enquiries to: Dr Bill Kingswell
Director of Mental Health

Telephone:
File Ref:

12 JAN 2015

Email:

Dear

Thank you for meeting me on the evening of 26 November 2014. I truly appreciate you taking the time to raise the issues and concerns that the closure of the Barrett Adolescent Centre (BAC) caused you and your child.

It was an extremely important opportunity for me to gain a better understanding of the challenges you and your child have faced coping with complex mental health problems. I have agreed to consider several key actions following our meeting.

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

Secondly, I agreed to consider the current policy preventing young people over 18 accessing an acute mental health bed for adolescents. Although some young adults may have reached formal adulthood, clinicians need to consider their patient's developmental achievements and connections to family and education when determining treatment.

A number of services are being developed in both the public and private sector for young people over 18. *Headspace* is designed for 12 - 25 year olds and the two residential services the Department has contracted in Cairns and Greenslopes are aimed at the 16 - 21 age group.

In line with recommendations, the Children's Health Queensland Hospital and Health Service established subacute inpatient beds at the Lady Cilento Children's Hospital to provide 24 hours per day, seven days per week care for young people with severe and complex mental health issues. This service provides extended treatment and rehabilitation with access to state of the art facilities, therapeutic programs and onsite schooling.

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

Postal
GPO Box 48
BRISBANE QLD 4001

Phone

Fax

The Queensland Mental Health Commission recently released its strategic plan committing the Department to develop a plan to deliver State funded mental health services. That plan will be underpinned by the National Mental Health Services Planning Framework and a mental health care type and classification now being developed by the Independent Hospital Pricing Authority. As we design and implement our State funded mental health service plan it is my intention to:-

1. Ensure you are engaged and consulted as part of that process; and
2. Ensure the extended treatment needs of adolescents with complex mental health conditions are properly considered as part of this process.

I also committed to considering the need for a wider range of support for parents. The Department funds a number of non-government organisations to provide carer support, for example, Mental Health Carer's Queensland, Stepping Stones, Aftercare and Centacare. All Hospital and Health Services offer a range of support for both individuals and groups. Some parents may have their own support, however, I am willing to facilitate additional support in the public or private sector for any parent who believes their needs are not being met.

Thank you for sharing your personal stories with me. I know this has been a very difficult time for many of the Barrett families and I appreciate your willingness to assist in the design of our future mental health services.

Should you have any questions or need the Department to arrange a multidisciplinary review of your child or find support for yourself or family, please contact Dr Bill Kingswell, Director of Mental Health, on telephone , or email at .

Yours sincerely

Ian Maynard
Director-General
Queensland Health

Statewide Subacute Bed Referral Panel Protocol

1. Panel operations

The statewide subacute beds form part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland.

The statewide subacute beds provide medium-term, developmentally-appropriate, hospital-based treatment and rehabilitation services in a safe and structured environment for young people aged 13 to 18 with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment.

A range of individual, group, and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. This will include recovery-orientated treatment and discharge planning that will assist progression in developmental tasks that may have been arrested secondary to the mental illness, and support the safe transition of the young person to more functional or independent living on discharge.

A key function of the statewide subacute beds is to build upon the existing comprehensive assessment of the young person, utilising the previous treatment history obtained from previous service providers and carers. A comprehensive family assessment, completed within four weeks of admission into the Unit, will form part of the treatment plan. Access to onsite schooling will be provided.

As a statewide service, a strong emphasis is placed on the development of cross-sector partnerships, working with other key service providers in the community to facilitate joint, assertive management, and discharge planning for the young person.

It is anticipated that the majority of patients accepted into the subacute beds will be current patients of an acute adolescent inpatient unit.

The Statewide Assessment Panel will work with referral parties to prioritise and triage new referrals into the subacute beds. The Panel will also have oversight of case review for existing subacute patients who may require an extension to their stay.

1.1. Principles of the Panel

- Service responses are based on the goal of the best outcomes for the young person.
- Consumer and family/care giver participation is encouraged.
- Young people are considered in their social and culture context and, whenever possible, interventions will focus on developing supportive social environments and facilitating young people to access and integrate with existing community educational, vocational, recreational and other relevant programs.
- The views of the young person and their family must be considered.

1.2. Panel members

Core panel members
The core members of the panel are:

Medical Director, Specialist Services, CYMHS, CHQHHS (Chair)
Nursing Director, LCCH Mental Health Unit, CYMHS, CHQHHS
Northern Cluster Representative, CYMHS

Central Cluster Representative, CYMHS
Southern Cluster Representative, CYMHS

A dedicated Secretariat will be appointed to the Statewide Assessment Panel.

Key stakeholders, such as the Primary Service Provider (PSP) and other mental health service provider/s, will be invited as relevant to individual consumer cases under review.

In recognition of the inter-related nature of a young person's education, mental health and behaviour, other agency representatives (such as a Department of Education, Training and Employment; Department of Housing; and Department of Communities, Disability and Child Safety) may also be invited to attend the panel, as required, to discuss particular consumer cases.

Quorum
The quorum for the panel consists of the Medical Director, CYMHS CHQHHS, plus two other panel members.

If any of these members (or their direct delegate) is not present for a panel meeting, a quorum will not be achieved and the meeting cannot proceed. Alternative arrangements for the panel meeting would then need to be made.

Invited parties
When the panel believes a key stakeholder (e.g. Principle Service Provider) is required to attend a panel meeting to discuss a specific young person, an invitation will be sent. If the stakeholder is unable to attend the meeting in person, they will be invited to provide advice or information on the consumer for the panel's consideration, e.g. through e-mail, teleconference, or video conference.

1.3. Coordination of panel meetings

To promote efficiency, effectiveness, and benchmarking opportunities, panel processes must be clear, documented, and consistent with best practice.

The Chair position will be held by the Medical Director, Specialist Services, CYMHS CHQHHS, or their delegate.

Other matters related to the coordination of panel meetings, such as the venue for meetings, time allocation, and arranging invitations to panel meetings for invited stakeholders, are the responsibility of the Secretariat of the panel. This will be achieved through the use of minutes, with clear action statements outlining responsibilities and timeframes.

1.4. Administration support to the panel

Secretariat support for the panel will be provided by CYMHS CHQHHS on a recurrent basis.

The role of the Secretariat includes:

- Assist with the coordination of panel meetings, and organise and distribute the agenda and associated documents e.g. new referrals, consumer reviews, etc.
- Ensure that all panel information and minutes are recorded and distributed to appropriate parties, and stored on the appropriate record and filing system.
- Ensure that all original consumer forms and information are stored on the appropriate record.
- Maintain reporting and data collection activities for the panel.

1.5. Panel meetings

The Panel will convene on an as required basis.

The agenda for panel meetings will be coordinated and set in advance of panel meetings (refer to **Statewide Assessment Panel Agenda** template).

Tasks that need to be carried out by respective agencies in between panel meetings need to be clearly identified and communicated across agencies.

The Panel Chair will need to ensure adequate information has been provided on the Consumer Intake Form together with a signed Consent to Obtain/Release Information Form (http://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs.htm).

Panel members will receive a copy of the meeting agenda and accompanying documentation (including new referrals, reports, and plans for existing referrals) at least 5 working days in advance of the panel meeting.

The recommended format for panel meetings is as follows:

- Previous Business
- Review of Consumer Summary Report (current and exiting consumers)
- New Referrals (intake and prioritisation)
- Panel Process Issues
- Other Business

The chairperson is responsible for ensuring panel meetings are:

- Effectively time managed and all agenda items are tabled
- Effectively facilitated so that relevant information and discussion points are elicited to ensure that the panel can attend to their business.

Panel discussions will be recorded in the panel minutes (refer to **Statewide Assessment Panel Minutes** template). Panel decisions regarding a new referral will be recorded on the **Consumer Summary Report**. Any subsequent discussions regarding the young person will also be recorded in this report.

It is the responsibility of the Chair, with input from other panel members, to ensure that the records are accurate and reflect the intent of the discussion.

If there is a dispute regarding panel decisions, the matter may be raised to the Chief Executive of CHQHHS.

1.6. Principles for panel decision-making

Panel discussions will be recorded in the minutes of the meeting and on the Consumer Summary Report.

Prioritisation of consumers for referral will be based on clinical grounds and the decision points will be clearly documented and discussed with referring services.

Where the panel does not recommend intake into a statewide subacute bed, the panel discussions should aim at developing alternative options for treatment. These options should also be recorded on the Consumer Summary Report.

1.7. Confidentiality and Privacy

Information raised and discussed at panel meetings will be treated with utmost care and sensitivity, and with the highest regard in respect of confidentiality and privacy. All staff participating in panel discussions should also be aware of professional and organisational ethical and legislative requirements in relation to privacy and confidentiality, including employee requirements and obligations set out in various departmental codes of conduct.

All forms which collect information for the purpose of referrals into the statewide subacute beds will comply with the Information Privacy Principles contained in the *Information Privacy Act 2009* and feature privacy notices.

All contracted service providers are required to be contractually bound to comply with the Information Privacy Principles prior to the exchange of information.

2. Referral

The referral process for the statewide subacute beds will operate in a manner that ensures young people referred are responded to in a timely way.

2.1. Eligibility criteria

A young person **may be eligible** for a statewide subacute bed if they:

- Are aged between 13 and 18 years of age, with flexibility in upper age limit depending on presenting issue and developmental age.
- Present with severe or complex mental health problems.
- Are likely to benefit from an extended treatment and rehabilitation model of care in a hospital-based subacute bed.

A young person will **not be eligible** for a statewide subacute bed if they:

- Could be managed in a less restrictive setting.
- Primarily need support with substance misuse issues.
- Their primary problem to be addressed is accommodation.

2.2. Referral Process

The PSP completes a Consumer Intake Form on CIMHA, which needs to include:

- Reason for Referral:
  - An up-to-date mental state examination and clinical formulation
  - A clear description of why an admission to a statewide subacute bed is sought at this time, including specific goals for the consumer. Include, where available, input from other CYMHS services that demonstrate the need for a more intensive bed-based intervention.
- Relevant History:
  - History of the presenting mental health issues
  - A brief summary of treatment to date
- Practical Issues:
  - Current living situation
  - Education, vocation, and /or employment status
  - Finances
  - Family supports and ability of family to travel to Brisbane for a comprehensive family assessment.
- As the statewide subacute bed service is a non-acute service, the *Response Category* and *Timeframe for Assessment* sections are not applicable.

The PSP also needs to ensure that a Consent to Obtain/Release Information Form has been signed by the young person; or a Consent to Obtain/Release Information Form has been signed by their parent/guardian.

Once complete, forms are to be emailed to the Secretariat (email: [redacted]

The PSP will receive an acknowledgement of their referral and the date of the panel meeting when their referral will be considered by the panel.

2.3. Panel discussion of referral

Once a referral has been received, and the consumer listed on the agenda for the next panel meeting, the PSP for the consumer, or their delegate, will be invited to attend the panel meeting to discuss the referral and provide additional information as required.

Panel members are likely to raise questions about the referral to ensure appropriateness (that eligibility criteria have been met and that other service options have been explored). Additional information may be sought to enable the panel to make their prioritisation decisions.

The panel will also enquire as to how the referring PSP, and the consumer's local CYMHS team, intends to remain engaged with the consumer prior, during, and post admission, if accepted.

3. Intake and prioritisation

3.1. Response to referrals

The Panel Chair (or their delegate) will be responsible for informing the PSP of the outcome of the panel discussion and decision regarding the referral. The decision will also be communicated via email to the PSP, with a copy to

The Secretariat will upload a copy of this communication onto the consumer's case file in CIMHA.

3.2. Response to referrals that are recommended for other service options

If the decision by the panel does not recommend intake of the young person into a statewide subacute bed, it is the responsibility of the panel to provide the reasons supporting this decision (e.g. referral does not meet access criteria for statewide subacute bed, or other service agencies are better placed to respond to the needs outlined in the referral). The Panel Chair is responsible for informing the PSP.

3.3. Response to referrals that meet eligibility but statewide subacute beds are at capacity

If the panel determines a new referral meets the eligibility criteria but the statewide subacute beds are at capacity, the panel will recommend that the young person be 'accepted – pending bed'. The panel may recommend alternative services to meet the young person's therapeutic or behavioural support needs, until such time that a place becomes available and where placement is still required.

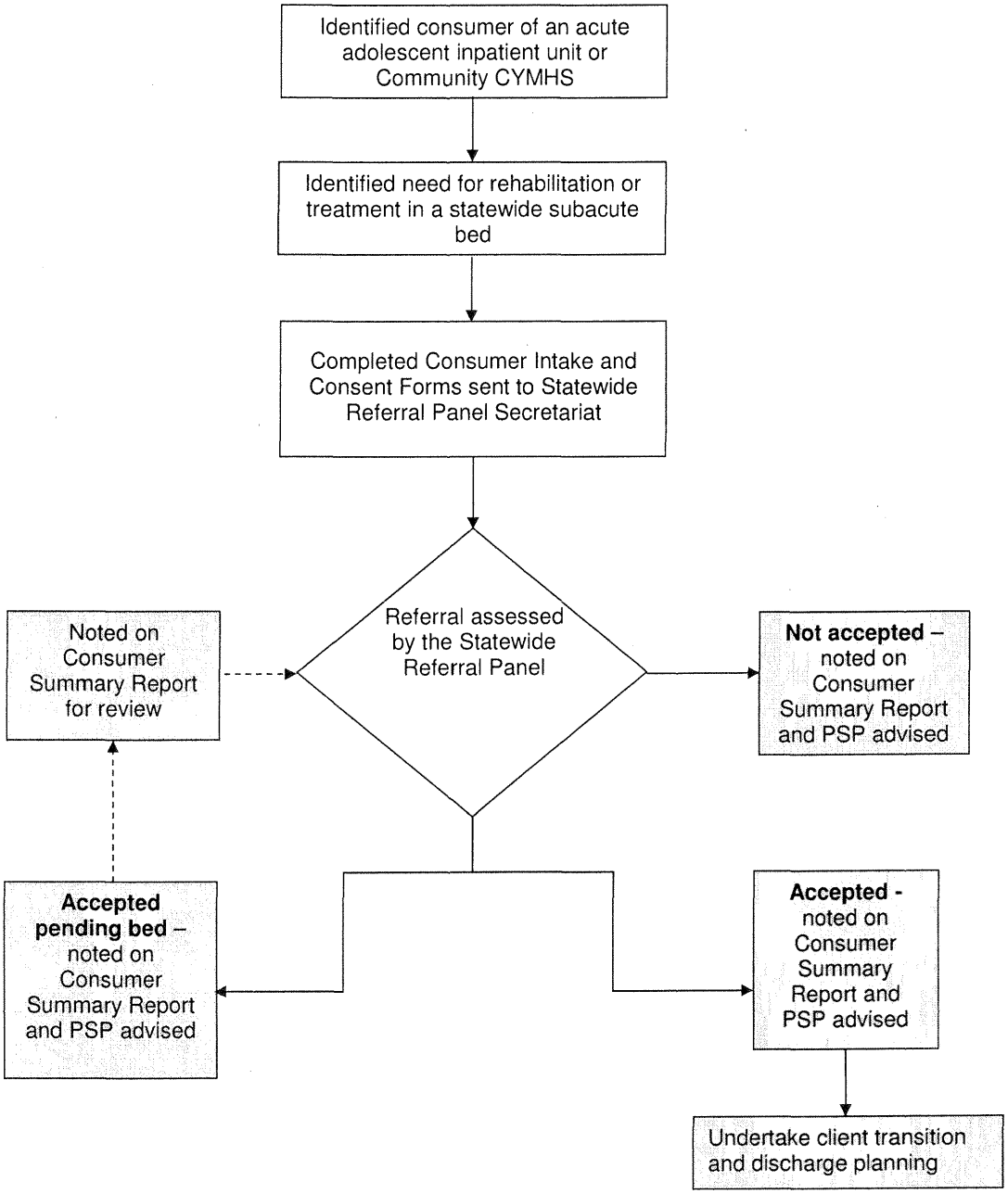
The referral will be noted in the Consumer Summary Report for review at subsequent panel meetings, to reconfirm placement need and any changes in priorities. The Panel Chair is responsible for informing the PSP.

Panel members should not provide an ongoing advisory or consultancy role for referrals that are not accepted into the statewide subacute beds.

3.4. Information collection, storage and data management

Consumer Intake and Consent Forms, any accompanying information, and the Consumer Summary Report will be kept on panel files.

Referral Process into Statewide Subacute Beds



Secretariat Process for Panel

- PSP sends referral via email to
- Secretariat confirms a completed Consumer Intake Form and signed Consent Form are attached.
- Secretariat forwards email onto Panel members for review.
- Panel Chair, or their delegate, confirms sufficient information is provided for panel assessment.
- Secretariat adds referral to next meeting agenda.
- Panel Chair contacts PSP to confirm panel meeting date for new referral assessment and invites PSP, or their delegate, to attend – Secretariat confirms via email.
- Secretariat circulates agenda, previous minutes, Consumer Summary Report, and any new referral documentation to panel members 5 days prior to scheduled meeting
- Secretariat minutes meeting of the Panel and updates the Consumer Summary Report
- Within 5 working days of the meeting, Secretariat finalises minutes and circulates meeting documentation to Panel and attendees, as appropriate.

Queensland
Government

Children's Health Queensland
Hospital and Health Service

Child and Youth Mental Health Service
Children's Health Queensland Hospital and Health Service Queensland Health

Enquiries to: Stephen Stathis
Medical Director
CYMHS CHQ HHS
Telephone:
Facsimile:

Dr. Donna Dowling
Clinical Director
Child, Adolescent and Young Adult Mental Health Service
Townsville Hospital and Health Service

Dear Donna

The statewide subacute beds form part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland. Statewide subacute beds provide medium-term, developmentally-appropriate, hospital-based treatment and rehabilitation services in a safe and structured environment for young people aged 13 to 18 with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment. Currently, there are four statewide subacute beds located within the mental health inpatient units (Ward 8b) at the Lady Cilento Children's Hospital.

A range of individual, group, and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. A key function of the statewide subacute beds is to build upon the existing comprehensive assessment of the young person, utilising the previous treatment history obtained from previous service providers and carers. A comprehensive family assessment, completed within four weeks of admission into the Unit, will form part of the treatment plan. Access to on-site schooling will be provided within the hospital campus.

It is anticipated that the majority of patients accepted into the subacute beds will be current patients of an acute adolescent inpatient unit. Referrals will occur via a Statewide Assessment Panel, who will work with referral parties to prioritise and triage new patients into the subacute beds. The Panel will also provide oversight for case review of existing subacute patients who may require an extension to their subacute admission.

Core members of the panel will include: Medical Director, Specialist Services, CYMHS, CHQ HHS (Chair); a senior child and adolescent psychiatrist representing the Northern Cluster; a senior child and adolescent psychiatrist representing the Central Cluster; a senior child and adolescent psychiatrist representing the Southern Cluster, and; the Nursing Director CYMHS CHQ HHS, who will provide liaison between the Panel and 8b. A dedicated Secretariat will be appointed to the Statewide Assessment Panel.

Office
Child and Youth Mental Health Service
Level 10, 199 Grey Street
South Brisbane Qld 4101

Postal
PO Box 5494
West End Qld 4101

Phone **Fax**

Key stakeholders, such as the Primary Service Provider (PSP) and other mental health service provider/s, will be invited as relevant to individual consumer cases under review. In recognition of the inter-related nature of a young person's education, mental health and behaviour, other agency representatives (such as a Department of Education, Training and Employment; Department of Housing; and Department of Communities, Disability and Child Safety) may also be invited to attend the panel, as required, to discuss particular consumer cases.

In time, the duties of the Panel may evolve and include the triage and review patients in other extended mental health treatment and rehabilitation services.

I wish to invite you onto the Panel as the core member representing the Northern Cluster. Please advise me in writing of your decision by close of business, Friday 15 May 2015. Don't hesitate to contact me if you have any questions.

Kind regards

Yours sincerely

Dr. Stephen Stathis
Medical Director
CYMHS, CHQ HHS
05/05/2015

Children's Health Queensland
Hospital and Health Service

Child and Youth Mental Health Service
Children's Health Queensland Hospital and Health Service Queensland Health

Enquiries to: Stephen Stathis
Medical Director
CYMHS CHQ HHS
Telephone:
Facsimile:

Dr. Shannon March
Clinical Director
Child and Young Adult Mental Health Service
Darling Downs Hospital and Health Service

Dear Shannon

The statewide subacute beds form part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland. Statewide subacute beds provide medium-term, developmentally-appropriate, hospital-based treatment and rehabilitation services in a safe and structured environment for young people aged 13 to 18 with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment. Currently, there are four statewide subacute beds located within the mental health inpatient units (Ward 8b) at the Lady Cilento Children's Hospital.

A range of individual, group, and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. A key function of the statewide subacute beds is to build upon the existing comprehensive assessment of the young person, utilising the previous treatment history obtained from previous service providers and carers. A comprehensive family assessment, completed within four weeks of admission into the Unit, will form part of the treatment plan. Access to on-site schooling will be provided within the hospital campus.

It is anticipated that the majority of patients accepted into the subacute beds will be current patients of an acute adolescent inpatient unit. Referrals will occur via a Statewide Assessment Panel, who will work with referral parties to prioritise and triage new patients into the subacute beds. The Panel will also provide oversight for case review of existing subacute patients who may require an extension to their subacute admission.

Core members of the panel will include: Medical Director, Specialist Services, CYMHS, CHQ HHS (Chair); a senior child and adolescent psychiatrist representing the Northern Cluster; a senior child and adolescent psychiatrist representing the Central Cluster; a senior child and adolescent psychiatrist representing the Southern Cluster, and; the Nursing Director CYMHS CHQ HHS, who will provide liaison between the Panel and 8b. A dedicated Secretariat will be appointed to the Statewide Assessment Panel.

Office
Child and Youth Mental Health Service
Level 10, 199 Grey Street
South Brisbane Qld 4101

Postal
PO Box 5494
West End Qld 4101

Phone

Fax

Key stakeholders, such as the Primary Service Provider (PSP) and other mental health service provider/s, will be invited as relevant to individual consumer cases under review. In recognition of the inter-related nature of a young person's education, mental health and behaviour, other agency representatives (such as a Department of Education, Training and Employment; Department of Housing; and Department of Communities, Disability and Child Safety) may also be invited to attend the panel, as required, to discuss particular consumer cases.

In time, the duties of the Panel may evolve and include the triage and review patients in other extended mental health treatment and rehabilitation services.

I wish to invite you onto the Panel as the core member representing the Southern Cluster. Please advise me in writing of your decision by close of business, Friday 15 May 2015. Don't hesitate to contact me if you have any questions.

Kind regards

Yours sincerely

Dr. Stephen Stathis
Medical Director
CYMHS, CHQ HHS
05/05/2015

Queensland
Government

Children's Health Queensland
Hospital and Health Service

Child and Youth Mental Health Service
Children's Health Queensland Hospital and Health Service Queensland Health

Enquiries to: Stephen Stathis
Medical Director
CYMHS CHQ HHS
Telephone:
Facsimile:

Dr. David Ward
Clinical Director
Adolescent Inpatient Unit
Royal Brisbane & Women's Hospital
Metro North Hospital and Health Service

Dear David

The statewide subacute beds form part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland. Statewide subacute beds provide medium-term, developmentally-appropriate, hospital-based treatment and rehabilitation services in a safe and structured environment for young people aged 13 to 18 with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment. Currently, there are four statewide subacute beds located within the mental health inpatient units (Ward 8b) at the Lady Cilento Children's Hospital.

A range of individual, group, and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. A key function of the statewide subacute beds is to build upon the existing comprehensive assessment of the young person, utilising the previous treatment history obtained from previous service providers and carers. A comprehensive family assessment, completed within four weeks of admission into the Unit, will form part of the treatment plan. Access to on-site schooling will be provided within the hospital campus.

It is anticipated that the majority of patients accepted into the subacute beds will be current patients of an acute adolescent inpatient unit. Referrals will occur via a Statewide Assessment Panel, who will work with referral parties to prioritise and triage new patients into the subacute beds. The Panel will also provide oversight for case review of existing subacute patients who may require an extension to their subacute admission.

Core members of the panel will include: Medical Director, Specialist Services, CYMHS, CHQ HHS (Chair); a senior child and adolescent psychiatrist representing the Northern Cluster; a senior child and adolescent psychiatrist representing the Central Cluster; a senior child and adolescent psychiatrist representing the Southern Cluster, and; the Nursing

Office
Child and Youth Mental Health Service
Level 10, 199 Grey Street
South Brisbane Qld 4101

Postal
PO Box 5494
West End Qld 4101

Phone **Fax**

Director CYMHS CHQ HHS, who will provide liaison between the Panel and 8b. A dedicated Secretariat will be appointed to the Statewide Assessment Panel.

Key stakeholders, such as the Primary Service Provider (PSP) and other mental health service provider/s, will be invited as relevant to individual consumer cases under review. In recognition of the inter-related nature of a young person's education, mental health and behaviour, other agency representatives (such as a Department of Education, Training and Employment; Department of Housing; and Department of Communities, Disability and Child Safety) may also be invited to attend the panel, as required, to discuss particular consumer cases.

In time, the duties of the Panel may evolve and include the triage and review patients in other extended mental health treatment and rehabilitation services.

I wish to invite you onto the Panel as the core member representing the Central Cluster. Please advise me in writing of your decision by close of business, Friday 15 May 2015. Don't hesitate to contact me if you have any questions.

Kind regards

Yours sincerely

Dr. Stephen Stathis
Medical Director
CYMHS, CHQ HHS
05/05/2015

EXHIBIT 123

WM HHS Transitional Service Options Overview

	Intensive Mobile Outreach Service	Day Program	Supported Accommodation
Service Description	Mobile intensive outreach services 7 days / extended hours	Transitional day program providing extended mental health treatment and rehabilitation Monday to Thursday, school hours, school terms 10 places	Bed-based residential and respite service for after hours and on weekends 4 beds 24 hours / 7 days
Location	West Moreton HHS & Brisbane metropolitan area Consultation – Liaison to local CYMHS services	West Moreton HHS	West Moreton HHS
Target Population	Current BAC patients as clinically safe and indicated. New patients meeting criteria. Age 15 – 21 years	Current BAC patients as clinically safe and indicated. New patients meeting criteria. Age 15 – 21 years	Current BAC patients as clinically safe and indicated. New patients meeting criteria. Age 15 – 21 yrs
Exclusion Criteria	Level of acuity or risk assessed as high – actively suicidal, homicidal or aggressive No capacity to engage and comply with treatment	Level of acuity or risk assessed as high – actively suicidal, homicidal or aggressive No capacity to engage and comply with treatment	Level of acuity or risk assessed as high – actively suicidal, homicidal or aggressive No capacity to engage and comply with treatment
Referral In Process	CYMHS Assessment and review by State-wide Assessment Panel	CYMHS Assessment and review by State-wide Assessment Panel	CYMHS Assessment and review by State-wide Assessment Panel
Length of Stay	Up to 12 months Case-by-case basis	Attendance up to 4 days per week for up to 12 months Monday to Thursday	Up to 12 months Case-by-case basis
Treatment	Delivered in least restrictive environment and utilising a recovery model Range of flexible outreach services delivered via consultation liaison model Education in-reach and vocational services where required (DETE) Integrate with local acute inpatient, day program, public community MH teams & NGO programs	Delivered in a therapeutic milieu Individual, family and group Therapeutic Program Rehabilitation Programs Flexible targeted programs Education in-reach and vocational services where required (DETE) Integrate with local acute inpatient, IMOS, public community MH teams & NGO programs	Provides accommodation but not the intervention Day program attendance optional In-reach CYMHS & IMOS support Integrate with local acute inpatient, day program, IMOS, public community MH teams & NGO programs
Referral Down or Out	Local CYMHS, Day Program	Local CYMHS, IMOS	Local CYMHS, Day Program, IMOS
Staffing	Experienced child and youth mental health staff, with capacity to work independently with supervision provided Consultation liaison model provided to the local mental health service of the consumer	Multidisciplinary mental health team	Aftercare staff on day/evening/night In reach clinical staff
Skills required	Multi-disciplinary staffing profile with clinical skills and training, sourced by Aftercare Training and supervision provided by DoH	Multi-disciplinary staffing profile with clinical skills and training, sourced by Aftercare Training and supervision provided by DoH	Multi-disciplinary staffing profile with clinical skills and training, sourced by Aftercare Training and supervision provided by DoH
Funding	Fund from BAC operational funds and DoH bridging funds	Fund from BAC operational funds and DoH bridging funds	Fund from BAC operational funds and DoH bridging funds
Governance	Partnership between Aftercare and WM HHS	Partnership between Aftercare and WM HHS	Residential accommodation to be in partnership with Aftercare and WM HHS
Benefits	Flexible service delivery, least restrictive setting, extended hours, part of integrated individualised package, recovery focussed, developmentally appropriate Pilot for new service options being developed Ensures no gap to services for consumers while new service options being developed	Flexible targeted programs, part of integrated individualised package, recovery focussed, developmentally appropriate, provides peer context to support adolescent development Pilot for new service options being developed Ensures no gap to services for consumers while new service options being developed	24 hour / 7 days supported accommodation, integrated with local acute inpatient, day program, IMOS, public community MH teams & NGO programs Pilot for new service options being developed Ensures no gap to services for consumers while new service options being developed
Risks	Insufficient capacity to manage acuity, severity & complexity of presentations Safety of home visiting, mobile service delivery	Insufficient capacity to manage acuity, severity & complexity of presentations Travel demands on consumers to West Moreton Extends separation period from 'home' HHS	Insufficient capacity to manage acuity, severity & complexity of presentations Safety for patients & staff Difficulty finding step down accommodation Will not target needs of current consumer group – low occupancy
Limitations	Resources (staffing, $), demand, procurement process timelines	Resources (staffing, $), demand, procurement process timelines	Resources (staffing, $), demand, procurement process timelines

WM HHS Transitional Service Options Plan

Recovery oriented treatment and rehabilitation for young people, aged 15 – 21years, with severe and persistent mental health problems that are unable to be cared for within existing service options

Phase 1

Activity Based Holiday Program

Site – The Park
16 December 2013 – 24 January 2014

Target population
Current BAC inpatients and day patients (as clinically safe and indicated)
Severe and persistent mental health problems – rehabilitation
Medium to high level of acuity

Referral Process
BAC Assessment and Referral

Overview of service / treatment
Qld Health delivered program
Activity and socialisation focus
Monday to Thursday school hours

Staffing Required
Core staff:– Aftercare team (clinical and other) + BAC staff

Length of Program Delivery
Up to length of Christmas School Holidays 2013/14

Governance
WM HHS

Phase 2

West Moreton Transitional Service:

- **Intensive Mobile Outreach Service**
- **Day Program**
- **Supported Accommodation**

Site – West Moreton HHS (?Goodna Community Health)
29 January 2014 – December 2014

Target population
Current BAC inpatients and day patients (voluntary status) 15y-21y
New patients meeting criteria from other HHSs – previously eligible for referral to BAC
Severe and persistent mental health problems – rehabilitation
Medium to high level of acuity
Patients can receive any of the treatment options, packaged as indicated by clinical presentations

Referral Process
CYMHS Assessment and Referral
State-wide Clinical Referral Panel (WM HHS lead)

Overview of service / treatment
Intensive Mobile Outreach Service: 7 days / extended hours
Delivered in least restrictive environment and utilising a recovery model – range of flexible outreach services for engagement, treatment & rehabilitation to assist young people to meet their developmental tasks in the context of recovery from mental health presentations
Day Program: Monday to Thursday school hours and school terms
Delivered in a therapeutic milieu – range of facilities in community
Individual, family and group therapeutic & rehabilitation programs
In-reach DETE
Supported Accommodation: 7 days
Delivered in a therapeutic milieu – domestic style facility
In-reach West Moreton clinical team

Staffing Required
Core staff:– Aftercare team (clinical and other) + identified WM clinician/s

Length of Program Delivery
IMOS & Day Program:Up to 12 months, Supported Accomm: Up to 6 months

Governance
WM HHS and Aftercare

Phase 3

Transition to State-wide Adolescent Extended Treatment and Rehabilitation Services*

***Details to be defined via the Statewide AETR Strategy, under leadership of CHQ HHS**

Target population
As per State-wide Adolescent Extended Treatment and Rehabilitation Strategy

Governance
CHQ HHS

Key Issues:

- Individual transition plans to 'home' HHS will continue as priority – continue to engage other HHSs in planning process
- Need to focus on individual recovery – orientated packages of care, that reintegrate and reconnect young people to their communities, family, school/vocation and local mental health services
- Clinical safety and risk mitigation are key priorities in decision-making
- Imperative at all levels to ensure no gap to service delivery for BAC consumers
- Interface between QH and DETE is high priority – Alignment between QH and DETE model of service delivery will require immediate negotiation

Business Case

For the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care

EXCERPT

Children's Health Queensland Hospital and Health Service

July 2014

V 4.0

Table of Contents

1 Project Proposal

Children's Health Queensland Hospital and Health Service is leading the development and implementation of the statewide Adolescent Mental Health Extended Treatment Initiative (AMHETI), which aims to ensure young people and their families across Queensland have access to quality mental health extended treatment and rehabilitation service options in the least-restrictive environment as close to their home and community as possible.

Work Unit: Child and Youth Mental Health Service (CYMHS)

Work Site: Children's Health Queensland Hospital and Health Service (CHQ HHS)

1.1 Strategic and Operational Alignment

This initiative aligns with *Strategic Direction 1: Leading the provision of quality health care for children and young people.*

1.2 Background

Queensland's public mental health system has undergone significant reform over the past ten years. The reform agenda includes a shift from institution-based service models, including extended treatment and rehabilitation, to more contemporary models of care that align with state and national policy. The impact of these important reforms has seen the care of consumers move primarily into community-based settings, where they are supported to engage in their own local neighbourhoods and facilities. This has been particularly vital for consumers requiring medium to longer-term care.

In alignment with the Queensland Plan for Mental Health 2007-17 (QPMH), a key area for reform within Mental Health and Specialised Services (MHSS) in the West Moreton Hospital and Health Service (WM HHS) is the development of The Park Centre for Mental Health (The Park) as an adult-only forensic and secure mental health campus. The high secure services have been expanded and, in July 2013, a new service option was established on campus, the Extended Forensic Treatment and Rehabilitation Unit.

In light of these significant changes, it is no longer safe or contemporary to provide long-term inpatient care for adolescents at the Barrett Adolescent Centre (BAC) on The Park campus. Compounding these changes at a service provision level, the existing infrastructure of the BAC is unable to be refurbished and the building will be decommissioned.

Through Stage 1 of the QPMH, an adolescent extended treatment unit was funded to replace the existing 15-bed BAC. The replacement service was to be located at Redlands within Metro South HHS, and had an indicative commissioning date of November 2013. Upon operation of the replacement 15-bed unit, the existing BAC would be decommissioned.

The Redlands adolescent extended treatment capital program encountered multiple delays and a significant budget over-run. There were unresolvable environmental barriers associated with the site, and the Department of Health ceased the development and redirected the capital funds toward other high priority health initiatives. Operational funding for the Redlands Facility, of approximately $1.8 million for 2013/14, has been retained and approved by the Department of Health to fund new adolescent mental health extended treatment and rehabilitation service options.

In December 2012, WM HHS initiated the Barrett Adolescent Strategy to identify new service options for adolescents requiring mental health extended treatment and rehabilitation in Queensland. An Expert Clinical

Reference Group (ECRG) was convened, consisting of a consumer representative, a carer representative, an interstate Child and Adolescent Psychiatrist, multi-disciplinary Child and Youth Mental Health clinician representation (including north Queensland), a representative of BAC, a representative of the BAC School, and a Non-Government Organisation (NGO) representative. The ECRG was chaired by the Director of Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch (MHAODB). The ECRG reported up to the WM HHS via a Planning Group, which was chaired by the Executive Director of Mental Health & Specialised Services, WM HHS.

In May 2013, a preamble and seven recommendations were submitted by the ECRG and considered by the WM HHS Board. This was followed by comprehensive consultation with the Minister for Health, the Queensland Mental Health Commissioner, CHQ HHS, Department of Education Training and Employment (DETE), and the Department of Health. The seven recommendations were accepted by the WM HHS Board.

On 6 August, 2013, the Minister for Health, the Honourable Lawrence Springborg MP made an announcement that adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from the Barrett Adolescent Centre at that time will be supported through their transition to other contemporary care options that best meet their individual needs.

Children's Health Queensland is leading the development and implementation of the statewide Adolescent Mental Health Extended Treatment Initiative.

1.3 Statement of Need

The closure of the BAC has provided an opportunity to review the model of care for adolescent extended treatment and rehabilitation to ensure young people receive contemporary, family-centred services in the least-restrictive environment as close to their home and community as possible.

The BAC represents just one service on a continuum of adolescent mental health care provided by the Queensland State Government. While the BAC provided care for 12 to 15 young people at any one time, Queensland Health is providing mental health care for a much larger cohort of young people across the state. Children's Health Queensland is now exploring the best way to enhance these current care options for young people, as well as the addition of new services, to address recognised service gaps in the continuum of care for adolescent mental health.

The goal is to ensure every adolescent in need of mental health care will receive the best support and treatment as close to their home and family as possible.

1.4 Objective/s

The objective of this initiative is to provide contemporary, evidence-informed treatment and rehabilitation care that treats young people in the least restrictive environment possible, recognises the need for safety and cultural sensitivity, and is provided with the minimum possible disruption to family, educational, social, and community networks.

Specifically, the initiative will:

1. Develop service options within a statewide mental health model of care for adolescent extended treatment and rehabilitation, within a defined timeline.
2. Develop an Implementation Plan to achieve the alternative model of care for adolescent mental health extended treatment and rehabilitation.

3. Ensure continuity of care for adolescents currently admitted to BAC, and on the wait list, through a supported discharge / transition process to the most appropriate care option/s that suit individual consumer needs, and that are located in (or as near to) their local community.

4. Oversee the redistribution of BAC operational funds, and other identified funding, to adolescent mental health service models to support the identified target group.

5. Develop a consistent and transparent Communication Plan regarding the implementation of the new service options.

6. Consider in all decision-making the key principles and recommendations as defined through the ECRG and Planning Group of the Barrett Adolescent Strategy.

7. Discharge all adolescents from the BAC facility by end January 2014, to enable finalisation of The Park campus as an adult-only forensic and secure mental health service facility, noting that this is a flexible date dependent upon the needs of the consumer group.

1.5 Scope

1.5.1 In Scope

- End-to-end recovery-oriented adolescent mental health extended treatment and rehabilitation services, that may be defined as a range of ambulatory mental health services that deliver mental health care to non-admitted patients, including services at non-hospital community mental health services, crisis or mobile assessment treatment services, and day programs. It may also include a small number of non-acute inpatient mental health services to admitted patients over a longer-term period and involve a specialist rehabilitation component to care.
- Linkages to other adolescent mental health services that do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)
- Linkages to Adult Mental Health Services in so far as to ensure smooth transition from Adolescent Mental Health Services
- Linkages to primary care service providers in so far as to ensure smooth transition to and from Adolescent Mental Health Services
- Governance and resource arrangements for the statewide adolescent mental health extended treatment and rehabilitation services, including, financial, workforce, and assets.
- The target consumer group is:
    - 13 - 18 years old, with flexibility in upper age limit depending on presenting issue and developmental age (as opposed to chronological age).
    - Severe and persistent mental health problems that may include co-morbid alcohol and other drug problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development.
    - Mental illness is persistent and the consumer is a risk to themselves and/or others.
    - Medium to high level of acuity requiring extended treatment and rehabilitation.

1.5.2 Out of Scope

- Individual consumer clinical treatment plans
- Current BAC operations

- Decommissioning of the BAC building
- Any system requirements or enhancements for electronic consumers records
- Other adolescent mental health services that do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)
- Non-adolescent mental health services
- Primary care service providers and their processes

1.6 Dependencies

There are no project inter-dependencies identified.

1.7 Benefits and Outcomes

- High quality, effective extended treatment and rehabilitation mental health service options available to consumers that are based on contemporary models of care and take into account the wide geographical spread of Queensland.
- Increased access for adolescent consumers to their families, community and social networks by having greater access to more local mental health services.
- Reduced re-admission rates, emergency presentations, lengths of stay in acute adolescent inpatient units, and occupied bed days.
- Improved, strengthened inter-sectoral partnerships in delivering adolescent mental health care.
- Value for money in the delivery of care for adolescents requiring extended treatment and rehabilitation mental health care.

Achievement of project objectives and outcomes will be measured through:

- Consumer, family, and carer feedback reflecting quality, effectiveness, and accessibility of extended treatment and rehabilitation mental health service options.
- Service data demonstrating increased local access to extended treatment and rehabilitation mental health services, and demand management across Queensland.
- Service data outlining patient flow. Mental Health Performance Management Framework State key performance indicators would include 28 day re-admission rates and 1 to 7 day community follow up pre and post discharge. Other indicators would include service activity presentations to the Department of Emergency Medicine, reduction in emergency examination orders, average length of stay, and occupied bed days.
- Staff feedback demonstrating improved service provision across Queensland.
- Feedback from service providers demonstrating improved, strengthened inter-sectoral partnerships in delivering adolescent mental health care.
- Financial assessment demonstrating value for money in the delivery of care for adolescents requiring extended treatment and rehabilitation mental health care.

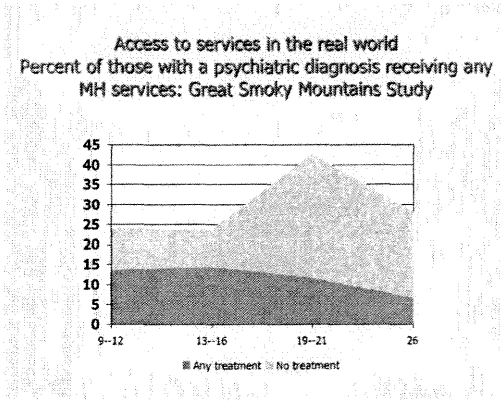
2 Demand for Services

Mental illness represents an estimated 11% of the disease burden worldwide. In Australia, mental illness is the largest cause of disability, accounting for 24% of the burden of non-fatal disease[1]. Furthermore, 75% of severe mental health problems emerge before the age of 25. Of the total population of young people aged between 13 and 18 years of age, it is estimated that 10% have mental health needs and 2.3% have a severe mental illness[2]. This equates to 35,044 young people with mental health needs and 8,060 with a severe mental health illness in Queensland[3].

The last national survey of child and youth mental health services was conducted in 1998 with a more recent study conducted from May through to December 2013. Results from the 2013 study will not be published until late 2014. As a consequence, there is no recent data regarding mental health services for young people in Australia at this time.

The National Mental Health Report 2013, commissioned by the Federal Government, did however find that the demand for services is on the rise, reflected in an increased rate of contact with primary mental health care by children and young people. This has increased three-fold from 2006-2007 to 2011-2012, where the increase was most marked for those aged 18-24 (rising from 2.2% to 7.5%) followed by those aged 12-17 (rising from 1.1% to 5.5%)[4].

It is also a well-known fact that young people are the most disengaged cohort along the mental health continuum, as demonstrated in the Great Smoky Mountains Study (Costello, et al, 1996) below. Consequently, the true extent of demand for services is difficult to quantify.



It has been identified by the Statewide Mental Health Network Child and Youth Advisory group, which comprises senior leaders in child and youth mental health across the state, that high risk, difficult-to-engage adolescents propose a significant risk factor for CYMHS. The Commission for Children and Young People and Child Guardian (CCYPCG) actively supports the sector's work in establishing best practice services to better meet the needs of these young people. The CCYPCG has also called on CYMHS to review current inter-Agency processes and services available to better meet the needs of these at-risk adolescents.

[1] *National Mental Health Report*, 2010, and *Mental Health Services In Brief*, 2011
[2] General Epidemiology data provided by the Mental Health, Alcohol and Other Drugs Branch
[3] Australian Bureau of Statistics, 2011, Census of Population and Housing
[4] Department of Health and Ageing, 2013, *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011*. Commonwealth of Australia, Canberra

3 The Proposed Model of Care

The proposed Model of Care provides recovery-oriented treatment and rehabilitation for young people aged 13-18 years with severe and persistent mental health issues that may include co-morbid alcohol and other drug (AOD) problems, which significantly interfere with social, emotional, behavioural, and psychological functioning and development. It is anticipated that there will be flexibility in the upper age limit, dependent upon presenting issues and developmental age, as opposed to chronological age.

The proposed Model of Care has been developed based on the recommendations from the ECRG, who explored national and international models of service, and used evidence-based practices to inform their recommendations.

The proposed Model of Care has also been developed in accordance with the principles and services outlined in the current draft of the National Mental Health Services Planning Framework (NMHSPF). The NMHSPF aims to provide a population-based planning model for mental health that will better identify service demand and care packages across the sector in both inpatient and community environments. The NMHSPF, when completed toward the end of 2014, will allow for more detailed understanding of the need for and types of mental health services across a range of environments.

Further research for this initiative included site visits to the Departments of Health in NSW and Victoria and these findings were also used to inform development.

The above recommendations, information and findings have culminated in a Model of Care comprising five service elements for extended treatment and rehabilitation.

3.1 Assertive Mobile Youth Outreach Services (New Service)

The Assertive Mobile Youth Outreach Service (AMYOS) is a new service option providing mobile assertive engagement and prevention-focused interventions in a community or residential setting. The aims of this service are to assist adolescents who are high risk and difficult to engage; to manage crisis situations; and to reduce the need for inpatient bed-based care.

Ideally, each AMYOS team would be resourced with a minimum of two full-time employees, supported by psychiatrists in statewide roles. Establishing an AMYOS team in each HHS will increase capacity to case manage an additional 16 to 20 young people, at any one time, per team, per HHS. These would be young people who would have previously not engaged with mental health services and have therefore received no mental health input, increasing their risk of suicide and other adverse or life-threatening events. The approach places a strong emphasis on the development of inter-sectorial partnerships, working with other key service providers in the community to facilitate joint care planning and case management for the young people in care.

A literature search revealed that the Victorian Intensive Mobile Youth Outreach Service (IMYOS), on which AMYOS has been modelled, is viewed as a leading service in Australia. Results from a clinical audit show that IMYOS interventions were effective in significantly lowering the risk of harm to self and others, and in reducing the number of admissions and lengths of stay in hospitals. A subsequent study found that IMYOS involvement resulted in significant improvements in client engagement and sustained engagement in treatment.[5]

[5] Schley, C., Radovini, A., Halperin, S., & Fletcher, K., 2011, *Intensive outreach in youth mental health: description of a service model for young people who are difficult-to-engage and high-risk*, Children and Youth Services Review, 33, p.1506-1514.

During a review of mental health services in Australia, the NOUS Group[6] identified that intensive case management models, such as assertive community treatment, can decrease rates and length of hospital stays, and produce cost savings. It was noted that "at the core of most successful models, and supported by a growing evidence base, is an intensive case management/care coordination function that helps patients to navigate their way through clinical and community services, thereby avoiding hospitalisation".

The inclusion of this service in the Model of Care will ensure:

- Greater flexibility to meet the needs of consumers, fostering greater participation in treatment;
- Decreased hospitalisation and lower admission rates;
- Decreased lengths of stay in acute inpatient units;
- Improvement in psychiatric symptoms and overall improved function; and,
- A more assertive approach to reducing high risk behaviours and self-harm.

3.2 Day Programs (Expanded Service)

Day Programs aim to reduce the severity of mental health symptoms and promote effective participation in areas such as schooling, social functioning, symptom management, and other life skills. They provide flexible and less restrictive treatment interventions that integrate with educational or vocational programs.

A recent evaluation of the Victorian Adolescent Day Programs suggests that they are an effective intervention for adolescents with mental health problems[7]. Adolescents reported significant improvements in peer relationships, school relationships, and overall mental health functioning with Day Program support.

It is proposed that existing Day Programs at the Mater Hospital, Toowoomba and Townsville be expanded through the addition of three new units in south-east Queensland, taking the total number to six Day Programs in Queensland. Each Day Program can treat up to 15 adolescents per day per unit. Expansion of these units would mean care could be provided for up to 45 additional adolescents per day, and an even greater number over the course of a week due to variations in individual care plans (most adolescents attend a day program 2 to 3 days per week).

Currently, there are only two day programs to service south east Queensland, where approximately 74% of the state's adolescent population reside. It has therefore been identified as a significant gap in service, with north Brisbane considered the most critical area.

3.3 Residential Rehabilitation Units (New Service)

The Residential Rehabilitation Units (Resi's) are a new service providing long-term accommodation and recovery-oriented treatment in partnership with non-government organisations (NGOs), with inreach services provided by mental health specialists. Each Resi can accommodate 5 to 10 beds per unit and would be established in areas where there is NGO support.

The Resi spans a gap in service for young people, aged 16 to 21 years, who do not have the skills or expertise for independent living, or a stable place of accommodation. This service focuses on supporting young people to:

[6] Nous Group, 2013, *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design*, www.medibankhealth.com.au/Mental_Health_Reform

[7] Kennair, N., Mellor, D., & Brann, P., 2011, *Evaluating the outcomes of adolescent day programs in an Australian child and adolescent mental health service*, Clinical Child Psychology and Psychiatry, 16, 21-31.

- Improve their capacity to manage and be responsible for self-care;
- Enhance their adaptive coping skills and decrease self-harming behaviour;
- Enhance their social and daily living skills to improve their ability to live independently in the community; and
- Develop and maintain links with the community, family, and social networks, education and vocational opportunities.

It is well recognised across the sector that there is a significant lack of supported accommodation for adolescents with mental health and substance abuse issues, and who sit outside the child protection system. One of the findings from an external review of the Barrett Adolescent Centre in 2009 was the absence of supported accommodation to transition adolescents out of the centre and back into the community, where the young person was unable to return to their family of origin.[8] This finding was also evidenced by the increasing average length of stay in the centre, which rose from 3 months at opening in to 4 years at the time of the review in 2009.

In a Victorian study, people recovering from mental illness identified that stable and affordable housing as the most critical issue affecting quality of life and capacity for recovery. It is estimated that over 40% of young people with severe mental illness are homeless or housed in tenuous forms of accommodation, often interspersed with periods of hospitalisation and sometimes incarceration.[9] The Victorian Government consequently continues to invest $8 million per annum in youth residential rehabilitation services, providing 166 beds through 17 Resi's across the state.[10]

Queensland has 80% of the population of Victoria and yet seven times the geographic area to cover.[11] To produce the same outcomes as the Victorian service model, Queensland would require 14 Resi's providing up to 140 beds across the state. Due to funding limitations, however, it is proposed that a Resi be established in each Mental Health Cluster (North, Central, and South – three in total) until success of this service in Queensland can be evaluated, supporting the establishment of more units.

3.4 Step Up / Step Down Units (New Service)

The Step Up / Step Down Unit (SUSDU) is a new service option providing short-term residential treatment by mental health specialists in partnership with NGOs. These purpose-built units could have up to 10 beds per unit and be established in areas where there is NGO support.

The SUSDU are provided for young people who have recently experienced, or who are at increased risk of experiencing, an acute episode of mental illness. The young person usually requires a higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided for in the community, but does not require the treatment intensity provided by acute inpatient units. It is therefore seen as a necessary and cost-effective addition to the continuum of care proposed.

These units are based on the Youth Prevention and Recovery Care (Y-PARC) services delivered in Victoria, which have anecdotally been proven effective at:

- Preventing further deterioration of a person's mental state and associated disability, and in turn reduced likelihood of admission to an acute inpatient unit (Step Up).

[8] *Review of the Barrett Adolescent Centre*, 2009, commissioned by the CE, Darling Downs - West Moreton Health Service District
[9] Nous Group, 2012, *Review of the PDRSS Day Program, Adult Residential Rehabilitation and Youth Residential Rehabilitation Services for the Victorian Department of Health*
[10] Ibid.
[11] http://www.ga.gov.au/education/geoscience-basics/dimensions/area-of-australia-states-and-territories.html

- Enabling early discharge from acute mental health inpatient units through the provision of an intensive safe and supportive sub-acute residential community program (Step Down).

There are currently three Y-PARCs in Victoria. Success of this service has created an impetus for the Victorian Government to explore the establishment of more, with the Victorian Minister for Mental Health stating, "This service has a critical role in caring for young people, providing intensive help earlier...it is particularly aimed at young people who need residential support as an alternative to inpatient care, or to help them transition from hospital back into the community."[12]

It is proposed that a SUSDU be established in each Mental Health Cluster (North, Central, and South – three in total) until success of this service in Queensland can be evaluated, supporting the establishment of more units.

3.5 Statewide Subacute Beds (New Service)

The statewide subacute beds are a new service providing medium-term, intensive, hospital-based treatment in a safe and structured environment for young people with severe or complex symptoms of mental illness and associated significant disturbance in behaviour that precludes them receiving treatment in a less restrictive environment.

Unlike acute inpatient units, this service is designed to undertake comprehensive assessments of issues, complicated by a high degree of complexity and chronicity, which young people and their families present with, particularly within a care-giving context. Organisation of ongoing care in these complex and chronic clinical presentations requires extensive collaboration and coordination that is beyond the scope and time available to acute inpatient units.

At this point in time, the demand for this service is unclear; however, it was noted by the ECRG that this service is an essential component of an overall model of care as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types.[13]

CHQ has established an interim arrangement with the Mater Hospital to provide two subacute beds to meet the needs of the more high-risk end of the mental health spectrum, previously treated in BAC, to ensure there is no gap in service to adolescents. This arrangement is in place for a period of nine months, until November 2014, to assess demand for longer term subacute beds. While the level of need for this service is determined, planning has commenced to allocate space for four subacute beds within the Lady Cilento Children's Hospital at South Brisbane.

It is important to note that the above Model of Care, and underpinning five service elements:

- Is supported by existing Community Child and Youth Mental Health Services and seven acute inpatient units located throughout Queensland (Royal Children's Hospital, Royal Brisbane and Women's Hospital, Mater, Logan, Robina, Toowoomba, and Townsville HHSs);
- Is based on evidence-informed services delivered in other States;
- Acknowledges the importance and role of education in all service options; and,
- Includes active engagement of the Non-Government Sector for service provision.

[12] Department of Health news release, 2012, *New youth mental health service opens on Peninsula*, http://www.health.vic.gov.au/news/youth-mental-health-service-opens-on-peninsula.htm
[13] Expert Clinical Reference Group, 2013, *Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services*

Delivering a range of services along a continuum of care provides:

- Greater choice in services for young people that will best meet their mental health recovery, and reduces the risk of disengaging from local mental health services;
- Ease of transition between services across the continuum;
- Reduced admissions into hospital-based services;
- Extended cover across the large, decentralised state of Queensland;
- Decreased risk of institutionalisation of young people by avoiding lengthy inpatient admissions away from their family home and/or community;
- Reduced reliance on bed-based options thereby increasing the capacity for families and support people to remain engaged in the young person's treatment; and
- Improved engagement and collaboration with service providers from other agencies and sectors.

The model of care improves on current service delivery through:

- Broader, comprehensive psychiatric input across the sector;
- Extended hours of service across the state; and,
- Speedier transition of young people back to their family and communities as a result of reduced lengths of stay at inpatient units and the provision of additional local support services, thereby reducing the risk of secondary disability as a consequence of institutionalisation, developmental arrest, deskilling, and disconnection from families, communities, and local mental health services.

Key stakeholders who were consulted on development of this Model of Care, including clinical experts, consumers, and their families, identified both the AMYOS and Resi's as priority services for implementation.

4 Issues

During development of the proposed Model of Care, the following issues were identified:

Age Limit

There is a need for flexibility in the upper age limit, which is currently set at 18 years of age. While eligible for adult mental health services, the developmental age of some adolescents is not reflective of their chronological age and more supportive and developmentally appropriate service options are needed for young people up to 21 years of age.

The Resi is currently the only service in the continuum that specifically accommodates an age range up to 21 years old. Whilst other services proposed would be able to service the same age range, it is not a supported mental health position in Queensland. Further consideration needs to be given to raising the age limit for all services in the proposed Model of Care.

Skilled Workforce

There is a current short fall in clinical child and youth mental health staff in Queensland. The 2017 target for full time equivalent (FTE) staff is estimated at 14 FTEs per 100,000 population[14]. As at June 2012, child and youth mental health FTEs were only at 58% of the total number of staff required. It is important to note that recruiting a suitably skilled workforce will be a significant critical success factor for service implementation.

Location of Services

A significant complexity for service delivery in Queensland is the geographic spread of consumers across the state. As demonstrated below, Queensland has the third highest population in Australia with the second largest land mass, over double the size of NSW and up to seven times that of Victoria.

State[15]	Population in millions	Square Kilometres in millions
New South Wales	7.407	0.801
Victoria	5.737	0.227
Queensland	**4.658**	**1.731**
Western Australia	2.517	2.529

The location and implementation of services will need to be prioritised against the demand for services based on population data. 2011 Census data estimates the adolescent population of Queensland (aged between 13 and 18 years of age) at 350,442[16], approximately 74% of which live in south-east Queensland. This data is presented in the tables below: the first table is sorted by population and the second table is sorted by mental health cluster.

[14] Community Mental Health Services Full Time Equivalent Report, Mental Health Alcohol and Other Drugs Branch, Qld Health

[15] http://www.ga.gov.au/education/geoscience-basics/dimensions/area-of-australia-states-and-territories.html

[16] Australian Bureau of Statistics, 2011, Census of Population and Housing

Table 1: Young Persons aged 13 to 18yo in Place of Usual Residence[17]

Geographical Catchment	Youth Pop'n	10% with Mental Health Needs[18]	2.3% with Severe Illness[19]
Metro North	43,958	4,396	1,011
Gold Coast	42,809	4,281	985
Logan/ Bayside/ Beenleigh	41,348	4,135	951
Metro South	39,961	3,996	919
Sunshine Coast	27,842	2,784	640
Darling Downs	26,067	2,607	600
Redcliffe/ Caboolture	23,095	2,310	531
Cairns and Hinterland	19,745	1,975	454
Central Queensland	18,657	1,866	429
Townsville	18,501	1,850	426
Wide Bay	16,199	1,620	373
West Moreton	14,056	1,406	323
Mackay	13,776	1,378	317
South West	1,779	178	41
Torres Strait-Northern Peninsula and Cape York	1,358	136	31
Central West	796	80	18
North West	495	50	11
TOTAL	**350,442**	**35,044**	**8,060**

[17] Australian Bureau of Statistics, 2011, Census of Population and Housing
[18] General Epidemiology data provided by the Mental Health, Alcohol and Other Drugs Branch, Queensland Health
[19] Ibid.

Table 2: Young Persons aged 13 to 18yo by Mental Health Cluster

Geographical Catchment	Youth Pop'n	10% with Mental Health Needs	2.3% with Severe Illness	By Cluster
Gold Coast	42,809	4,281	985	Southern
Logan/ Bayside/ Beenleigh	41,348	4,135	951	Southern
Metro South	39,961	3,996	919	Southern
Darling Downs	26,067	2,607	600	Southern
West Moreton	14,056	1,406	323	Southern
South West	1,779	178	41	Southern
TOTAL	**166,020**	**19,386**	**4,459**	
Metro North	43,958	4,396	1,011	Central
Redcliffe/ Caboolture	23,095	2,310	531	Central
Sunshine Coast	27,842	2,784	640	Central
Central Queensland	18,657	1,866	429	Central
Wide Bay	16,199	1,620	373	Central
Central West	796	80	18	Central
TOTAL	**130,547**	**10,271**	**2,362**	
Cairns and Hinterland	19,745	1,975	454	Northern
Townsville	18,501	1,850	426	Northern
Mackay	13,776	1,378	317	Northern
Torres Strait-Northern Peninsula and Cape York	1,358	136	31	Northern
North West	495	50	11	Northern
TOTAL	**53,875**	**5,388**	**1,239**	

Non-Government Organisation Engagement

Two of the new services proposed are dependent upon NGO collaboration. It is important to note that the Queensland NGO market is relatively immature in the specialised field of adolescent mental health services. It is therefore acknowledged that NGOs will require time to build skills and capabilities to deliver services. Furthermore, time will be required to undertake robust procurement processes.

Service Governance

There is a risk that funding for adolescent mental health services may be reallocated to other services where appropriately skilled resources cannot be recruited. To mitigate this risk, governance and funding will be overseen by CHQ, as part of its statewide remit for children's health services. This will be managed through Service Level Agreements with respective Hospital and Health Services (HHS). Day-to-day reporting and management of positions under the AMYOS, Day Program, and SUSDU services will be the remit of the local HHS.

5 Financial Analysis

5.1 Current Funding Available

Current operational funding includes a reallocation of approximately $3.8m recurrent operational funding from the BAC. This amount has decreased since 2011/12 due to a 50% reduction in staffing at the BAC, removing approximately $2m from the adolescent mental health sector.[20]

In addition to the BAC operational funds, $2m recurrent operational funding will come from the ceased Redlands Project. This equates to a total of $5.8m for adolescent mental health extended treatment and rehabilitation services in Queensland.

It should be noted that there is no capital funding currently available to establish new services.

In contrast, the Department of Communities currently provides $18 million per annum to fund the Evolve program.[21] Evolve, a comparative service to the adolescent mental health service, provides therapeutic and behavioural support for children in out-of-home care with complex and severe needs who are under a child protection order (typically the top 3% of complex mental health cases requiring child protection). This would support the position that the current identified operational funds of $5.8m are insufficient to care for the much larger cohort of young people, outside the child protection system, with severe or complex mental health needs.

Additional recurrent operational and capital funding will be required to implement the proposed model of care and to realise the full benefits and outcomes that an enhanced continuum of services could provide.

5.2 Recurrent and Capital Cost Options

A phased approach to implementation has been developed with consideration of population, demand, and the local mental health service capacity to enhance services in the proposed locations. Consideration has also been given to local mental health service infrastructure, and the capacity to support new services and integrate them within existing team structures. It would be envisaged that the commencement of services in larger metropolitan and regional areas would ensure robust clinical and corporate governance systems, enable an integrated approach, and support the implementation of an evaluation framework, all of which will be critical to the success of the new services. These initial sites will help shape and promote the implementation of a sustainable and transferable model that can be adapted to the individual needs of the local HHS. The level of state-wide support required for more rural and remote areas could then be determined prior to implementation of more new services. Shared learnings would be used to inform the structures of new services in areas with less mental health capacity to ensure the optimal level of safe, appropriate, and effective care.

The format for service implementation has also been developed based on the following assumptions:

- Acknowledgement that all resources cannot be recruited at once;
- Recurrent funding sources need to be identified for new services;
- Service coverage in metro and regional areas will expand over time; and
- Telepsychiatry support from centralised CYMHS specialists will be a requirement to support clinical services in rural and remote areas.

[20] Child and Adolescent Mental Health FTE data, 2011-12, provided by the Mental Health, Alcohol, and Other Drugs Branch
[21] Department of Communities, Child Safety, and Disabilities 2012-13 Annual Report

5.2.1 Recurrent Costs

The proposed implementation, including budgeted expenditure, is outlined below. It is anticipated that three new services could be funded through current identified operational funding, being a Residential Rehabilitation Unit, a new Day Program Unit, and seven AMYOS teams (highlighted in blue below). These services alone would treat up to 130 more young people per week than could be cared for had the BAC remained open.[22]

Statewide Adolescent Extended Treatment and Rehabilitation Strategy Business Case Summary

Service Funding Options v4.0	Service Commences	2014/15	2015/16	2016/17
Residential Rehabilitation Unit	February	$1,379,025	$1,488,212	$1,527,111
Interim Statewide Subacute Beds	February	$76,813	$0	$0
Statewide Assessment Panel (Coordinator)	From July	$79,539	$81,542	$83,597
AMYOS Psychiatrists x 2 + coordinators	From July	$939,060	$928,872	$952,218
AMYOS x 7 Teams	From July	$1,955,843	$2,165,549	$2,220,493
New Day Program (North Brisbane)	From July	$1,456,001	$1,494,066	$1,533,134
TOTAL		**$5,886,281**	**$6,158,241**	**$6,316,553**

The following table identifies new recurrent operational funding required to implement the full model of care.

Service Funding Options	Commence	2014/15	2015/16	2016/17
Statewide Subacute Beds (4 beds)	From	$661,455	$1,005,880	$1,031,317
AMYOS Psychiatrists x 2	Jul-14	$756,079	$734,131	$752,639
AMYOS x 12 Teams (rest of Qld)		$3,719,396	$3,712,369	$3,806,559
TOTAL		**$5,136,930**	**$5,452,380**	**$5,590,515**
Day Program 2 (Logan)	From	$0	$1,528,015	$1,568,101
Resi Rehab Unit 2 (North Cluster)	Jul-15	$0	$1,570,550	$1,527,111
Step Up/Step Down Unit 1 (Central Cluster)		$0	$3,586,651	$3,648,007
TOTAL		**$0**	**$6,685,216**	**$6,743,219**
Day Program 3 (Gold Coast)	From	$0	$0	$1,568,101
Resi Rehab Unit 3 (Central Cluster)	Jul-15	$0	$1,570,550	$1,527,111
Step Up/Step Down Units 2 & 3 (North & Southern Clusters)		$0	$3,586,651	$7,330,981
TOTAL		**$0**	**$5,157,201**	**$10,426,193**
GRAND TOTAL		**$5,136,930**	**$17,294,797**	**$22,759,927**

Implementation of the full Model of Care would mean that each week an additional 260 young people with serious and complex mental health problems such as suicidality, depression and psychosis, who would otherwise disengage or be unable to obtain mental health services, would receive appropriate care.[23]

[22] The Barrett Adolescent Centre was a 15 bed unit plus Day Program with 15 places – providing care for up to 30 young people at any one time.

[23] Figures are based on approximate caseload numbers per service and don't account for differences in care plans, duration of treatment and lengths of stay for individual consumers across the continuum of services.

5.2.2 Capital Costs

The following capital estimates are based on fit out and building estimates for the construction of similar bed-based units in Queensland, and are an indication of the type of capital investment that would be required. The accuracy of these estimates would need to be verified by an appropriately qualified quantity surveyor.

Capital Fit-Out Costs ($2,000/sqm)	2014-15	2015-16	2016-17
Day Program (2 units)		$501,272	$516,310
Step Up/Step Down Unit (3 units)		5,092,320*	$ 2,622,545
Total	**$0**	**$5,593,592**	**$3,138,855**
Capital Construction Costs ($3,200/sqm)			
Day Program (2 units)		$1,612,568	$1,660,945
Step Up/Step Down Unit (3 units)		$10,863,616*	$5,594,762
Total	**$0**	**$12,476,184**	**$7,255,707**

* Cost for establishing two Step Up/Step Down Units in 2015/16.

Due to the complexity of individual mental health care provided to young people, it is not possible to calculate an accurate cost per consumer for each service. Care plans, duration of treatment, and length of stay will differ for each individual consumer across the continuum of care.

6 Recommended Option

To deliver a robust and comprehensive model for adolescent mental health care, it is strongly recommended that the full spectrum of services be funded. It is important that each service element is not viewed as a stand-alone component of the model but rather as a necessary integrated element along a continuum.

If these services are not funded, gaps in delivery and care will remain. In the absence of appropriate community care, there is an increased risk of recurrence in mental illness, self-harm, and suicide upon discharge from acute inpatient units, greater number of admissions into acute inpatient units, and longer lengths of stay in acute inpatient units. The ability for consumers, and their families, to navigate their way through clinical and community services will continue to be challenging and difficult without the support of intensive case management and coordination. Furthermore, without appropriate funding, adolescent mental health services in rural and regional areas will remain limited. Young people will need to be removed from their families and communities in order to receive appropriate mental health treatment. Risks of institutionalisation and deskilling as a result of lengthy hospital inpatient admissions will continue, and the follow up and recovery of consumers on discharge will be compromised.

Following the closure of the BAC, and the increased public scrutiny into adolescent mental health treatment, any gaps in the continuum of care that result in poor mental health outcomes, including the risk of significant self-harm or suicide, exposes the Government and CHQ to significant reputational risk.

Attachment 1: Consultation undertaken:

An **Expert Clinical Reference Group** (ECRG) was convened, consisting of a consumer representative, a carer representative, an interstate Child and Adolescent Psychiatrist, multi-disciplinary Child and Youth clinician representation (including north Queensland), a representative of BAC, a representative of the BAC School, and a Non-Government Organisation (NGO) representative. The ECRG was chaired by the Director of Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch (MHAODB). The ECRG reported up to the WM HHS via a **Planning Group**, which was chaired by the Executive Director of Mental Health & Specialised Services, WM HHS.

Seven recommendations were submitted by the ECRG and considered by the WM HHS Board (**Appendix 1**). This was followed by comprehensive consultation with the Minister for Health, the Queensland Mental Health Commissioner, CHQ HHS, Department of Education Training and Employment (DETE), and the Department of Health.

In August 2013, the Statewide Adolescent Extended Treatment and Rehabilitation Strategy (now known as the Adolescent Mental Health Extended Treatment Initiative or AMHETI) was established. The **AMHETI Steering Committee** met for the first time on 26th August. The purpose of the AMHETI Steering Committee is to oversee the implementation of AMHETI, and provide a decision-making, guidance, and leadership role with respect to mental health service planning, models of care, workforce planning, financial management and consumer needs associated with future adolescent extended treatment and rehabilitation services. The committee is co-chaired by the Divisional Director and Medical Director of the CHQ Child and Youth Mental Health Service (CYMHS). Membership includes representatives from Mental Health (Metro South, Mater, Townsville, and West Moreton HHS), the CHQ HHS, MHAODB, headspace, and a consumer and carer.

On 1st October, the **Service Options Implementation Working Group** was convened. The purpose of this group was to develop contemporary service options, within a statewide model of service, for adolescent mental health extended treatment and rehabilitation. The group was chaired by the Manager, Clinical Governance Office of the Chief Psychiatrist – the Mental Health, Alcohol, and Other Drugs Branch (MHAODB), and comprised of representatives from across the state and Hospital and Health Service Districts, including mental health clinicians across nursing, allied health and medical professions, a carer representative, and a non-government organisation representative.

Supporting References and Project Documentation:

- Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care (**Appendix 2**) and Detailed Service Elements (**Appendix 3**)
- Adolescent Mental Health Extended Treatment Initiative Project Plan
- Victorian Site Visit Report, 2013
- NSW Site Visit Report, 2013
- Queensland Plan for Mental Health 2007-2017
- COAG National Action Plan on Mental Health 2006-2011
- COAG Roadmap for National Mental Health Reform 2012-2022
- National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011. Commonwealth of Australia, Canberra
- Mental Health Services In Brief, 2011
- National Mental Health Report, 2010

- Community Mental Health Services Full Time Equivalent Report (2012), for the Mental Health Alcohol and Other Drugs Branch
- Intensive Mobile Youth Outreach Service (IMYOS) Information Sheet (2012), Victorian Department of Health
- Youth Prevention and Recovery Care (Y-PARC) Model of Care, Victorian Department of Health
- Adult Prevention and Recovery Care (PARC) Services Framework and Operational Guidelines (2010), Victorian Department of Health
- Intensive outreach in youth mental health, 2011, Children and Youth Services Review, Vol. 33, 1506-1514
- Review of the PDRSS Day Program, Adult Rehabilitation and Youth Residential Rehabilitation Services (2011), for the Victorian Department of Health, Nous Group
- The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design, Nous Group

M

Rebecca Bensted

From: Anne Brennan
Sent: Thursday, 20 February 2014 2:35 PM
To: Stephen Stathis
Subject: RE: BAC waitlist

My thoughts re these consumers:

[redacted]

Anne
A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health
[redacted]

>>> Stephen Stathis 2/20/2014 12:32 pm >>>

No trouble, Anne.

Leanne and I had a very productive meeting working through young people: See attached.

[redacted]

I've cc'd Ingrid into this email, as she is the 'keeper of all documents'!!

Cheers

Stephen

From: Anne Brennan [ ]
Sent: Thursday, 20 February 2014 9:46 AM
To: Stephen Stathis; Leanne Geppert
Subject: Re: BAC waitlist

Hi
I am very sorry that I did not respond. I am not working Wednesdays and have no remote email access. Available today if you are.
Anne

A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health
Ph

>>> Leanne Geppert 2/18/2014 7:55 pm >>>
ok, will wait to see if Anne ok with time, and i have asked jill to arrange tconf. will send thru details to you tomorrow am, L

Dr Leanne Geppert
Sent from my iPad

> On 18 Feb 2014, at 7:45 pm, "Stephen Stathis " wrote:
>
> That works fine 4 me. R u free then, Anne. Do we need to set up a teleconference or will the two of you ring in together?
>
> Sent from my iPhone
>
> On 18/02/2014, at 7:14 PM, "Leanne Geppert" < > wrote:
>
> Hi all
> I am doing interviews tomorrow until 3.30. Would 4pm be ok just to be safe? I think we may be in 3 different locations for the phone in - I can ask Jill (Berni is away tomorrow) to org tconf facility, and send through details to you if that suits.
> L
>
> Dr Leanne Geppert
> Sent from my iPad
>
> On 18 Feb 2014, at 5:30 pm, "Stephen Stathis < >"
< > wrote:
>
> Sounds like a very logical plan, Leanne. I fear this is driving me to become a risk-management beaurocrat rather than a clinician.
> Are you both free sometime tomorrow afternoon after 3PM? 15-20 minutes should do it.
> Stephen
>
> _____

> From: Leanne Geppert [ ]
> Sent: Tuesday, 18 February 2014 5:13 PM
> To: Stephen Stathis; Anne Brennan
> Subject: RE: BAC waitlist
>
> Hi to you both
> Might be worth reconvening over phone about this?
> As you say Anne, Kathy has contacted CYMHS and there are cases of long disengagement from the CYMHS. I am concerned about sending a letter directly to parents from BAC waitlist out of the blue, saying we are closed and to recontact local CYMHS if support needed - if the parents have an expectation that the referral is still active, it may not be the right way to share the information.
> I think it would be better if the referring CYMHS contacted the family - realistically, they should have withdrawn the BAC referral at the time they discharged the young person, and if the contact raises ongoing mental health issues, they would be the service to respond.
>
> Happy to touch base quickly for 10 mins sometime to discuss if you have time, L
>
> Dr Leanne Geppert
> Acting Director of Strategy
> Mental Health & Specialised Services
> _____
> West Moreton Hospital and Health Service
> T:
> M:
> E:
>
> The Park - Centre for Mental Health
> Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
> Locked Bag 500, Sumner Park BC, QLD 4074
> www.health.qld.gov.au<http://www.health.qld.gov.au/>
>
>
>
>>>> Anne Brennan 2/18/2014 3:54 pm >>>
> Hi Stephen and Leanne
> There seems to be a range of opinions as to how to deal with these final few on the waitlist.
> We concluded our teleconference 2 weeks ago with a plan that involved Kathy Stapley contacting the families. She preferred to contact the CYMHS clinics so we wrote letters to families and called the clinics.
>
> Those letters have been witheld and I understand from Berni that Leanne's preference is for CYMHS to contact families.
>
> Stephen, you are suggesting CYMHS clarify situation and then I offer assessment of needs. When we have called CYMHS they have informed us of long non-attendance but they have no indication of reasons for disengagement. Where they have had info, I have documented that to you both.
>
> I am happy to do whatever you both think best to finalise these cases. Let me know the plan.
> Anne
>
> A/Clinical Director
> Barrett Adolescent Centre
> The Park-Centre for Mental Health
> Ph
>
>
>>>> Stephen Stathis < > 2/14/2014 5:09 pm >>>
> Thanks for all this follow up, Anne and Leanne.
> Anne, in your transitional role it would be wise to attempt to contact these families and find out what the reasons for disengagement were. We are unable to offer increased services at this time; they would need to be followed up at their local CYMHS or other appropriate local services. In your role, you could offer a reassessment to determine if their mental state had deteriorated and/or you still believe they need mental health support if so, broker a re-engagement with CYMHS (or other mental health services). We would need to let the local CYMHS know

beforehand, to make certain they agree with the plan. Might be going overboard, but I am aware of the political sensitivities of these young people.
> Give me a call if you have other thoughts/questions.
> Cheers
> Stephen
> Ps. Thanks for your suggestions last night, Anne. Very helpful.
>
> _____
> From: Anne Brennan [ ]
> Sent: Friday, 14 February 2014 12:46 PM
> To: Leanne Geppert
> Cc: Stephen Stathis
> Subject: =?utf-8?B?UmU6IEJBQyB3YWl0bGlzdA====?=

[redacted]

> Anne
>
> A/Clinical Director
> Barrett Adolescent Centre
> The Park-Centre for Mental Health
> Ph
>
>
>>>> Leanne Geppert 2/14/2014 12:12 pm >>>
> thanks Anne
> so, are we confident that no one has fallen through the gaps? L
>
> Dr Leanne Geppert
> Acting Director of Strategy
> Mental Health & Specialised Services
> _____
> West Moreton Hospital and Health Service
> T:
> M:
> E:
>
> The Park - Centre for Mental Health
> Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
> Locked Bag 500, Sumner Park BC, QLD 4074
> www.health.qld.gov.au<http://www.health.qld.gov.au/>
>
>
>
>>>> Anne Brennan 2/13/2014 4:56 pm >>>
> Hi Leanne and Stephen
> All consumers on BAC waitlist and assessment list have been contacted,or the referring service has been or in some cases both.
> Spreadsheet attached.
> Let me know if there is further action required.
> Anne
>
> A/Clinical Director
> Barrett Adolescent Centre
> The Park-Centre for Mental Health
> Ph

N.

Stephen Stathis

From: Anne Brennan <[redacted]>
Sent: Tuesday, 25 February 2014 3:52 PM
To: Stephen Stathis; Bernice Holland; Kathy Stapley; Leanne Geppert
Subject: Re: Fwd: BAC Follow up

In my spreadsheet attached to email 12/2/14 there is further info re each of these consumers. It is not on CIMHA.

[redacted]

A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health
[redacted]

>>> Leanne Geppert 2/25/2014 3:02 pm >>>
Thank you Kathy, again this is excellent work and very helpful.

Stephen and Anne, these do look like they need further consideration. Shall I get Berni to arrange a 30min t/conf for us?
regards
Leanne

Dr Leanne Geppert
Acting Director of Strategy
Mental Health & Specialised Services

West Moreton Hospital and Health Service
T: [redacted]
M: [redacted]
E: [redacted]

The Park - Centre for Mental Health
Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
Locked Bag 500, Sumner Park BC, QLD 4074
www.health.qld.gov.au

Guideline

Document Number QH-GDL-365-5:2015

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

1. Purpose

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

Scope

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

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

2. Related documents

Authorising Policy and Standard/s:

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

Procedures, Guidelines and Protocols:

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

Queensland Government

Forms and templates:

- Statewide suite of clinical documentation.

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

Background

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

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

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

The key aims of transition planning are to ensure that:

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

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

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

Context

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

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

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

A systematic and formal transition process

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

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

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

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

Early preparation

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

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

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

Preparation will involve:

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

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

Identification of a local transition coordinator/facilitator

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

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

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

Good communication

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

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

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

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

Individual transition plan

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

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

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

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

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

Encourage and enable young people to self-manage

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

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

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

Follow up and evaluation

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

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

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

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

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

5. Review

This Guideline is due for review on: 21 September 2018

Date of Last Review: Not applicable

6. Business Area Contact

Mental Health Alcohol and Other Drugs Branch

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

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

8. Approval and Implementation

Policy Custodian:

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

Responsible Executive Team Member:

Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

Approving Officer:

Executive Director, Mental Health Alcohol and Other Drugs Branch

Approval date: 21 September 2015

Effective from: 21 September 2015

Version Control

Version	Date	Prepared by	Comments
V.1	07.09.2015	L Wagner	Final Version