Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Sharon Kelly
Executive Director Mental Health and Specialised Services
Telephone:
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Ms Kristi Geddes
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PO Box 7844
Waterfront Place QLD 4001

By Email:

Dear Ms Geddes

Health Service Investigation – Barrett Adolescent Centre (Your Ref: SGE KXMM 1084936)

I refer to your letter to me dated 11 September 2014 regarding the investigation under Part 9 of the *Hospital and Health Boards Act 2011* (the Act) in relation to the closure of the Barrett Adolescent Centre (the Centre).

I understand that the investigators are seeking further information and/or documents to assist with their investigation, and have sought this information pursuant to section 194(2) of the Act.

With respect to the further information and/or documents requested, I advise as follows:

1. **Any document setting out a statement of duties or role description for care coordinators**

   Please find enclosed the following documents which set out the duties and roles of care coordinators (also known as case coordinators):

   Attachment 1 – Document titled 'Case Coordinator's Role' for the Centre – This document was located following a review of the Centre's records.

   Attachment 2 – Care Planning Package Tool Kit – This document describes the philosophy behind care planning, the roles and associated tasks, and forms part of a suite of tools and resources available to all care coordinators at The Park – Centre for Mental Health Treatment, Research and Education (The Park) via a shared electronic staff folder. This folder is accessible by way of an icon on the desktop of all clinical area computers.

Attachment 3 – Individual Care Plan Checklist: Adolescent - Care coordinators of the Centre utilised the Individual Care Plan Checklist to guide care planning at new episodes, standard and ad hoc review points, and at the end of an episode.

Attachment 4 – Extract from a document titled "The Barrett Adolescent Centre - Information for Teenagers" – This document was provided to each patient upon their admission to the Centre. The extract explains the role of the care coordinator on page 8.

Attachment 5 – Extract from a document titled "The Barrett Adolescent Centre – Information for Parents and Carers" – This document was provided to the parents of each patient upon their admission to the Centre. The extract also explains the role of the care coordinator on page 5.

The staff orientation program for all clinical staff includes a session on care planning and recovery, and introduces the statewide Consumer Integrated Mental Health Application (CIMHA) and expectations of CIMHA use across all clinical settings. A summary of the purpose and requirements of CIMHA is attached (Attachment 6). All care coordinators use CIMHA to provide shared access to their Consumer Care and Review Summaries which summarise the care being provided to each patient. They also use CIMHA to participate in Discharge Summaries issued by the patient's treating clinician.

2. **Information about the shared role of care coordinators, where patients were allocated more than one or also allocated an 'associated care coordinator', including whether there were clearly delineated roles between them**

As explained in the Care Planning Package Tool Kit at Attachment 2, each patient is allocated one care coordinator (CC), and ideally one care coordination associate (CCA). Patients are not allocated more than one CC. The role of the CCA is to proxy for the CC when that person is unavailable and to take on duties delegated by the CC. The CCA has the same authority as the CC, but cannot plan care, except in consultation with the CC, or, in the case of Enrolled Nurses, Rehabilitation Therapy Aides and discipline associates, under the supervision of a Registered Nurse or the relevant qualified discipline clinician.

The Care Planning Package Toolkit further defines the roles of CCs vis-à-vis CCAs.

3. **Information and/or documents about the 'business as usual' transition/discharge practice for the service, as articulated in formal policies and procedures, including any service transition/discharge policy or procedure**

Please find enclosed the following documents which describe the 'business as usual' transition/discharge practices for all mental health services, including the Centre:

Attachment 7 – Procedure titled "Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts" – This procedure was effective from 8 November 2010 until 12 May 2014 and describes the processes for managing the transfer of care of mental health consumers. Following the formation of Hospital and Health Services on 1 July 2012, this procedure continued to apply and be followed with all references to "Districts" being interpreted as referring to "Hospital and Health Services".

Attachment 8 – Procedure titled "Inter Hospital and Health Service Transition of Care of Mental Health Consumers from one Hospital and Health Service to another". This procedure replaced the procedure enclosed at Attachment 7, coming into effect on 13 May 2014 and reflects the transition to Hospital and Health Services.

Attachment 9 – Further extract from the document titled "The Barrett Adolescent Centre – Information for Parents and Carers". The extract provides a summary of discharge planning for patients admitted to the Centre.

Also, as referenced in Attachment 6, CIMHA is a key statewide tool supporting a range of clinical processes including discharge of patients and transition of care from one service to another.

4. **Any specific policies, procedures and/or statements of duties put in place for the transition coordination for these particular patients**

There were no specific policies, procedures or statements of duties put in place for the transition coordination of the adolescents who were inpatients or day patients of the Centre between 6 August 2013 (when the Centre's closure was announced) and January 2014 when the Centre was closed.

All staff involved in the transition of these patients were expected to employ 'business as usual' transition practice, policies and procedures for these patients as further outlined at point 3 above with the additional support offered by the West Moreton Management Committee, the Clinical Care Transition Panel and the Complex Care Review Panel.

5. **Further information about the role played by RN Vanessa Clayworth and Megan Hayes, OT, in the transition planning process, including whether specific roles were ever formalised and copies of any applicable written statements of duties and/or role descriptions developed**

RN Vanessa Clayworth

RN Vanessa Clayworth was appointed as the Acting Nurse Unit Manager of the Centre on 5 August 2013. In this role, Ms Clayworth was responsible for providing clinical advice in respect of the care of the Centre's patients, as well as overseeing the day-to-day management of the Centre.

Shortly following the announcement of the Centre's closure, it was recognised that extra clinical support would be required to assist with the transition of the affected patients' care from the Centre to alternative services.

Accordingly, in October 2013, Ms Clayworth was moved into the role of Acting Clinical Nurse Consultant. This allowed Ms Clayworth to focus on providing clinical advice on the care planning of the patients being transitioned and to provide clinical support to the Clinical Care Transition Panel and the Complex Care Review Panel.

The day-to-day management of the Centre which was formerly part of Ms Clayworth's role was assumed by Mr Alex Bryce, who was appointed as the Acting Nurse Unit Manager of the Centre on 14 October 2013.

The role description for the Nurse Unit Manager role at the Centre is attached as Attachment 10. The Clinical Nurse Consultant role comprises the clinical component of the Nurse Unit Manager role. Hence, when Ms Clayworth moved into the role of Acting Clinical Nurse Consultant as described above, she continued to perform the clinical component of her Nurse Unit Manager role while the non-clinical components were performed by Mr Bryce. We have been unable to locate a role description for a Clinical Nurse Consultant at the Centre, however we have enclosed a role description for a Clinical Nurse Consultant in our Medium Secure Unit to provide more clarity around the role of a Clinical Nurse Consultant (see Attachment 11). The Nurse Unit Manager role description (including the clinical component of it) continued to apply to the roles during the transition period and was not amended to reflect the specificities of this particular assignment.

The above changes in roles were communicated to staff by way of a staff communique issued on 3 October 2013, a copy of which is attached at Attachment 12.

Megan Hayes, Occupational Therapist

Ms Megan Hayes was a trusted and experienced allied health clinician at the Centre, employed as an Occupational Therapist HP3. Ms Hayes was asked to participate in the Clinical Care Transition Panel to provide an allied health perspective in light of her experience with the Centre and her level of knowledge surrounding the patients and their care. Ms Hayes' participation in the panel formed part of her usual role and, as such, her role description was not amended to reflect the specificities of this assignment.

6. **Whether BAC routinely conducted follow up with former patients and, if so, copies of any policies and/or procedures regarding the practice and summary reports of the outcomes from such follow up**

Given that patients discharged from the Centre were referred to other services to provide them with continued support in the community (which services assumed responsibility for their ongoing care), it was not the Centre's formal practice to routinely follow up with former patients. Accordingly, there are no policies and/or procedures regarding the practice nor summary reports of the outcomes from such follow up. I do however understand that the Centre's staff may have occasionally contacted patients post-discharge on an informal basis to check on their welfare.

7. **In relation to the BAC Review conducted in or around 2008, please provide any excerpt relevant to the topic of transition and/or discharge planning of patients**

With respect, I do not believe that this request falls within the scope of the Terms of Reference for this investigation.

I trust this information has been of assistance. Please let me know if you require any further information or explanation.

Yours sincerely

Sharon Kelly
Executive Director Mental Health and Specialised Services
West Moreton Hospital and Health Service
19 September 2014

Attachment 1

(Standards Appendix)

CASE COORDINATOR'S ROLE

(Barrett Adolescent Centre)

Case Coordinators are responsible for the effective management of a patient's care as directed by the Treatment Team. This is primarily a role of nursing staff. Case Coordinators are individually allocated prior to or on admission by the Nurse Practice Coordinator – Clinical Nurses Consultant in consultation with the Clinical Liaison Person and the nominated Case Coordinator. Selection is made with regard to clinical experience, caseload and specific skills or training. *(Related Standards NSMHS)*

Responsibilities of the Case Coordinator includes:

- Reporting to the Treatment Team at Case Conference. The Case Coordinator is to advise the team on the patient's recent and present well-being using identified problems (as per clinical history or Individual Treatment Plan). The Case Coordinator is to report on progress in relation to treatment objectives and the effectiveness of interventions. The Case Coordinator may present or document planned interventions for discussion and ratification by the team. Whenever unable to attend Case Conference, this clinical input is to be clearly documented for presentation. *(10.4, 10.5)*

- Being the primary liaison person with all other care agencies. These include other hospitals, Department of Families, schools, community clinics eg Child and Youth Mental Health Service, accommodation services, and other health practitioners involved in the patient's care. *(8.1.2, 8.1.3, 8.2, 8.3, 11.4.E.5, 11.4.E.4)*

- Attending all treatment plan review meetings (Intensive Case Workups) to assist the team in evaluating and developing treatment strategies for identified problems. *(11.5.1, 8.1.2, 8.1.3, 10.6)*

- Coordinating the implementation of treatment programs or strategies as directed by the team. This may include the monitoring of baselines, formulating behaviourally orientated interventions, assisting the adolescent with the use or mastery of various therapeutic strategies eg relaxation or behaviour rehearsal, and devising structured plans for other staff/carers to follow to promote a consistent approach to the patient's care. *(11.5, 11.4.E.5)*

- Building and maintaining a good therapeutic relationship with the patient and their carers. This enables the Case Coordinator to use cooperative and collaborate processes in addressing the patient's problems or day to day difficulties. The Case Coordinator engages the patient in participatory planning to facilitate the use of more effective problem-solving skills and coping strategies.

- Ensuring care is culturally appropriate if the patient is from a different cultural background. Liaising with the relevant cultural agencies, eg NESB cultural advisors, interpreter services, ATSI Liaison Officer and community support groups. Identifies sensitive cultural issues, bringing these to the attention of the team and taking appropriate action to address these. *(11.4.E.13, 7.1, 7.2, 7.3, 7.4)*

.../2

- Working in cooperation with the designated family therapist by arranging sessions with the families and participating as co-therapist. The Case Coordinator is largely responsible for dealing with family issues at times when problems arise. Acts as a support for family members and if required may facilitate attendance at other support agencies, eg Relationships Australia, ARAFMI. *(1.8, 3.2, 11.4.E.7)*

- Communicating on a regular basis with the parent or legal guardian to keep them well informed of the patient's well-being, treatment program and any changes that may occur. *(3.1, 3.2)*

- Accessing information from previous treatment teams or practitioners to assist in the assessment and treatment of the patient. This may include results of previous organic screening, psychometric testing and discharge summaries. *(8.2.4, 8.3.3)*

- Coordinating arrangements between staff, carers and other agencies concerning:

  - leaves on weekends and during holidays
  - financial needs, eg banking, pocket money
  - attending external appointments, eg medical consultations
  - school attendance or reintegration
  - respite care or alternative living arrangements

  (8.1.2, 8.1.3, 8.2.2, 8.2.3, 8.3, 11.4.E.8, 11.4.E.7, 11.4.E.5)

- Dealing with complex problems or care issues and arranging meetings with various individuals who may include the primary therapists, teacher, carers and the patient to develop treatment strategies. This may be a continuing process with meetings occurring throughout the assessment, treatment and discharge planning phases of the admission. *(11.4.D, 11.5)*

- Arranging a relief Case Coordinator prior to taking any leave of absence. Must give a comprehensive handover of the case. When not rostered on duty the Clinical Nurse will ensure continuity of care by attending to any of the above responsibilities as required. *(11.1.4, 11.4.D.6)*

CASE CO-ORDINATION

ACHS Standards

1.2.3 The health professional responsible for the care of the patient / consumer obtains informed consent for treatment.

1.2.4 Throughout their care, patients / consumers are informed of their rights and responsibilities.

1.2.5 The organisation encourages and provides opportunities for the patient / consumer to involve family, carers and friends in their care.

1.2.8 Planning for separation begins at first contact, is interdisciplinary and ensures a coordinated approach to separation and continuing management.

1.3.1 Appropriate professionals perform a comprehensive patient / consumer assessment that is coordinated and reduces unnecessary repetition.

1.4.1 A coordinated plan of care with goals is developed by the health care team in partnership with the patient / consumer and carer. The plan is developed in consultation with the patient / consumer and carer and addresses the relevant clinical, social, emotional and spiritual needs of the patient / consumer.

1.5.2 The health care team delivers care in partnership with the patient / consumer and carer and revises the plan of care and goals in response to patient / consumer progress.

1.5.3 Rights and needs of patients / consumers are considered and respected by all staff.

1.5.4 Care is coordinated to ensure continuity and to avoid duplication.

1.5.5 Education is provided by appropriate personnel to help the patient / consumer and carer understand the patient's / consumer's diagnosis, prognosis, treatment options, health promotion and illness prevention strategies.

1.6.1 Data relating to the goals and outcomes of patient's / consumer's care are analysed to provide information for care improvement.

1.6.2 Indicator data are collected and aggregated, and comparative analysis undertaken to improve patient / consumer care and management of services.

1.7.1 The patient / consumer and carer understand the plans and their responsibilities for continuing management. The plan is included in the clinical record of the patient / consumer.

1.8.1 Care is integrated between the organisation and other relevant services in the community to ensure the needs of the patient / consumer are met. The organisation provides information about the continuing management plan to the patient / consumer, carer, and relevant health care providers in a manner that maintains patient / consumer

confidentiality and privacy.

1.8.2 The organisation arranges access to other relevant community services in a timely manner, and ensures the patient / consumer is aware of the appropriate services before separation.

NHMS Standards

1.2 Consumers and their carers are provided with a written and verbal statement of their rights and responsibilities as soon as possible after entering the MHS.

1.3 The written and verbal statement of rights and responsibilities is provided in a way that is understandable to the consumer and their carers.

1.4 The statement of right includes the principles contained in the Australian Health Ministers *Mental Health Statement of Rights and Responsibilities* (1991) and the United Nations *General Assembly Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1992).

1.5 The right of the consumer not to have others involved in their care is recognised and upheld to the extent that it does not impose imminent serious risk to the consumer or other person(s).

1.6 Independent advocacy services and support persons are actively promoted by the MHS and consumers are made aware of their right to have and independent advocate or support person with them at any time during their involvement with the MHS.

1.8 The MHS provides consumers and their carers with information about available mental health services, mental disorders, mental health problems and available treatments and support services.

1.10 The MHS has an easily accessed, responsive and fair complaints procedure for consumers and carers and the MHS informs consumers and carers about this procedure.

3.1 The MHS has policies and procedures related to consumer and carer participation which are used to maximise their roles and involvement in the MHS

3.2 The MHS undertakes and supports a range of activities which maximise both consumer and carer participation in the service.

7.1 Staff of the MHS have knowledge of the social and cultural groups represented in the defined community and an understanding of those social and historical factors relevant to their current circumstances.

7.2 Information, relevant to care and continuing management, is given to the patient /

client and carers, and relevant health providers, and is included in the medical record of the patient / client.

7.3 The MHS delivers treatment and support in a manner which is sensitive to the social and cultural beliefs, values and cultural practices of the consumer and their carers.

8.1.2 The consumer's transition between components of the MHS is facilitated by a designated staff member and a single individual care plan known to all involved.

8.1.3 There are regular meetings between staff of each of the MHS programs and sites in order to promote integration and continuity.

8.2.2 Mental health staff know about the range of other health resources available to the consumer and can provide information on how to access other relevant services.

8.2.3 The MHS supports the staff, consumers and carers in their involvement with other health service providers.

11.1.3 Mental health services are provided in a convenient and local manner and linked to the consumer's nominated primary care provider.

11.1.6 The MHS informs the defined community of its availability, range of services and the method for establishing contact.

11.2.6 An appropriately qualified and experienced mental health professional is available at all times to assist consumers to enter into mental health care.

11.2.7 The process of entry to the MHS minimises the need for duplication in assessment, care planning and care delivery.

11.2.8 The MHS ensures that a consumer and their carers are able to, from the time of their first contact with the MHS, identify and contact a single mental health professional responsible for coordinating their care.

11.3.3 The MHS has a procedure for appropriately following up people who decline to participate in an assessment.

11.3.5 The assessment process is comprehensive and, with the consumer's informed consent, includes the consumer's carers (including children), other service providers and other people nominated by the consumer.

11.3.9 There is opportunity for the assessment to be conducted in the preferred language of the consumer and their carers.

11.3.10 Staff are aware of, and sensitive to, cultural and language issues which may affect the assessment.

11.3.14 The MHS ensures that the assessment is continually reviewed throughout the consumer's contact with the service.

11.3.15 Staff of the MHS involved in providing assessment undergo specific training in assessment and receive supervision from a more experienced colleague.

11.3.17 All active consumers, whether voluntary or involuntary, are reviewed at least every three months. The review should be multidisciplinary, conducted with peers and more experienced colleagues and recorded in the individual clinical record.

11.3.18 A review of the consumer is additionally conducted when:

- The consumer declines treatment and support
- The consumer requests a review
- The consumer injures themselves or another person
- The consumer receives involuntary treatment
- There has been no contact between the consumer and the MHS for three months
- The consumer is going to exit the MHS
- Monitoring of consumer outcomes (satisfaction with the service, measure of quality of life, measure of functioning) indicates a sustained decline.

11.3.19 The MHS has a system for the routine monitoring of staff case loads in terms of number and mix of cases, frequency of contact and outcomes of care.

11.4.6 The MHS ensures access to a comprehensive range of treatment and support services which address physical, social, cultural, emotional, spiritual, gender and lifestyle aspects of the consumer.

11.4.7 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in regard to dual diagnosis, other disability and consumers who are subject to the criminal justice system.

11.4.8 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in addressing the particular needs of people of ethnic backgrounds.

11.4.9 There is a current individual service plan for each consumer, which is constructed and regularly reviewed with the consumer and, with the consumer's informed consent, their carers and is available to them.

11.4.10 The MHS provides the least restrictive and least intrusive treatment and support possible in the environment and manner most helpful to, and most respectful to, the consumer.

11.4.11 The treatment and support provided by the MHS is developed collaboratively with the consumer and other persons nominated by the consumer.

11.4.A.1The setting for the learning or the re-learning of self care activities is most familiar an/or the most appropriate for the generalisation of skills acquired.

11.4.A.2 Self care programs or interventions provide sufficient scope and balance so that

consumers develop or redevelop the necessary competence to meet their own everyday community living needs.

11.4.A.4 The MHS ensures that the consumer has access to an appropriate range of agencies, programs and/or interventions to meet their needs for leisure, recreation, education, training, work, accommodation and employment.

11.4.A.5 The MHS supports the consumer's access to education, leisure and recreation activities in the community.

11.4.A.6 The MHS provides access to, and/or support for consumers in employment and work.

11.4.A.7 The MHS supports the consumer's access to vocational training opportunities in appropriate community settings and facilities.

11.4.A.8 The MHS promotes access to vocational support systems which ensure the consumer's right to fair pay and conditions, award (or above) payment for work and opportunities for union membership.

11.4.A.9 The MHS supports the consumer's desire to participate in Further or Continuing Education.

11.4.A.10 The MHS provides or ensures that consumers have access to drop-in facilities for leisure and recreation as well as opportunities to participate in leisure and recreation activities individually and/or in groups.

11.4.A.11 The consumer has the opportunity to strengthen their valued relationships through the treatment and support effected by the MHS.

11.4.A.12 The MHS ensures that the consumer and their family have access to a range of family-centred approaches to treatment and support.

11.4.A.13 The MHS provides a range of treatments and support which maximise opportunities for the consumer to live independently in their own accommodation.

11.4 B Supported accommodation* is provided and/or supported in a manner which promotes choice, safety and maximum possible quality of life for the consumer.

11.4.B.2 Consumers and carers have the opportunity to be involved in the management and evaluation of the facility.

11.4.B.3 The accommodation program is fully integrated into other treatment and support programs.

11.4.B.4 Accommodation is clean, safe and reflects as much as possible the preferences of the consumers living there.

11.4.B.6 A range of treatment and support services is delivered to the consumers living in the

accommodation according to individual need.

11.4.B.7 Consumers living in the accommodation are offered maximum opportunity to participate in decision making with regard tot he degree of supervision in the facility, décor, visitors, potential residents and house rules.

11.4.B.8 There is a range of accommodation options available and consumers have the opportunity to choose and move between options if needed.

11.4.B.9 Where desired, consumers are accommodated in the proximity of their social and cultural supports.

11.4.B.11 The accommodation maximises opportunities for the consumer to exercise control over their personal space.

11.4.B.12 Wherever possible and appropriate, the cultural, language, gender and preferred lifestyle requirements of the consumer are met.

11.4.B.13 Consumers with physical disabilities have their needs met.

11.4.B.14 The MHS supports consumers in their own accommodation and supports accommodation providers in order to promote the criteria above.

11.4.B.15 The MHS provides treatment and support to consumers regardless of their type of accommodation.

11.4.B.16 The MHS does not refer a consumer to accommodation where he/she is likely to be exploited and/or abused.

11.4.C.3 The MHS obtains the informed consent of thee consumer prior to the administration of medication or use of other medical technologies such as Electro Convulsive Therapy.

11.4.C.4 The consumer and their carers are provided with understandable written and verbal information on the potential benefits, adverse effects, costs and choices with regard to the use of medication and other technologies.

11.4.C.11 The MHS promotes continuity of care by ensuring that, wherever possible, the views of the consumer and, with the consumer's informed consent, their carers and other relevant service providers are considered and documented prior to administration of new medication and/or other technologies.

11.4.D.6 The MHS promotes continuity of care for consumers referred outside the MHS for a particular therapy.

11.4.D.6 The MHS promotes continuity of care for consumers referred outside the MHS for a particular therapy.

11.4.E.5 The MHS ensures that there is continuity of care between inpatient and community

settings.

11.4.E.6 As soon as possible after admission, the MHS ensures that consumers receive an orientation to the ward environment, are informed of their rights in a way that is understood by the consumer and are able to access appropriate advocates.

11.4.E.7 The MHS assists in minimising the impact of admission on the consumer's family and significant others.

11.4.E.8 The MHS ensure that the consumer's visitors are encouraged.

11.4.E.12 The MHS, where appropriate, enables consumers to participate in their usual religious and/or cultural practices during inpatient care.

11.4.E.13 Consumers and their carers have the opportunity to communicate in their preferred language.

11.5.0 Consumers are assisted to plan for their exit from the MHS to ensure that ongoing follow-up is available if required.

11.5.2 The exit plan is reviewed in collaboration with the consumer and, with the consumer's informed consent, their carers at each contact and as part of each review of the individual care plan.

11.5.3 The exit plan is made available to consumers and, with the consumer's informed consent, their carers and other nominated service providers.

11.5.4 The consumer and their carers are provided with understandable information on the range of relevant services and supports available in the community.

11.5.5 A process exists for the earliest appropriate involvement of the consumer's nominated service provider.

11.5.6 The MHS ensures that consumers referred to other service providers have established contact and that the arrangements made for ongoing follow-up are satisfactory to the consumer, their carers and other service provider prior to exiting the MHS.

11.6.0 The MHS assists consumer to exit the service and ensures re-entry according to the consumer's needs.

11.6.1 Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.

11.6.2 The MHS ensures that the consumer, their carers and other service providers and agencies involved in follow-up are aware of how to gain entry to the MHS at a later date.

11.6.3 The MHS ensures that the consumer, their carers and other agencies involved in follow-up, can identify an individual in the MHS, by name or title, who has

knowledge of the most recent episode of treatment and/or support.

11.6.4 The MHS attempts to re-engage with consumers who do not keep the planned follow-up arrangements.

11.6.5 The MHS assists consumers, carers and other agencies involved in follow-up to identify the early warning signs which indicate the MHS should be contacted.

Attachment 2

Queensland Government
West Moreton Hospital and Health Service
Mental Health and Specialised Services
The Park – Centre for Mental Health

Care Planning Package

Tool Kit

Adult Services

Version 3 August 2013

Contents

Care Coordination Framework

Care Coordination is a pivotal aspect of mental health service delivery that reflects supports and nurtures the embedding and growth of the principles of consumer and carer participation. It involves identifying the range of an individual consumer's needs and monitors progress towards meeting those needs in consultation with the consumer, their carer/s and with other health care resources nominated by the consumer.

Care Coordination and Care Planning are intimately linked. Whilst it is the role of the Care Coordinator (CC) to ensure that planned care is implemented, the role of developing the Individual Care Plan (ICP) and evaluating the care outcomes is the role of the multidisciplinary team.

The key principles of Care Coordination include:

- Individualised care
- right of consumers to comprehensive and appropriate care
- consumer participation in all aspects of care
- best practice
- accountability
- efficient and coordinated care;
- evaluation of care outcomes
- continuity of care

The Care Coordination model will be flexible and responsive to the needs of consumers and carers. It will utilise a joint planning process between consumers, carers and Care Coordination in the development of ICP's.

The ICP will be in an 'easy to read' format and available to the consumer and carer. Collaborative links will be developed with other health providers and strategies in the ICP will reflect a coordinated approach from all those nominated by the consumer as health resources.

CC's will be allocated to all consumers and will act to ensure that the treatments and care prescribed by the multidisciplinary team are implemented by the appropriate clinicians and/or agencies.

PROCEDURE

CC's can be allocated from the Medical, Nursing and Allied Health disciplines, as can Care Coordination Associates (CCA). Enrolled Nurses (EN) and Enrolled Nurse Advanced Practitioner (ENAP), may be allocated to the role of Care Coordinator and/or Care Coordination Associates, with appropriate support and mentoring from senior clinicians.

Ideally, there will be a CC *and* a CCA allocated to each consumer. The role of the CCA is to proxy for the CC when that person is unavailable and to take on duties delegated by the CC. The CCA has the same authority as the CC, but cannot plan care, except in consultation with the CC, or, in the case of Enrolled Nurses (EN's), Rehabilitation Therapy Aides (RTA's) and discipline associates, under the supervision of a RN or the relevant qualified discipline clinician.

One CC for each consumer will be drawn from the nursing service to maximise the availability of CC presence on the ward/residence. As a general rule, no staff member who works predominantly on the night shift will act either as a CC or CCA. However, where it is clinically useful to utilise a night shift worker as an associate, then this practice is acceptable.

In allocating CC's, consideration should be given to consumer need, staff skills and workload. However, all clinical staff must accept an active role within the Care Coordination framework.

Where possible, the consumer should have the opportunity to choose his or her CC and processes should be implemented to facilitate this at the local level. Consumers have the right to request a review of their CC allocation at any time.

On admission to the service or ward/residence area, a CC (and CCA where possible) will be allocated to the new consumer by the RN in charge. At the next Multidisciplinary Team Meeting, the CC and CCA positions should be ratified or alternative CC's should be nominated.

In ward/residence areas where admissions are planned, the multidisciplinary team will nominate the CC and CCA in advance of the admission. The nominated CC should make contact with the referring Client District agency to initiate the assessment and care planning priorities for the consumer.

Allocation Nurse

The Care Coordination approach is complemented by the allocation of allocation nurses to each consumer on a shift-by-shift basis. The nurse in charge of the ward/residence should facilitate this.

Ideally, the nursing staff who are CC's or CCA's will assume this role for those consumers on each shift. This enhances the notion of establishing a single point of accountability for the provision of care for consumers. The nursing staff allocation list should be displayed in a prominent area of the ward/residence for the consumers' information and updated each shift by the nurse in charge.

Reporting Relationship

The CC plays an active role in developing and monitoring a consumer's treatment plan, as well as liaising with other staff to ensure that treatments that have been prescribed by the multidisciplinary team are implemented in a timely manner.

The responsibilities of the CC are to participate in the development of an ICP; to ensure that appropriate documentation occurs; and to ensure that the plan is implemented and reviewed on a regular basis.

It is the responsibility of the staff designated in the plan to fulfil their respective roles and commitments to the consumer's care, with the CC acting to advise each clinician or service of their role in the consumer's treatment and to work directly with the consumer to meet his or her needs in accordance with the ICP, as appropriate.

The ICP is developed in conjunction with the multidisciplinary team and the consumer. The CC is a member of the multidisciplinary team and should, wherever possible, be present at Multidisciplinary Team Meetings when the ICP is reviewed. Where this is not possible, the CCA (or another staff member) should be properly briefed to proxy for the CC at the meeting.

Care Coordination – ICP Development

Within 72 hours of admission, the CC must develop an interim ICP that addresses the issues that have led to the consumer being placed in the ward/residence and initiate an Exit Plan. The interim ICP should address the consumer's immediate presenting problems, with a focus on safety. Each clinican may determine any additional requirements for the interim ICP.

The Exit Plan should begin gathering information regarding such things as: the consumer's preferred GP or psychiatrist; community supports and services that may be required; and an evaluation-of-care methodology that suits the consumer. The plans should be developed in consultation with the consumer. The CC should take this opportunity to understand and document the consumer's expectations of his or her treatment. The consumer's written consent to the involvement of family members in care planning should also be sought (see the section on *Carer participation and sharing information with carer*, page 23)

At the first meeting of the multidisciplinary team, a comprehensive review of the consumer's clinical presentation should occur, and the allocation of the CC and CCA should be ratified by the team. The multidisciplinary team members are to review the interim ICP and begin planning multidimensional care for the consumer that is focused toward community placement, and that is cognisant of the consumer's expectations.

The CC is to ensure that assessment of the consumer occurs to assist in planning and measurement of outcomes. The assessment and screening tools can include, but are not limited to, the following in the Care Planning Package:

- Outcome Measures (HoNOS, HoNOSCA, Life Skills Profile, Mental Health Inventory and other tools as outlined in the Queensland Health Outcomes Protocol)
- Risk Assessment Profiles on Aggression, Self-Harm and Absconding
- Consumer Participation Plan where appropriate

Clinical areas/teams may include other assessment and screening tools as required by their consumer population or individual consumer's needs.

Using the results of assessments, the CC will construct an ICP in consultation with the consumer and family members (where appropriate). All the above mentioned tools also form part of the care plan (e.g. the risk management plan attached to the Risk Assessment Profiles). Where the consumer dissents from the framework, attempts should be made to encourage the consumer to engage in the proposed plan. If this is not possible, then attempts should be made to negotiate an approximation of the proposed framework that is satisfactory to the consumer.

The ICP is a working document that is regularly reviewed and updated at least every 91 days in the context of a Multidisciplinary Team Meeting. The plan and the interventions that are attempted are subject to ongoing evaluation. Non-effective interventions should not be continued for extended periods of time. The plan should evolve. All attempted strategies and subsequent outcomes should be documented in the *Progress of Care* section of the ICP to ensure continuity of care and appropriate tracking of clinical outcomes.

A weekly review of consumer care from an ICP perspective should be documented in the clinical record by the CC to ensure effective clinical communication and review. *All* clinical entries should be made in the context of the ICP, usually either to flag interventions that have been made that have implications for an identified consumer issue, or to highlight the need for intervention in a new issue.

Review Process

Each clinical area should identify a responsible person to coordinate ICP reviews with the multidisciplinary teams and the CC's. Adequate notice must be given to the responsible CC, so that arrangements can be made to attend the Multidisciplinary Team Meeting or to brief the CCA or a proxy.

The need for emergent review of consumer treatment on occasions is inevitable. Attempts should be made, by the person convening the meeting to confer with the CC, even if he or she cannot attend the

meeting. In any case, the outcomes of emergent discussions should be clearly documented in the clinical record and should be flagged for the attention of the CC.

The emphasis in the above approach is upon ensuring the regular detailed review of all consumers and the effective flow of communication that recognises and values the role of the CC. Individual CC's will play an important role in ensuring that updated information is available at the relevant team review and that relevant amendments are documented in the ICP.

Evaluation of ICP's and Care Coordination Processes

Evaluation of ICP functionality and Care Coordination processes should be programmed at three levels:

1. Regular communication between the CC and the consumer to determine level of fit between consumer expectation and planned outcomes. Issues highlighted by such discussion should be conveyed to the multidisciplinary team.
2. During multidisciplinary team meetings. Particular attention should be paid to issues that have been standing for longer than three months (unless an extended timeframe has been anticipated during the development of the ICP).
3. Operational issues arising from care coordination should be documented and forwarded to the relevant Work Improvement Group (WIG) for resolution.

LEGAL/ETHICAL ISSUES

In terms of ultimate medico-legal accountability, the Consultant Psychiatrist retains this responsibility and the CC is responsible to the Consultant Psychiatrist with regard to care planning issues.

About the Care Planning Package

Background

The care planning package at The Park – Centre for Mental Health has evolved and adapted to provide recovery-oriented individualised care, whilst meeting local requirements and national standards for documentation and safety.

The care planning tools used at The Park have been audited every six months since 2003, to gather information on how the tools are used, quality of care plans, and integration of tools and measures. As a result of longitudinal audit information, consumer and clinician feedback, the changing clinical scene and documenting practices (eg computer systems for recording information), the new care planning package has been developed to enhance the way in which we plan and deliver care.

Using the Strengths model in care planning

The recovery principles have guided clinical practice and service planning at The Park. Changing practices towards consumer focussed care has involved a considerable change in work practices, attitudes and culture. These initial steps have laid the foundations for a strengths-based model of care.

The Strengths model is a way of viewing the people we work with, providing a focus on the positive aspects of a person, rather than just deficits or pathology. This model fits well with the recovery principles. The table below outlines the principles of the Strengths Model:

Six Principles of the Strengths Model - Rapp and Wintersteen (1989)

- The focus is on individual strengths rather than pathology
- The care coordinator / client relationship is primary and essential
- Interventions are based on the principle of client self-determination
- Assertive outreach is the preferred mode of intervention
- Long-term psychiatric consumers can continue to learn, grow, and change and can be assisted to do so
- Resource acquisition goes beyond traditional mental health services and actively mobilises the resources of the entire community

The Strengths model has been used and researched successfully in community mental health settings and is becoming accepted practice in many inpatient settings across the world. At The Park, the Strengths model can guide our care planning practices to ensure that consumer's strengths become the driving force for goal setting and working towards recovery.

For more information about the Strengths model and care planning, refer to the Resources section (page 24).

Computers and care planning

Completing care plans and associated information electronically is increasingly a requirement of mental health services. Electronic care planning has advantages in terms of time taken to review and update care planning tools, and sharing information within mental health services.

CIMHA is a consumer-centric clinical information system designed to support mental health clinicians in the provision of safer quality mental health services. CIMHA is used to record and access clinical information on consumers that is essential to care planning. In particular, care planning requires the use of CIMHA for:

- Inputting and reporting on outcome measures
- Recording Mental Health Act 2000 status, forms and requirements
- Recording 'alerts' and risk information
- Sharing information within the mental health network and updating care coordinators through clinical notes, messages, etc.

All clinicians should receive training and orientation to CIMHA, and be able to use the application as part of your day-to-day clinical work. CIMHA recognises care coordinators (or Primary Service Providers, as they are designated in the system), which means that care coordinators can quickly access the consumers they are allocated, and other clinicians can identify who they need to contact to share information on a consumer.

Key Care Planning information should be uploaded on to CIMHA for these reasons. Documents to be uploaded include the Individual Care Plan and any other important clinical information that may be pertinent to the consumer's overall treatment and care.

For more information on the use of CIMHA, please talk to your supervisor, contact the district ***Mental Health Information Systems Coordinator (MHISC),*** or access the online fact sheets and tutorials at http://qheps.health.qld.gov.au/mentalhealth/cimha/resources.htm

Guidelines for Electronic Use of Care Planning Documents

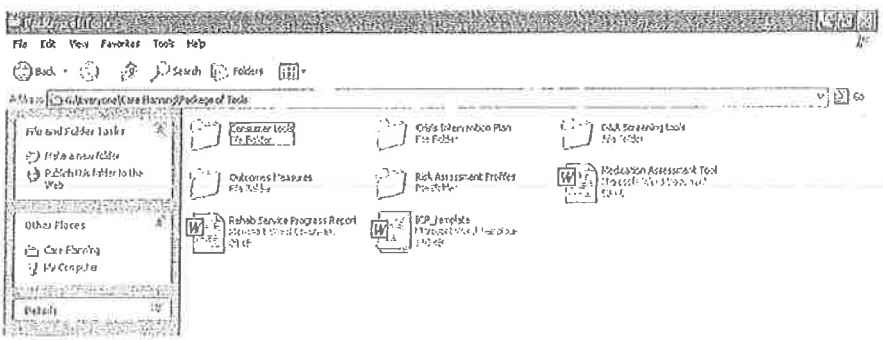
The Individual Care Plan is designed to be used as an electronic tool, to improve ease of completion and make reviews more efficient. Using care plans electronically does pose some considerations in relation to:

- Confidentiality;
- currency of documents;
- version control (e.g. making sure the right version is accessible, and that old versions are deleted); and
- Access (e.g. ensuring that care plans are saved to a location accessible to those who need it).

The following guidelines and conventions are provided to address these issues and make electronic care planning user-friendly for all clinical teams.

Accessing the care planning tools electronically

All care planning tools used for adult consumers across the facility are available at G:\Care Planning\Package of tools. You will see in this folder the following screen:



Separate folders contain the tools for consumer tools, crisis intervention plan, risk assessments, drug & alcohol screening, and outcome measures for printing (e.g. MHI). The ICP template is in a 'word template' form (easy to identify by the yellow top on the icon).

Completing an ICP electronically

Once the ICP template form is opened, it becomes a new document to be saved by the user. The template form cannot be saved over; this will hopefully reduce the chance of people accidentally saving care plans to G: drive.

The ICP template has form fields (grey areas) to indicate where information is required. By clicking with the mouse cursor on these grey areas, you can see whether the field is for text, a drop-down menu, or tick box. You can also use the tab or arrow keys to move from one field to the next. Tick boxes can be completed either using a mouse click, or the spacebar key. For some fields, an explanation of what is required will appear in the bottom left of the screen, just under the toolbar. This may help you to know what to put in that field.

The easiest way to find out how to use the form is to have a go! While you are still able to complete the ICP in hardcopy by printing out the template form, it does mean that you won't be able to view the drop-down menus and other prompts that are on the electronic version.

Saving Your ICP

Once you have completed the ICP, or if you wish to save what you have done so far, go to 'File' and the 'Save As'. You will need to change the document name (it will probably have "Date of Completion" as the document name). The recommended convention for naming your care planning document is:

Consumer's Surname_Consumer initial_Year(XX)Month(xx)

Some examples of this convention are:

Frankston_B_0703.doc	Indicates an ICP for B. Frankston completed in March 2007
Henderson_W_0710.doc	Indicates an ICP for W. Henderson completed in October 2007.

The reason for this convention is that it will save documents in alphabetical (by surname) and chronological (by the reverse date) order.

All clinical areas should have their own folders which can only be accessed by clinical staff from that area. Within these folders there may be individual consumer folders. The current ICP document should be saved to the consumer's folder. If you are unsure how to access these folders, please talk to your CNC or NUM.

It is very important that no consumer information is saved to G:\Everyone or to G:\Care Planning. These folders can be viewed by anyone at The Park, and saving information here is a breach of privacy and confidentiality. Please double-check the save destination (where you are saving the document to) before clicking on the 'save' button.

Uploading Care Planning documents to CIMHA

Once the ICP has been signed off by the Clinical Team, it should be uploaded to CIMHA. This can be done by scanning the documents, emailing them to yourself and saving them on a secure network folder.

Alternatively, select "Cute PDF" as the printer for the document and save on a secure network folder. From here the document can be uploaded as an attachment to CIMHA by opening the consumer record, selecting the clinical note type (Case Review Summary), adding the Attachment Summary Template and loading the template. Finally, complete the Summary details and attach the PDF document as per normal.

The importance of hardcopy

When your ICP has been completed, it should be printed out, signed, presented to the clinical team, and filed in hardcopy in the clinical file. As we continue to work with paper-based recording systems, it is very important that these records are current and complete. A hardcopy in the clinical file may also be more accessible for quick review by other staff working with the consumer.

Reviewing your ICP & saving your review

When the review for the consumer you care coordinate is coming near, you can open the saved ICP electronically in Microsoft Word, and make any necessary changes quite easily. The bulk of information will already be there. It is important to still go through each of the areas to check that the details are updated. The 'Progress of Care' section at the end of the ICP gives the opportunity to record any goals that have been achieved.

Once you have completed your review, go to the File menu and click 'Save As'. Change the date on the document name before saving.

Once the reviewed ICP has been approved by the clinical team, the outdated ICP can be deleted from the electronic folder. ***Only current ICPs should be available on the clinical area folders, to avoid error in accessing outdated documents.*** Remember to upload the most recent versions of your ICP to CIMHA after sign off.

Accessing ICPs

Individual Care Plans can be accessed electronically through the clinical area's folder. If you are unsure how to access these folders, please talk to your CNC or NUM. Your work colleagues may also be able to orientate you to the clinical area folder and consumer folders.

Other considerations

Most documents in the care planning package are able to be completed electronically. Opportunities to develop your computer skills, through practice, attending training sessions, or picking up tips from your colleagues can help ensure that you feel confident and competent to complete care plans using computers.

The Care Planning Package Checklist

The Care Planning Package Checklist provides care coordinators and clinical team members with a quick reference of the tools that need to be completed for the care planning review, as well as the dates of previous reviews. A new checklist should be completed each care plan review.

The best way to complete the checklist is to print it and complete it manually as each tool is reviewed or revisited. The checklist provides a quick guideline for completion at the top of the page (see *Appendix A*, page 30)

There is space provided to include the risk screen rating for each review, and additional tools that the specific clinical area may use (refer to section *Other Assessment/clinical area tools* on page 28).

Reviewing or revisiting?
Care coordinators and consumers may sometimes feel that they are completing tools unnecessarily, when the information or scores haven't changed in the three month period. For some forms, it may be acceptable to re-visit the information to check that it is still accurate, without having to complete a full new form. Other tools have a standard or legal requirement to be completed every three months. Tools which are required to be *completely reviewed* at least every three months are:

- Outcome measures (HoNOS, LSP, MHI)
- Risk Screen Tool
- Involuntary Patient Summary
- Individual Care Plan
- Clinical chart audit is to be completed each 3 monthly review.

Tools that can be *revisited*, and signed off if no change is required, include:

- Consumer participation plan (check with the consumer if anything is different)
- Strengths assessment tool (this should be a 'living' document and added to as new strengths are discovered; however a new form doesn't have to be completed unless there has been significant changes, the consumer wants to start a new form, or the current form has become difficult to read. Each form has provision for signing a number of reviews).
- Drug Check, Audit & RTCQ

The Individual Care Plan & Recovery and Relapse Prevention Plan

The Individual Care Plan (ICP) and Recovery & Relapse Prevention Plan (RRPP) are the documents which bring all the assessments and information together and outline the goals for the consumer to work towards recovery. The ICP has a strengths focus, and aims to highlight the consumer's goals as well as the clinical issues. It aims to be a living document that is used to direct care and clinical decision making. For a completed example of the ICP, see *Appendix B*, pg 31.

Orientation to the ICP
The first page of the ICP includes identifying data, a consumer profile, alerts, review dates, and consumer involvement. All parts of this front page are to be completed. The 'Summary of Presenting symptoms' box is a chance to document briefly the main presenting issues and clinical concerns of the past 3 months only.

The following pages of the care plan have been divided into sections that relate to the categories of the Strengths Assessment (see information below). These categories are:

- Maintaining mental health
- Physical health, nutrition & ADLs (Weight, diet, physical comorbidities, self care & hygiene)
- Substance misuse
- Daily living situation/Financial/Vocational/Educational
- Social Supports & spirituality
- Leisure/Recreational

Each of these categories have a page devoted them, outlining the issues, assessment scores, goals and strategies, and progress of care. Here are some of the features of each category:

Substance Misuse: Drugs, Tobacco, Alcohol & Other Harmful Substances.

☒ *Drug Check & Audit* Completed on CIMHA Date: 1/08/2013 Substance Misuse Problem identified ☒ Yes ☐ No	☒ *Readiness to Change Questionnaire* Completed/Reviewed Date: 1/08/13 ☒ *Smoking Cessation Pathway* Completed Date: 1.08/13
Consumer's Goal Statement: I want to stop smoking forever	Summary of Current Issues: Was a heavy smoker (40 a day) but has been successfully using inhaler & patches to cease smoking. Occasional drug use when on leave.

HoNOS Scores	3	3		LSP Scores	6	2	

Areas to consider: Motivational Interviewing, ATODs Support, MAISE Program, Psycho education Programs
Refer to Drug Check & Audit, Readiness to Change model, D&A Pathway

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Start decreasing use of Nicotine Replacement Therapies.	Reduce daily use of inhaler. Continue to wear NRT patches.	Encourage use of inhaler as PRN only.	Nursing staff	1/10/13
Routine UDS to be completed when return from overnight leave as per LCT conditions	I will not use drugs while on leave & cooperate with UDS on return	Administer UDS when consumer returns from leave.	Nursing staff	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care) *e.g. education programs, medication/social strategies etc*		
Strategy	Did it work? Provide details	Date Attempted/Implemented
Attended MAISE rehabilitation program	Helped Mike understand his recreational drug use, Mike has avoided situations likely to lead to drug use while on LCT.	April 2013

Category heading:

This gives the names and brief description of the category.

Data relevant to this category:

Some categories have a section at the top of the page that allows you to outline information and assessments relevant to that category. This provides a quick reference for some important data.

Consumer's Goal Statement:

This is the consumer's goal for this category (if the consumer has one).

- The goal statement may come directly from the aspirations column in the Strengths Assessment.
- It should be written using the consumer's own words as much as possible, and specified as precisely as the person understands it.

The consumer's goal is not to be debated, but rather accepted and further explored. It may or may not be aligned with the clinical team's views. It is important for clinicians to remember that acknowledging consumer's goals is an important motivating factor and may provide a driving force for implementing strategies that are agreed upon by both the consumer and the clinical team.

Summary of Current Issues:

This box allows clinicians to outline the current concerns of the clinical team. This may include "problems" or "deficits", barriers to treatment, risk factors, and other influencing factors the care.

Outcome measure Scores:

This greyed row of boxes allows clinicians to record the outcome measures scores relevant to this particular category. This outlines the HoNOS and LSP scores that are relevant.

For instance, in the category "Daily Living Situation/Financial/Vocational/Educational, there are two HoNOS items (Item 11 and 12) and two LSP items (Item 13 and 16) that are relevant to that category. There is a blank box next to each item number for the clinician to insert the score. Each category has a footnote that describes the items outlined on that page. The use of the HoNOS and LSP scores in each category helps to link the outcome measures with the treatment strategies in the care plan. Items of the HoNOS that are clinically significant (ie a score of 3 or 4) should have relevant strategies for addressing these problems outlined in the care plan.

'Areas to Consider' and 'Refer to':
Under the outcome measures scores, there is a box which can assist care coordinators when developing care plan strategies. "Areas to consider" gives care coordinators a list of ideas for treatment and recovery strategies relevant to that category. "Refer to" gives a list of assessments or information sources that provide information relevant to that category.

The planning table:
The planning table details the *strategies, consumer actions, support role/treatments, responsible team members* and *review dates* required for the care plan, relevant to that category. Strategies may be seen as then short-term, "small-step" goals towards achieving the overarching recovery goals for the consumer, and for addressing the main clinical concerns. See the information on pages 14-15 about goal setting and developing strategies.

The *"Consumer Actions"* column refers to the tasks or techniques that the consumer plans to undertake to meet the strategy.

The *"Support Role/Treatments"* column outlines the tasks or techniques that the clinicians, carers and others plan to undertake to meet that strategy.

"Team Members Responsible" refers to the specific person/s who will implement the support role/treatments. "Review Date" is a date set by the care coordinator and consumer when it seems reasonable to review that strategy – it may be the same as the 3-monthly review date, or it may be sooner, depending on the strategy.

Progress of Care:
The table at the bottom of each page provides an opportunity to record strategies that have been attempted in the past, relevant to the category. By recording what has been attempted, whether it worked or not and why, and when it was attempted, clinicians and consumers can have an overview of progress, and a historical reference of past treatments and programs.

If a strategy has been recorded in the progress of care, this doesn't mean that it will no longer be relevant to the consumer, or can't be tried again. It's important to remember the situation and context of treatments, people involved, etc and how these may influence outcomes. Details in this table can provide clinical teams and consumers with valuable insights into how the journey of recovery has developed so far.

Recovery and Relapse Prevention Plan (RRPP)
The RRPP is on the last page of the ICP. It provides an opportunity to record ways for consumers, carers and clinicians to identify triggers, relapses, ways of coping with stress and managing crisis situations. This section can be completed in a number of ways:

- by the consumer on their own;
- by the consumer with help from the care coordinator/clinician (e.g. in a discussion, with the clinician writing things down);

- with input from carers or family;
- using information from the Strengths Assessment;
- a combination of the above.

This is a tool that is 'owned' by the consumer, and can support the consumer to think of what to try in stressful or crisis situations. It is something that may change a little or a lot with each review, as consumers develop different coping mechanisms and learn how to identify triggers and symptoms more easily. This is not a tool that can be completed just by the care coordinator or clinician, though they can help the consumer to identify what works for them through questions, prompts and examples.

Tips on completing the ICP and RRPP:

Only sections that are relevant for the consumer for that period need to be completed

For example, if the consumer doesn't have any substance misuse issues, it is only necessary to complete the tick box at the top of this category, and the rest can be left blank. Likewise, not all sections need to have lots of strategies or goals. Consider what is specific and achievable for the next three months.

If a consumer doesn't consider a category relevant, but the clinical team does, this can still be completed with strategies developed – bearing in mind that there may not be much in the "consumer actions" column. For instance, if a consumer does not feel they have a substance misuse issue, but the clinical team are concerned by their drug use, there may be strategies developed around education and the use of motivational interviewing; the consumer may only agree to "listen to information given" as part of the consumer actions.

"Strategies" are the short-term goals that are specific, measurable, and achievable.

Developing goals that work is a skill, and is an important way of ensuring that a care plan is individualised to the consumer. The strategies are the short-term goals that provide the "baby steps" to attaining the goal statement. They are developed by breaking down goals into the small steps required to reach the goal. Strategies should be:

- Stated in positive terms
- Have a high probability of success (so start with the smallest "baby steps"!)
- Measurable and observable
- Specific (not vague) and time-limited (has a review date)
- Understandable and meaningful to the person

For example a goal statement might be "I want to be an actor". Using solution-focused questioning, you might elicit from the consumer that she thinks to be an actor, she needs to look good, needs to know about drama and acting, and needs to see some live performances to find out more. Strategies might then break down further to be:
"I will get my hair cut and styled"
"I will borrow some plays from the library to read the parts"
"I will save money to buy a ticket to see a live theatre show when I'm on leave"

The big goal statement may actually break down to goal statements for different sections of the ICP, eg with the above example, the consumer may decide she'd like to lose weight and be more physically fit to be an actor, and she might have a goal of joining a drama group as her goal statement in the Leisure/recreational section.

Short term goals/strategies can be written using the 'SMARTA' approach:

S pecific
M easurable
A chievable

R elevant
T ime-framed
A greed upon

Care Coordinators can assist consumers in setting SMARTA goals, by helping them break large or long-term goals into smaller, achievable steps, and getting the consumer to consider how they will know when they have reached that goal. Often, setting smaller, specific and concrete goals can help the consumer see when an outcome is achieved and provide a clearer direction.

Examples of the SMARTA approach:

- *Good:* Jacob will independently engage in one leisure activity in the community on a weekly basis by the next review.
- *Not so good:* Jacob will increase his community outings.

- *Good:* Anne will use a washing machine to wash her clothing with staff supervision once a week by 4 weeks.
- *Not so good:* Anne will wash her own clothes.

The actions should then reflect the step-by-step approach needed to achieve the goal.

The Goals/strategies/actions care plan is one way of recording goals and outcomes for consumers. Other ways that may complement the ICP and help consumers include:

- Pictorial representations of goals
- Writing goals in the consumers' own words
- Using an audio cassette recording of the goals and their steps.

Whichever means of recording goals that is used, a copy or version of the record, which reflects the same goals, strategies and outcomes, should be provided to or discussed with the consumer, and a copy kept with the ICP in the clinical chart.

Risk Screen Tool

Suicide/Self Harm, Violence, Vulnerability and Absent without approval can present serious problems for all concerned. The state-wide standardised Risk Screen tool has been developed to better manage these behaviours. The Risk Screen is completed on admission and reviewed at least three monthly (more frequently in some clinical areas). Ad hoc assessments of risk are also carried out when there is a change in the consumer's behaviour (or risk factors), a critical incident or prior to transfer or discharge. This Risk Screen Tool is a template on CIMHA.

The first component of the tool is a checklist of prompting questions regarding static and dynamic risk factors. Static factors are those factors which do not readily change (e.g. age) while dynamic factors change over time and are amendable to intervention.

Below the checklist there is a free text field for details regarding risk and mitigating factors. The most important part of the risk assessment is the information recorded in this section. The comments noted should yield the information required to: generate a risk rating; and, to support the clinical decision making process behind the rating documented. For example, if a risk history has been identified in the checklist further explanatory information can be provided here: e.g. *"Joe has made suicide attempts in the past but has not had a known episode of self harm or suicide attempt for approximately 10 years."*

This detail may support the decision to rate Joe as a low risk of suicide. The risk history in both the checklist and free text fields should cover all past clinical history.

There is a Child Protection Risk Screen asking if the consumer has any custody or care responsibilities for children. If yes, a Child Protection form must be completed on CIMHA. This is followed by a box requiring the allocation of an overall risk rating.

The final section is for **Clinical and Risk Formulation / Assessment Summary** which is a free text field designed to capture detailed consumer-specific information to enable effective and appropriate clinical risk management. Information to include in this section:

- Protective and mitigating factors
- Stressors
- Strength and supports
- What will increase or decrease the consumer's risk?
- Is the consumer possibly in early psychosis or prodromal?
- Consider historical information in relation to current dynamic and contextual factors
- Where risks are identified, document strategies to address the identified risk factors

The Risk Screen tool is a standardised template on CIMHA. While a Care Coordinator generally completes the Risk Screen, the management of the risk should be a team effort and not the responsibility of any one individual.

The data gleaned from the use of Risk Screen is likely to be useful in decision making around risk – however, it is only one aspect of risk assessment and should never override clinical judgement. However, it is important that the Risk Screen be reviewed as required and revisited to reflect any changes in behaviour.

Other risk tools used in clinical areas may include the DASA and HCR-20.

See Appendix D (page 41) for an example of a Risk Screen tool.

Outcome Measures

The emphasis on health outcomes and information systems to support quality improvement has been gaining momentum in the wider health sector for several years. The implementation of routine outcome collection in 2004 by all Queensland mental health services, has led to services becoming more able to explore and ask questions about the benefits or otherwise of the treatment or care they provide and the complexity and characteristics of the populations they serve. Services have also begun to use the information to explore the connections between service provision and changes in levels of consumer well-being.

The outcome measures used also provide important information for care planning. Examples of how the information can be used in the clinical setting include:

- To monitor the progress of consumers receiving mental health services.
- As a clinical tool to inform treatment planning.
- To evaluate the effectiveness of treatment and individual care plans.
- To increase dialogue amongst members of the treating multidisciplinary team.
- To facilitate engagement and partnerships with consumers and carers in care planning.
- To assist in professional supervision.

Table 1 outlines the suite of measures generally used by Child and Youth, Adult and Older Persons mental health services.

Child and Youth Services	Adult Services	Older Persons Services
CLINICIAN RATED / COLLECTED		
• Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) • Children's Global Assessment Scale (CGAS) • Factors Influencing Health Status (FIHS) • Principal Diagnosis (ICD-10-AM) • Mental Health Legal Status	• Health of the Nation Outcome Scales (HoNOS) • Life Skills Profile (LSP) • Focus of Care (FoC) • Principal Diagnosis (ICD-10-AM) • Mental Health Legal Status	• Health of the Nation Outcome Scales for Older People (HoNOS65+) • Life Skills Profile (LSP) • Focus of Care (FoC) • Resource Utilisation Groups - Activities of Daily Living Scale (RUG-ADL) • Principal Diagnosis (ICD-10-AM) • Mental Health Legal Status
CONSUMER SELF-REPORT		
• Strengths and Difficulties Questionnaire (SDQ)	• Mental Health Inventory (MHI)	• Mental Health Inventory (MHI)

The Outcome Measures are completed on CIMHA according to a collection protocol. You can also access hardcopy forms from QHEPS or from *G:\Care Planning\Package of Tools\Outcome Measures* when the CIMHA system is down, for consumers to complete their tools, or if your clinical team prefers to complete the tools together. For more detailed information on accessing tools and how and when to complete the measures, talk to your supervisor and go to http://qheps.health.qld.gov.au/mhinfo/outcomes.htm for resources. Your clinical area should also have a copy of the ***Clinician's Handbook Outcomes Initiative*** and ***Beyond Outcomes Desktop Flip-Chart*** available for your reference.

The Individual Care Plan now includes in each section a reference to the HoNOS and LSP scores relevant to that health/life domain. This provides an easy reference for clinicians to see how goals relate to clinically significant scores. See the section above on completing the ICP for more information.

Strengths Assessment

Adapted from "Strengths Model for Special Care Settings" by Paul Liddy. Available from G:\Care Planning\Strengths Model

The Strengths Assessment is a tool designed to help the client and care coordinator become conscious of the resources a person possesses, not only at this point in time but also what they have accumulated in experience and knowledge in the past and what external resources they possess or have access to. The form is available via *G:\Care Planning\All Tools - Care Planning Package\Consumer tools.* See *Appendix C* on pg. 39 for an example.

The middle column of the Strengths Assessment asks the question "What do I want?" This is at the very heart of the work we do with people and getting this dream or aspiration is critical to moving recovery forward. From the middle column a list of priorities is distilled and work can begin on a chosen goal using the recovery goal worksheet.

All of this does not happen at once and a varying amount of time must be invested in simply engaging with the person so as to gain trust and build a partnership. During the course of multiple conversations, strengths will become apparent, be noted and begin to populate the Strengths Assessment. At first the tool may lack an amount of detail but over time and with increasing engagement it will become more specific and thorough.

Certainly the style of a Strengths Assessment should mimic a conversation that proceeds at the person's pace and is smooth and natural. The aim is to gain information that is genuine and meaningful to the client rather than simply what they think that you want to hear. Many frustrations and failed goal attempts come from forcing the Strengths Assessment upon people and treating it as a piece of one time paperwork rather than as an active living tool which will be added to and refined continuously over the course of engagement.

What the Strengths Assessment is aiming to capture and clarify are the qualities, talents, skills, resources and aspirations that a person has for their recovery journey. One would not expect to see a collection of deficits or negative comments. There is usually nothing contained within this information that helps people be successful. But have no fear, any relevant limitations will be uncovered during the goal planning phase and can be viewed positively as challenges to be overcome. Recording them on the Strengths Assessment, however, can have the effect of limiting the vision of participants to the possibilities, effectively closing the door on potentially viable alternatives.

If you have never attempted a Strengths Assessment with a consumer before, it may be helpful to try it out on a colleague, friend or family member first – just have a brief conversation, and see what strengths you can identify, along with your current knowledge of the person.

Personal Qualities
This box on the second page gives an opportunity to capture those personal strengths which may not fit neatly into the domains. Qualities such as "friendly", "enjoys the moment", "has a great sense of humour", "generous", "tenacious" etc might be written here.

Prioritising goals
The Strengths Assessment builds up over time, and it may be difficult to know which aspirations are most important to the consumer at any one time. At the bottom of the Strengths Assessment is a box which allows the consumer to highlight the three priorities for goals or aspirations. These priorities should be reviewed every three months when the care plan is reviewed, to check for changes in priorities and whether any goals have been reached.

Life domains
The following lists are sample areas to explore in each life domain. They are not exhaustive or prescriptive and should NOT be used as an interview or interrogation! Remember that this process of Strengths Assessment is ongoing and continues for the length of the recovery journey. A relaxed and positive style will more likely elicit useful information than a style that is rushed or forced. Taking time early will potentially save time in the long-term!

Areas to Explore through the Strengths Assessment

Mental Health

Present moment
- How do you see or understand your illness?
- Medications. How do you manage your medication? How do you handle side effects?
- Do you experience symptoms of your illness? What are they like? What kinds of things do you do to cope with or manage your symptoms?
- What produces stress for you? What do you do to manage stress?
- Coping tools and strategies – what are you doing now to stay well?
- Who do you find it useful to talk to when your feeling down or unwell?

Link to Recovery and Crisis Prevention Plan

Desires/Aspirations
- As suggested by the consumer in their own words. For example:

"To get out of this place."
"Being able to stop the voices"
"Knowing when I'm getting sick."
"I want to be able to relax."
- Consider miracle question. If you woke up tomorrow and the illness was gone.....what would you be like? What would you do?
- Are there things you'd like to manage better in terms of your mental health?

Resources
- Care coordinator, care coordinator
- Family, Friends
- General practitioner, Psychiatrist
- Support groups, community groups (eg church, NGOs, sports teams)
- Recovery and Crisis Prevention plan / relapse management plan
- Identify what has worked in the past. If unable to identify, ask what the person was doing when they were well/ before becoming unwell.

Physical Health, Nutrition, Activities of Daily Living

Current Status
- How would you describe your health at present?
- Is being in good health important to you? Why/why not?
- What kinds of things do you do to take care of your health or to stay healthy?
  - Medical Doctor currently seeing
  - Dentist
  - Diet and eating habits
  - Do you exercise? What type?
  - Use of over the counter medications.
  - Birth control
  - Smoking habits
- What are some of your daily habits or routines? How do you take care of your personal hygiene and appearance?

Desires/Aspirations
- Are there things you are working on or would like to work on with regard to your physical health? (e.g., losing weight, managing symptoms, smoking less, drinking less, healthy eating, etc.)
- What is important to you in this area? Is there anything you would like to learn more about, improve or change in this area?
- Are their habits or routines that you'd like to develop to look after yourself, your appearance and your hygiene?

Resources

Address resources used in the past for any of the areas mentioned in current status.
- What healthy practices have been used in the past?
- What educational sessions have been offered in the past, did this help?
- Previous lifestyle behaviours that promoted/improved physical health?
- Previous interest in physical activity/sport/cooking?
- Were any of the resources used in the past (DR's, hospitals, exercise activities, medications, diets, symptom management techniques, etc.) particularly helpful?
- How were ADLs performed in the past?

Daily Living Situation/Financial

Current Status
- What is good about where you live? What do you like about where you live? (e.g., warm, good food, activities, etc.)
- Do you have a TV you can watch?
- What personal assets related to daily living does the person have? (e.g., Do you have a radio, music player, TV, etc.?) Not This can help identify wants – does the person wish he/she had a computer?
- Are there details, special attributes about the setting that the consumer is proud of or enjoys? (eg collects things, paintings, is particularly tidy, embroiders, has aquarium, etc.).
- What does the person enjoy doing or is good at doing in terms of daily living task if anything? (e.g., cooking, cleaning, grooming, etc.)
- Do you have a bank account? What kind?
- Payee? Name & address
- How do you budget & manage your

Desires/Aspirations
- Do you like where you live? When you leave the facility where would you like to live?
- Do you like living alone? With other people?
- If you could change one thing about your living situation, what would it be?
- What would your ideal living situation be? (e.g., living on a farm, buying a home, etc.)
- Is there anything you would want to make your living situation easier? (e.g. a music player, posters, books, etc.)
- What is most important to you in your living situation? (e.g., feeling safe, people to talk with, private space, etc.)
- What would you like to be different with regard to finances? How?
- What is important to you regarding you

Resources
- Where have you lived in the past (list each)? With whom? For how long? What was the type (apartment, group home, house, nursing facility) and location?
- Are there things you really liked about any of the past living situations?
- What was your favourite living situation? Why?
- Are there things you had in a past living situation that you do not have now but you would like to have again?
- What was the person's income in the past? From what sources? (e.g. Has the person worked in the past? Did they get benefits they do not receive now?)
- Did the person use/have any resources in the past

money?
- How do you pay your bills?
- Do you have extra spending money each week? How much?

Income (type and amount), eg:
- Centrelink (DSP, etc), DVA
- Income from work
- Family/friends loans/assistance

finances? (e.g., I want extra money each week to buy treats; I want to be able to rent movies; I wish I had a savings account, etc.).
- Are there benefits the person is entitled to, but is not getting?

that they are not using now? (e.g., payee, taking a financial management class, used to have a savings/checking account, etc.)

Vocational/Educational

Current Status

- What is the person doing with regard to productive activity? Include type, where, and amount of time. (e.g., Correspondenc classes in art, self-paced learning on a topic of interest).
- Activities that could be included in this category: volunteer work, school, odd job helping others, etc.
- Highest level of education (e.g., GED, hig school, 22 hours of undergraduate work, B.A., etc.)
- What do you like about your current activities, etc.?
- What is important to the person about what they are doing? (e.g. "I like the extra money", "helping people", "being around people", "being in charge of something", etc.)

Particularly if the person is not doing anything in this area, what are their interest skills, abilities related to productive activity? (e.g. "I'm very mechanical", "I enjoy the outdoors", "Art is my passion", etc.)

Desires/Aspirations

- Do you have any desire to work? Go to school? Volunteer? Earn extra money?
- If so, what would that be doing? What do you enjoy doing? What do you have experience doing? (e.g., "I'd like to get a nursing degree", "I like to wo outside and with my hands", "I like helping people", etc.)
- If you could be or do anything you wanted (career-wise), what would that be? What is it about that that interests you?
- If the person is doing some type of activity currently, is the person satisfied with what they are doing? Is there anything about what they are doing they would like to change? Is there any other activity they would like to do in addition?

Resources

- What type of activity (work, school, volunteer work, training, etc.) have you done in the past? For how long? When? Where? What did you lik or not like about it?
- What kind of vocational services have you received in the past?
- Have you been/are you on any work incentive programs?
- What work situations have you found most enjoyable and why?

Social Supports/Spirituality*

Current Status

- Who do you spend time with? Who are your friends? Who do you feel close to? Who makes you feel good when you're around them?
- Do you have anybody that comes to visit you or that you spend time with? What kinds of things do you do together?
- Do you have a pet? Would you like one?
- Do you have visits from any members of your family? Are the visits pleasant or stressful? Do you rely on any members of your family for support?
- What is it you like and dislike about being with other people?
- What is it about being alone that you like? What kinds of things do you do when you are alone? What do you do when you fee alone?

- Is there anything in your life that brings you a sense of comfort, meaning, or purpose in your life?
- What gives you the strength to carry on in times of difficulty?
- What do you believe in?
- What do you have faith in?

Aspirations/Desires

- Is there anything that you would like to be different in your social life?
- Are there any areas of you life you would like to have more support in? (e.g., spirituality, better relationship with family, more friends, someone to share your interests, etc.)
- Are there organizations, groups, clubs that you do not currently belong to, bu would like to? (e.g., church, rotary club, book club, astrology club, etc.)

- Are there beliefs and values you'd like to learn more about?
- Are there steps along your spiritual journey that you'd like to reach?
- Would you like to explore your faith further? How might you do that?

Resources

- Have there been important people in your life (e.g., friends/family) that you have felt supported by in the past but currently do not spend time with? Who?
- Are there places you used to hang out/ people you used to hang out with that you do not currently? Describe who and where.
- In the past, did you belong to any groups, clubs, and/or organizations? What were they? Did you enjoy them? What did you enjoy about them?

Examples of past or current spiritual activities or pursuits may include:
- Meditation
- Art
- 12-step programs
- Temple
- Music
- Community service
- Organised religion
- Nature
- Fellowship with others
- Political justice
- Altruism/giving

*Definition of spirituality
Spirituality refers to any set of beliefs and/or practices that give a person a sense of hope, comfort, meaning, purpose in their life, or a connection to the greater universe. For some people this may have to do with God and some type of organized religion, for others it may be an individual relationship with a higher power, for others it may not be specifically defined. Religion is not necessarily synonymous with spirituality.

Do not limit the definition to only an institution, church, or denomination. Also, do not impose your own thoughts or beliefs on the person.

Leisure/Recreation

Current Status
- What do you do for fun?
- What are your hobbies?
- What do you do to relax and enjoy yourself?
- Do you ever go out on leave, escorted or unescorted? If so, what do you usually do
- Do you have a TV? Would you like one? What is your favourite TV show? Do you like movies? What kind? Who is your favourite actor?
- Do you like to read? Who is your favourite author/type of books?
- Do you like to cook? What is your favourite meal?
- What talents do you have? What are you hobbies?
- If you could do anything you wanted for one day, what would you do?
- When do you get bored? What do you do when you get bored?

Desires/Aspirations
- What fun things do you like to do, but are not doing currently?
- Have you ever wanted to try something that sounded like fun, but you never have done?
- Explore desires listed in current status.

Resources
- Explore past involvements, interests, activities listed in current status. Where did the person do the activities? With whom?
- What activities did you most enjoy in the past? What was it about the activities you enjoyed?

Frequently Asked Questions about the Strengths Assessment

(1) "How do I proceed if the person says they don't want to fill out the strengths assessment?

Always remember the fourth principle - the relationship (not the assessment form) is primary and essential. The care coordinator should always use the strengths assessment in the context and flow of the relationship, not as a static document that is forced on a person whether they like it or not. If the person is resistant to having information about them written down in this manner, respect their decision. You can fill out a strengths assessment on your own simply as a way of keeping track of the client's strengths for your own recall.

Every few meetings try introducing the document in a new way. Be sure to focus on the fact that this is not a typical "treatment" form, but rather a way to keep track of the abilities, strengths, and dreams that the person wants to achieve. When people understand that the strengths assessment is not the typical deficit, professionally directed form, but rather a celebration of all that makes them unique, they usually become more willing to give it a try.

(2) "What if the person has a history of criminal behaviour, suicide attempts, or alcohol or drug abuse, but they don't want it to be on the form? Do you just leave it out of the assessment?"

The short answer to this question is... yes. The strengths assessment is a document that is directed by the client. Many consumers may be able to reframe such things as past criminal behaviour or an addiction as a strength (e.g., how far they have come, what they have learned through the process, etc.) or as a goal (e.g., I want to take my 12 step program more seriously). However, if it is not something the person wants to be on their assessment, that choice must be honoured. As a trusting relationship develops, this information may be something that will come up at a future time.

Remember, the strengths assessment is not typically the only written assessment that is completed by the mental health agency. For billing, legal, or other risk assessment protocol most programs require a complete psychosocial history be completed in the first few weeks of intake. These documents may include important information related to past behaviour to assess for risk that the care coordinator may need to know. However, they do little to inspire the hope and future focus that promotes recovery. Some agencies have a separate intake worker fill out the initial psychosocial assessment at intake rather than the case manger. This separation helps to keep the primary helping relationship with the care coordinator focused primarily on strengths.

(3) How do you keep the strengths assessment as an on-going, working document?

Remember – the strengths assessment is a "working document". This means that it is constantly being updated. The strengths assessment can be added to or amended at any time but it is most beneficial if this can be done in conjunction with the client. The client should have a recent copy and there should be a recent copy in the chart to be referenced by other staff (e.g., vocational counsellors). Remember, the strengths assessment is not paperwork, but a central tool to promote recovery and growth. Do not let it get buried in the chart with all the other forgotten forms!

(4) "What if the person gives you information that you think is delusional (e.g., "What is your income?" "I receive a million dollars a year from the FBI.") Do I write that down?"

The short answer, once again, is...you guessed it – yes. Writing something down on the strengths assessment does not imply that we fully agree with it. The strengths assessment is a record of what the consumer tells us about themselves, their ideas and beliefs, not our opinion of the validity or "truth" of their views. If we were to not write this information down (or worse yet, attempt to convince the consumer that what they are telling us is false) we will run the risk of breaking the trust that is the foundation of the helping relationship.

What we should do is seek to learn more and find out what is underneath people's perceptions about themselves. For example, if someone were to say, "I have a telepathic relationship with my boyfriend in New York," we might explore with, "What about your relationship do you enjoy? What parts are difficult?" When done with good clinical skill and genuine interest, this type of exploration does not reinforce a harmful delusional system but rather sets the foundation of trust and safety that people often need to step out into recovery.

Consumer Participation Plan

- The Consumer Participation Action Plan should be completed on admission for consumers who have identified communication issues, and reviewed (or revisited) every three months. The form is available via *G:\Care Planning\All Tools - Care Planning Package\Consumer tools*
- If there are no changes to the information collected in the Consumer Participation Action Plan – the tool DOES NOT need to be re-done. Simply re-date the tool and review it at the Individual Care Plan review presentation at the Team Meeting.
- There are three sections to the tool. Each section covers a different aspect of participation-
  - The first column provides a few options for the consumer and the care coordinator to consider. Read through each question together with the consumer. The consumer may want to choose more than one option (or alternatively, the consumer may want to choose options that are not listed on the tool). Where appropriate, point to the graphics to assist the consumer to focus on each option. The care coordinator may also decide to use some follow-up questions to gather more information from the consumer on a particular item.

- The middle column is used to record the consumer's **preferences** in relation to the questions in the first column. This gives an opportunity for the care coordinator to acknowledge exactly what the consumer wants- even if it is impractical. This column should be completed by the consumer. The consumer should write down exactly what they want, including information about who should be involved, and when (or how often) they'd like for things to happen (e.g., I want to attend the team meetings every time my Care Plan is reviewed, with my carer). The care coordinator can assist the consumer to write down their preferences – but at this stage, it should be about finding out what the consumer wants, and helping them to define this more clearly.

- The third column is used to record the "agreed actions" arising from what the consumer has identified in the middle column. This column should be completed by the care coordinator. This column should reflect the final outcome of any negotiations between the care coordinator/treating team and the consumer as to what is achievable. The care coordinator should write down specific and detailed (who, what, when) **actions** that should be carried out to meet the consumer's identified preferences and needs (e.g., Care Coordinator will provide a reminder when the Care Plan review is on- a week in advance, and also on the day the Care Plan is presented at the team meeting). The "agreed actions" should be discussed at the Individual Care Plan review meeting and approved by the multidisciplinary treating team.

Drug Check and AUDIT

The Drug Screen and AUDIT are the standardised tools to be used for screening of alcohol and drug problems for adult consumers at The Park. These tools are available as templates on CIMHA.

It is suggested that these tools are used with in the following way:

On Admission:

- The Consumer Assessment form on CIMHA should be completed by admitting staff, which includes a drug check to identify potential problems or hazardous use. A copy is to be included in the clinical file.
- The AUDIT should be completed on CIMHA by admitting staff or the care coordinator/associate, with a copy in the clinical file.

If a problem of use is identified with these tools:

- The full Drug Screen tool on CIMHA should be completed with the consumer, which includes the Severity of Dependence Scale and brief Readiness to Change assessment.
- The Problem List (on CIMHA) and complete Readiness to Change Questionnaire (*G:\Care Planning\All Tools - Care Planning Package\D&A Screening tools*) are to be completed with the consumer for each problem substance identified.
- The clinical team may also use other assessment tools that they feel are appropriate.
- The results of these screening tools should be fed back to the clinical team and possible interventions discussed, if required.

Reviews:

- **For those consumers identified as having a problem with substance misuse**, the Drug Screen and AUDIT should be completed with each care planning review every 3 months, or on a frequency determined by the clinical team. The Problem List and additional tools may be completed every 12 months or when clinically indicated, e.g. in planning transition or discharge.
- **For consumers who do not have an identified substance misuse problem**, review using the Drug Screen & AUDIT should be done annually.

Other/Ad Hoc:
Use of the screening tools is also recommended for consumers who are not regularly screened in the following situations:

- If the treating team suspect that the consumer has recently commenced or recommenced using drugs/alcohol.
- If the consumer returns a positive urinary drug screen.
- If the consumer admits to having used or had access to drugs/alcohol.
- If there is a score of 2 or higher on item three of the HoNOS at any 3 monthly review.

The assessment results should inform care planning. **All consumers with an identified substance misuse problem should have relevant treatment goals and strategies written in the Individual Care Plan.** Please see the Drug & Alcohol Clinical Pathway as a reference point for possible treatment options.

What if the consumer refuses to complete the tools?
If the consumer refuses to participate, the team can still identify potential drug use issues using other sources, e.g. past history, observation, clinical notes, relatives, referring agencies. Treatment and interventions should still be planned, and assume that the consumer is at a pre-contemplative stage of change (see "Stages of Change" document in *G:\Everyone\Drug&Alcohol\Stages of Change.pdf*). It should be noted in the care plan if the consumer has not participated in the screening and assessment process.

Notes about the tools:

- Attempt to get at least two sources of information to complete the screening tools, usually the consumer and another source (clinician, family member, clinical chart, etc).
- Scoring guidelines are provided on the tools for the Drug Screen & AUDIT.
- The Readiness to Change Questionnaire provides a guide to which stage of change the consumer is at in relation to their substance use. This can assist clinical teams in deciding on appropriate interventions to attempt with the consumer.
- All tools are available at *G:\Care Planning\Tools\D&A Screening Tools* OR *G:\Everyone\Drug&Alcohol\Screening tools*

Involuntary Patient Summary

The *involuntary patient summary* maintains current information that is pertinent to risk assessment and risk management. This form is a template on CIMHA.

The purpose of the summary is to ensure information is readily available to front line and mental health staff, particularly for those who are unfamiliar with the consumer. Completion of the summary is mandatory for all forensic patients and classified patients; however, the summary may also be completed for patients under involuntary treatment orders.
The summary must:

- include diagnosis; *Mental Health Act 2000* status; LCT provisions and conditions; offence history; contact details of the treating service and any other pertinent information
- be completed in CIMHA every three months and more frequently as new information presents, such as AWOP incidents or new offences are accrued
- at each update, a hard copy is to be placed in the front of the clinical file and MHA Administrator's (Medical Services Officer) file. **Please ensure that the MSO either receives a hard copy, or is notified when an IPS is updated on CIMHA.**

Information recorded in the summary should be relevant to risk management and risk assessment. Information from the summary may be transcribed onto the *Additional information to accompany authority to return patient to AMHS* form, as appropriate.

Carer participation and sharing information with carers

Carers, family and friends are an important support and resource for consumers, source of information for mental health teams, and can greatly assist in working towards recovery goals. There are issues that need to be considered, however, in terms of the consumer's consent for carer involvement and information sharing.

The *Consent to Carer/Family/Friend Involvement in Care* form is a way to record a consumer's consent for family & friends to be involved, how they wish to be involved, and provides a record of up-to-date contact details and special considerations.

This form is to be completed on admission, and revisited during care planning review to ensure that recorded details and consumer's wishes remain current. A copy is to be sent to the Clinical Initiatives Coordinator so that carers may be sent information packs and be included in The Park's carer database. The form is accessible from *G:\Everyone\Carer Participation\Consent to CFF Involvement in Care.doc.* See *Appendix E,* page 43 for an example of this form.

A *Carers, Family and Friends - Involvement in Care* information sheet (*Appendix F*) is also available for care coordinators to discuss with consumers the benefits of involving carers and the consumer's and carer's rights in terms of consent and information sharing. The fact sheet is available from *G:\Everyone\Carer Participation\Fact Sheet.Consent Involvement in Care.doc.*

For more information on carer participation at The Park, contact Consumer Services or the Clinical Initiatives Coordinator.

Mental Health Child Protection Form

The *Child Protection Form* is a standardised note template in CIMHA. The *Child Protection Form* should be completed, saved and signed electronically on CIMHA. A hard copy must be printed and filed behind the Individual Treatment Plan divider of the clinical record.

The following process applies to all consumers who are current consumers with a mental illness and have care responsibilities (on a full-time or periodic basis) to children under 18yrs. "Care responsibilities" for a mental health consumer who is an adult (18yr+) with a mental illness includes:

- biological children and children within a step or de-facto relationship; and
- children for whom a mental health consumer has care responsibilities on a full-time or periodic basis (including access arrangements to own children or sole care of partner's, housemate's or friend's children)

Admission

On every admission to the clinical area the Care Coordinator (CC), in collaboration with the clinical team, must aim to identify any children (0-17yrs) for whom the consumer has care responsibilities (see definition). This information should be sought through consumer interview and collateral information. If the consumer is unable or unwilling to provide information regarding their care responsibilities for children, collateral information must be sought. This is to be conducted with the informed consent of the consumer.

If it is identified that the consumer has care responsibilities for children, the *Mental Health Child Protection Form* must be completed. This form identifies:

- the demographic details of the children
- the immediate welfare needs of the children
- the presence (or absence) of an immediate reasonable suspicion of child abuse and neglect at the time of completion of the form necessitating a report to the Department of Child Safety.

In the event a *Child Protection Form* has already been initiated by another Mental Health Service, this form should be reviewed to ensure all information is correct and up to date and reporting is to be initiated as required (see section on Reporting Reasonable Suspicion).

On admission, the CIMHA system also requires identification of child protection issues. The user registering the admission will be required to respond to the following question:

'Does the consumer have custody or care responsibilities (either on a full-time or periodic basis), to any child/ren (0-17 years) in their current living address?'

If unknown at time of admission the registering user should tick *'No'*. In the event a *Child Protection Form* is initiated, this section of the service episode information in CIMHA should be updated accordingly.

If deemed necessary by the clinical team, where a consumer has custody or care responsibilities, a *Family Support Plan* and *Child Care Supplement Plan* can also be completed at this time. These forms are available on CIMHA.

Review

The *Child Protection Form* should be reviewed by the CC, in collaboration with the clinical team, at the three monthly Care Plan review. The form should be updated and reporting initiated as required (see section on Reporting Reasonable Suspicion).

Review of the *Child Protection Form* should also occur when there has been a change in the consumer's status in regards to their care responsibilities for children, e.g. gives birth, change in accommodation, relationship changes.

Discharge

The *Child Protection Form* should be reviewed by the CC in collaboration with the clinical team, prior to discharge. The form should be updated and reporting initiated as required (see section on Reporting Reasonable Suspicion).

Upon ending the service episode in CIMHA the following questions will need to be answered:

1. *'Does the consumer have custody or care responsibilities (either on a full-time or periodic basis) for a child?'*

   If *'Yes'* is entered in response to the above question the following will be asked:

2. *'Has an assessment been conducted using the 'Guidelines for the consideration of issues related to the impact of mental illness on a consumer's parenting role Assessment of the Impact of Mental Illness on Parenting'?'*

   A response of *'No'* will require a reason as to why this has not been completed.

Reporting Reasonable Suspicion of Child Abuse and Neglect

If a Queensland Health employee has reasonable suspicion of child abuse and neglect, a report should be made to the Department of Child Safety. This report should be based, wherever possible, on a comprehensive clinical assessment of both the risk and protective factors impacting on the child or young person.

For information and assistance in relation to reporting reasonable suspicion of child abuse and neglect contact the CNC Child Protection or [redacted] or pager [redacted] during business hours. The form for reporting to the Department of Child Safety can be found in the Child Protection Resource Folder located in each unit or online at http://qheps.health.qld.gov.au/csu/pdf/scan_forms/form_interactive.pdf

Other Assessments/ clinical area tools

Your clinical area may have a number of other tools that are used to assess and plan the clinical needs of consumers. For more information on these, and how they are used in your area, talk to your Clinical Nurse Consultant or clinical supervisor. Some of the tools used in the clinical areas include:

For Extended Treatment and Rehabilitation/Dual Diagnosis:

- Medication Self-Management Checklist
- ETR & DD Consumer and Family Consultation Form
- ADL Checklist

For High Security:

- HCR-20
- DASA

Other tools include, but are not limited, to:

Assessment Checklist Cultural Diversity – for use with people from culturally and linguistically diverse backgrounds. The care plan includes a prompt question and link to this form.

Clinical Chart Audit – is a quality improvement tool to ensure that clinical charts and documentation are meeting national accreditation, Queensland Health, and local standards. These are generally completed by the care coordinator as they review the clinical documentation in preparation for care plan reviews every three months.

Crisis Intervention Plan – used particularly with forensic clients, or those at high risk, as a communication tool. Outlines the risk management and crisis intervention plan for the consumer, e.g. whom to contact and how to respond to the consumer in a crisis. Useful for sharing with police, community services and family as part of a consensual intervention plan. The Crisis Intervention Plan is a standardised tool on CIMHA and is to be completed in consultation with the Forensic Liaison Officer (FLO).

Inter-Service Communication Plan – formerly, the Crisis Management Plan, this form was developed for forensic clients, or those at high risk, who are accessing more than two nights unescorted leave in the community. It is provided to receiving services and agencies including supported accommodation service contacts, family members, approved responsible adult and provides information on risk management, e.g. whom to contact and how to respond to the consumer in a crisis. The Inter-Service Communication Plan is unique to The Park and is to be completed in consultation with the Forensic Liaison Officer (FLO).

Resources

Relevant G:drive directories:

G:\Care Planning (includes the package of tools, audit results, and relevant information)
G:\Everyone\Carer Participation (includes forms, fact sheet, and carer participation plan).
G:\Care Planning\CIMHA (includes training resources, fact sheets and relevant information).
G:\Everyone\Drug&Alcohol (includes tools and relevant information).

Workplace Instructions on care coordination available from:

G:\Everyone\Workplace Instructions – All Areas

Strengths Model information available from:
G:\Care Planning\Strengths Model

Library resources/references:

Rapp, Charles A. & Goscha, Richard J. (2006). *The Strengths Model: Case management with people with psychiatric disabilities*. New York: Oxford University Press. (Available on interlibrary loan).

Rapp, Charles A. (1998). *The Strengths Model: Case management with people suffering from severe and persistent mental illness*. New York: Oxford University Press.
(From The Park library call no. 362.20425STR 1998).

Walsh, Joseph. (2000). *Clinical case management with persons having a mental illness: A relationship-based perspective*. Belmont: Wadsworth.
(From The Park library call no. 362.20425CLI 2000).

Repper, J. & Perkins, R. (2003). *Social inclusion and recovery : a model for mental health practice*. New York : Baillière Tindall.
(From The Park library call no. 362.20425 SOC).

Perkins, Rachel & Repper, Julie. (1999). Working alongside people with long term mental health problems. Cheltenham : Stanley Thornes.362.2042562 WOR

Ralph, Ruth O. and Corrigan, Patrick W. (eds) (2005). Recovery in mental illness : broadening our understanding of wellness. Washington, DC : American Psychological Association. 616.891 REC 2005

Hall, A. , Wren, M., & Kirby, S. (eds) (2008). Care planning in mental health : promoting recovery. Oxford : Blackwell Publishing. 616.890231 CAR 2008

Appendix A

The Park - Centre for Mental Health

CARE PLANNING PACKAGE CHECKLIST

Affix Patient ID Label Here

- The tools listed below are the required documents that make up the Care Planning Package. These tools need to be reviewed every three months. Additional tools that are specific to clinical areas or specific patients can be added as required.
- Indicate in the tick box once each assessment has been completed, reviewed, refused or is not applicable (N/A).
- Ensure all documentation is signed by relevant parties ie. Care Coordinator (CC), Doctor &/or Consumer where possible

Date:	/ /	Review type:	New episode ☐	Standard Review ☐	Ad Hoc Review ☐ End of Episode ☐
Risk Screen Tool	Completed on CIMHA ☐	Comments:			
Individual Care Plan	Completed ☐	Uploaded on CIMHA ☐	Comments:		
Recovery & Relapse Prevention Plan	Consumer Completed ☐	Reviewed - No changes ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐	
Strengths Assessment Tool	Completed ☐	Reviewed - No changes ☐	Allied Person Input ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐
HoNOS	Completed ☐	Entered on CIMHA ☐			
Life Skills Profile (LSP)	Completed ☐	Entered on CIMHA ☐			
Mental Health Inventory (MHI)	Consumer Completed ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐	Entered on CIMHA ☐	
Involuntary Patient Summary (IPS)	Completed on CIMHA ☐	Sent to Medical Services ☐	N/A ☐		
Allied Person	Completed ☐	Sent to Medical Services ☐	Reviewed - No changes ☐	N/A ☐	
Drug Check, Audit & Problem List	Completed on CIMHA ☐	Reviewed - No changes ☐	N/A ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐
Consent to Carer/Family/Friend Involvement	Consumer Completed ☐	Copy to Clinical Initiatives Coordinator ☐	Reviewed - No changes ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐
Consumer Participation Action Plan	Completed ☐	Reviewed - No changes ☐	N/A ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐
Crisis Intervention Plan (CIP)	Completed on CIMHA ☐	Copy to DHLO & AMI NM ☐	Reviewed - No changes ☐	N/A ☐	
Inter Service Communication Plan	Completed & uploaded on CIMHA ☐	Copy to DHLO & AMI NM ☐	Reviewed - No changes ☐	N/A ☐	
Child Protection Form	Completed on CIMHA ☐	Printed & submitted for filing ☐	N/A ☐		
Other Assessments/Clinical Area Tools: *eg LCT, HCR-20, QPS Exam Assistance Form, Allied Health reports*					
Clinical Chart Audit	Completed ☐				

Appendix B

INDIVIDUAL CARE PLAN (ICP)

The Park – Centre for Mental Health

Patient ID Label

CONSUMER PROFILE

	Name	*Signature*	
Consumer:	Mike Leggings		**Date Completed:** 30/7/2013
Care Coordinator:	Johnny C. Lately		**Review Date:** 1/8/2013
Assoc. Care Coordinator:	Anna Conda		**Approximate MHRT Date :** 13/9/2013
Authorised Doctor:	Bill Waternauese		

Note: The ICP must be signed by the Authorised Doctor to comply with the MHA2000. When signed by an Authorised Doctor, this form replaces the MHA2000 Treatment Plan Form.

Regular assessment to be conducted by the authorised psychiatrist (*state the intervals in days or weeks*): 6 weekly

☒ **ICP discussed with consumer**
☒ **Consumer given copy of ICP**
☐ **Consumer attended Team Meeting**
☐ **Unable to discuss with consumer due to:**

Significant Progress/Setbacks for the consumer over the last 3 months (*including medication changes, PRIME Incidents, seclusion, engagement in structured day, leave etc*):

- Michael continues to have auditory hallucinations, some of which are distressing and others he finds comforting or amusing.
- Expresses anxiety over financial matters, keeping his flat, and fear of neighbours stealing property (?delusional)..
- Some agitation over past 3 months; two incidents of requesting time in comfort room
- Disorganised thinking, poor concentration and attention.
- Medication:

Olanzipine 10mg nocte
Alprazalam 1mg PRN

Diagnosis: Schizophrenia, unspecified F20.9

Mental Health Act 2000 Status:

☐ Voluntary ☐ ITO ☒ Forensic ☐ SNFP
☐ Classified ☐ Chap 7 (part 2)

Current Limited Community Treatment (*currently accessing*):

☐ Escorted Campus Leave ☐ Unescorted Campus Leave ☐ None
☐ Escorted Ground Leave ☐ Unescorted Ground Leave
☐ Escorted Off-Ground Leave ☐ Unescorted Off-Ground Leave ☒ Overnight Leave

Has a *Crisis Intervention Plan (CIP)* and/or *Inter-Service Communication Plan* been completed in conjunction with the Forensic Liaison Officer (FLO)?

CIP: ☒ Yes ☐ No ☐ Not Required
ISCP: ☐ Yes ☐ No ☒ Not Required

Does this consumer have active **alerts** in place?

☐ Yes ☒ No ☐ Has alert been entered/reviewed on CIMHA?

Maintaining Mental Health: Managing Symptoms, Recognising Signs of Becoming Unwell, Risk Assessment & Management Plan

Has the consumer completed a *Strengths Assessment* ? ☒Yes ☐ No	Has seclusion and/or restraint been used with this consumer? ☒Yes ☐ No
Has the consumer completed a *Consumer Participation Action Plan* ? ☐Yes ☒ No	Has a *Trauma Restraint and Seclusion Tool* been completed? ☒Yes ☐ No
	Has a *Seclusion Episode Form* been completed? ☒Yes ☐ No
Consumer's Goal Statement: I want to learn how to relax and stop the jitters when they happen.	**Summary of Current Issues:** Troubled by auditory hallucinations (the male voice he calls "my uncle" telling him he's worthless). High levels of anxiety. Restlessness, poor concentration, disorganised thoughts. Previous aggression. See psychologist report 22/6/13.

HoNOS Scores	1	2	2	0	4	2	6	3	7	0	8	2

LSP Scores	7	0	10	2	11	1	12	1	14	1	15	1

Areas to consider: Psycho education, Consumer's coping strategies, Managing medication side effects, Psychological interventions, Counselling, Relaxation techniques, restrictive practices. Refer to Consumer Strengths Assessment, Risk Screening Tools & Management Plans, Behaviour Management Plans, Psychologist Assessments, HCR20

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Try three different relaxation techniques to use when Mike is feeling anxious.	I will find out about different techniques and choose 3 to try. Learn and practice techniques, one at a time.	Provide information and training for relaxation techniques. Support and encourage Mike in practicing relaxation. Help Mike identify which techniques work best, and why. CBT approaches to be tried through weekly sessions.	Psychologist, rehab staff. All staff. Psychologist, CC, rehab staff. Psychologist	1/10/13
Chart the use of PRN medication for anxiety.	Mike will record his mood and triggers for when he requests PRN medication.	Record symptoms, triggers and other factors when PRN medication given on PRN Chart.	Nursing staff	1/10/13
Continue with medication regime and monitoring side effects.	Take medication as prescribed. Tell staff about any concerns or changes.	Administer medication as prescribed and monitor side effects, particularly weight gain.	Medical & nursing staff.	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)

e.g. medications, psycho-social interventions, risk management strategies

Strategy	Did it work? Provide details	Date Attempted/Implemented
Use distractions when Mike is disturbed by voices.	Using music and TV as distractions worked well, and talking reassuringly to Mike. Playing cards or games does not work effectively, as Mike is unable to concentrate.	Commenced May 2013 Continue as required.

HoNOS: 1- Overactive, aggressive, disruptive or agitated; 2- Non-accidental self injury. 4- Cognitive problems; 6- Problems with Hallucinations/Delusions; 7- Problems with Depressed Mood; 8- Other mental/behavioural problems
LSP: 7- Violence to others; 10- Medication reliability/compliance; 11- Willingness to take medication; 12- Co-operation with health workers 14- Offensive behaviour; 15- Irresponsible behaviour.

Physical health, Nutrition & ADL's: Weight, Diet, Physical Co-morbidities, Self Care, Hygiene.

Height 179 cm	Weight: 82 kg Date: 1/8/13	BMI: 25.5 Date: 1/8/13	Waist Circumference: 92 cm Date: 1/8/13	Weight Hx (inc dates): Has put on 5kg in approx 6 months. Stable at 77kg 2011-2012.

Consumer's Goal Statement:	**Summary of Current Issues** *(inc physical co morbidities)*:
I'd like to feel fit again. My black jeans are too tight.	Recent weight gain. Lack of physical activity. Issues with hygiene and self care – recurrent skin and fungal infections.

HoNOS scores	5	1	10	2		LSP scores	4	2	5	1	6	2	9	0

Areas to consider: Fasting Glucose, Cholesterol (HDL-C, LDL-C) Triglycerides, Blood Pressure, Behavioural Therapy Strategies, Lifestyle/Activity Changes, Dietary Modifications, Support Services (eg Lifestyle Clinic, Dietetic Services, Diabetes Clinic), Self Care, Hygiene, Infectious Diseases, Disabilities, Acute and Chronic Conditions
Refer to Metabolic Management Action Plan, Weight & Obesity Management Action Plan, Rehab Progress Reports, Lifestyle Clinic Report

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Attend Lifestyle Clinic through GHS	Attend appointments. Attempt changes to diet & activity as suggested by dietician.	Remind of appointments. Advise on specific goals and strategies for Mike. Support lifestyle changes. Monitor physical health & weight.	Nursing staff. Dietitican & GHS All staff. Nursing staff & CC.	1/10/13
Mike will engage in at least one physical group activity each week.	I will choose a sporting or moving activity to attend each week (eg walking, swimming).	Encourage and support Mike to attend rehab activities on offer. Ask Mike specifically when activities are being run.	All staff. Rehab team	1/10/13
Improve hygiene and skin care.	I will have a shower every day and put the cream on my skin morning and night.	Prompt Mike to shower and apply antifungal ointment. Assist if necessary. Prompt Mike to change clothes regularly.	Nursing staff & CC	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. diet, exercise programs, education, clinical interventions

Strategy	Did it work? Provide details	Date Attempted/Implemented

HoNos5- Physical Illness or Disability. 10- Problems with ADL's
LSP: 4- Personal grooming. 5- Clean clothes 6- Neglect of physical health. 9 does this person generally maintain an adequate diet

Substance Misuse: Drugs, Tobacco, Alcohol & Other Harmful Substances.

☒ *Drug Check & Audit* Completed on CIMHA Date: 1/08/2013 Substance Misuse Problem identified ☒Yes ☐ No	☒ *Readiness to Change Questionnaire* Completed/Reviewed Date: 1/08/13 ☒ *Smoking Cessation Pathway* Completed Date: 1/08/13
Consumer's Goal Statement: I want to stop smoking forever	**Summary of Current Issues:** Was a heavy smoker (40 a day) but has been successfully using inhaler & patches to cease smoking. Occasional drug use when on leave.

HoNOS Scores	3	3	LSP Scores	6	2

Areas to consider: Motivational Interviewing, ATODs Support, MAISE Program, Psycho education Programs
Refer to Drug Check & Audit, Readiness to Change model, D&A Pathway

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Start decreasing use of Nicotine Replacement Therapies.	Reduce daily use of inhaler. Continue to wear NRT patches.	Encourage use of inhaler as PRN only.	Nursing staff	1/10/13
Routine UDS to be completed when return from overnight leave as per LCT conditions	I will not use drugs while on leave & cooperate with UDS on return.	Administer UDS when consumer returns from leave.	Nursing staff	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. education programs, nicotine replacement strategies etc.

Strategy	Did it work? Provide details	Date Attempted/Implemented
Attended MAISE rehabilitation program	Helped Mike understand his recreational drug use. Mike has avoided situations likely to lead to drug use while on LCT.	April 2013

HoNos: 3- Problem drinking or drug taking LSP: 6- Neglect of physical health.

Daily Living Situation/Financial/Vocational/Educational: Current & Future Accommodation, Money Management, Qualifications, Ambitions

Finances	☐ Capable	☒ Incapable	☒ Public Trustee	☐ Family (give details)	☐ Waiver type:

Consumer's Goal Statement:	Summary of Current Issues:
I want to live in a flat with my brother Frank. I would like to work as an accountant one day, because I like numbers and money.	Limited budgeting and money management skills, mostly due to impulsiveness (has good numeracy skills). Previously lived with brother, though concerns regarding influence in illicit drug use and peer group. See Strengths Ax and Occupational therapy report (2/6/13).

HoNOS scores	11	2	12	3	LSP scores	13	2	16	3

Areas to consider: Trust Agreements. Money Management, Volunteer work, Vocational Training Programs, HASP, Transitional Housing, CCU relocation, Self-care skills, Shopping, Driving, Community access/use of public transport. Food preparation skills, Housekeeping, Time management, Laundry, Use of a mobile phone / public phone/land line phone, Medication management, Caring for a child or pet

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Use LCT opportunities to plan and practice money management.	I will find out how much things cost, like going to the movies, and save for them.	Identify ways of budgeting with Mike. Use tools from the Money Management programs to assist.	CC, rehab staff and OT	1/10/13
Explore Mike's interest in accounting and bookkeeping.	I will talk to my dad's mate, John, who's an accountant. I'll borrow books from the library about bookkeeping and look it up on the internet.	Provide opportunities for Mike to find information, eg trips to library & supervised internet access. Support Mike in understanding this information.	CC. rehab staff and OT	1/10/13
Explore feasibility of living with brother Frank.	I will ask Frank to come and talk with the team, and if he doesn't mind me living with him again.	Arrange meetings with family (brother, sister, and mother) to discuss concerns and options for living arrangements in future (inc. access to drugs).	Social worker	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)

e.g. course attendance, work programs, accommodation options

Strategy	Did it work? Provide details	Date Attempted/Implemented
Undertake Money Management program	Mike completed the 8-week program, and showed good skills in calculating, but limited skills in knowing how much things cost and budgeting for daily living costs.	Completed February 2013
Started ACE course in using Microsoft Excel and Word	Mike's mental state declined after the second week of the course, and did not complete it.	Attempted June 2012.

HoNos: 11- Problems with living conditions, 12- Problems with occupation and activities. LSP: 13- Problems with others in the household. 16- Type of work is this person capable of performing.

Social Supports/Spirituality: Community Support, Family, Friends, Church, Spiritual & Cultural Needs.

Allied Person: ☒ Yes Name: Anne Leggings ☐ No – yet to be specified ☐ Not Applicable	Guardianship Order: ☐ Yes ☒ No If yes, what is the nature of the order:
Has this care plan been discussed with the Carer? ☒ Yes ☐ No Has a *Consent to Carer/Family/Friend Involvement in Care* Form been completed? ☒ Yes ☐ No Does the Consumer come from a CALD background? ☒ Yes ☐ No If yes, is the Cultural Mental Health Worker engaged? ☐ Yes ☒ No Has the ATSI Liaison Officer been engaged? ☐ Yes ☐ No ☒ N/A	Has the *Cultural Diversity Assessment Checklist* been completed? ☒ Yes ☐ No Are there other External Agencies/NGO's engaged? ☐ Yes ☒ No If yes, provide details: Has the family been referred to the Rehabilitation Social Worker for a single session family support program? ☒ Yes ☐ No
Consumer's Goal Statement: I'd like to follow my faith and find out more about Judaism. I want to make friends who won't push me back into drugs. I'd like to have a girlfriend.	**Summary of Current Issues:** Mike's mother is from Israel and follows the Jewish faith. Mike followed Judaism and learnt some Hebrew as a boy, and has recently shown interest again. Mike has no close friends, apart from 'party' acquaintances who took drugs. Mike has lost a lot of money in the past by giving it to 'friends' who then spent it on alcohol and drugs.

HoNOS scores	9	2		LSP scores	1	2	2	0	3	1	8	3

Areas to consider: Strengths Assessment, NGO engagement, Family engagement, How does the person keep in touch with family & other support networks?

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Arrange weekly contact with the Brisbane Jewish youth group.	I will attend the Jewish youth group every week, and will try to make friends their. I will talk to the Rabbi when I'm feeling lost spiritually.	Enable LCT for Mike to attend youth group. Provide opportunities for Mike to discuss the group, and practice social skills and developing friendships.	CC, all staff.	1/10/13
Practice social skills during weekly BBQs.	I will try to have a conversation with someone different every week. I'll practice the things that I learn with the staff.	Encourage Mike to have conversations with others. Prompt Mike with techniques, ideas for topics & openers, avoiding distraction of voices, etc.	CC, All staff CC, all staff.	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)

e.g. linkages with community, family visits, church attendance

Strategy	Did it work? Provide details	Date Attempted/Implemented
Attended 8-week Social Skills Training rehab program	Mike gained some insight into issues with drug-using acquaintances. Practiced assertiveness, which he has used to some success on the ward (eg refusing to give money to others when he doesn't want to).	Completed program in March 2012

HoNOS: 9- Problems with relationships; LSP: 1- Difficulty responding to conversation; 2- withdraw from social contact; 3- show warmth to others; 8- make/keep friendships.

Leisure/Recreational: Interests, Hobbies, Sporting Activities

Consumer's Goal Statement:	Summary of Current Issues:
I'd like to go to Punt Road in Melbourne one day and meet the Richmond Tigers (AFL team). I'd like to go to a live footy game again. I want to go to the movies more often.	Mike is an avid fan of the Richmond Tigers AFL team, and follows the games each week (watches them if they are televised). Mike used to play team AFL. Not currently engaged in any sporting or physical activity. Enjoys singing and some other group activities.

HoNOS scores	12	3	LSP scores	2	0

Areas to consider: Strengths Assessment
Refer to Participation in Structured Day activities

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Use money management strategies to plan 2 trips to the movies in the next 3 months.	I will check my spending and make sure I have money saved to go to the movies. I will check the newspaper for movies and times I'd like to go.	Encourage Mike to avoid impulsive spending. Provide support to plan movie trips (eg finding section in newspaper, discussing movie reviews). Provide LCT opportunities and staff to attend.	CC & A/CC Clinical team, rehab team.	1/10/13
Practice football skills at least once a week (see goals in Physical Health section)	I will ask for the footy and have a kick around the yard with the guys at least every Monday.	Provide football and opportunities to practice. Encourage activity. Refer to exercise physiologist for physical assessment and exercise tips.	Nursing and Rehab staff. CC & exercise physiologist.	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. attendance at Diversional Activities, Groups, Outings

Strategy	Did it work? Provide details	Date Attempted/Implemented

HoNOS: 12- Problems with occupation and activities. LSP: 2- withdraw from social contact

Recovery & Relapse Prevention Plan: How can I stay well & avoid crisis? What can I & others do to help when I am feeling stressed?

What I am like when I am feeling alright & well:	I like singing and talking to others when I'm well. I used to sing to myself a lot. I want other people's company when I'm feeling good.
Things I need to do to keep me feeling well:	I need to take my medication. I need to keep busy and find things to occupy my mind and body. I need to listen to music when the voices get annoying.
Things that cause me stress. Are there people, places or things to avoid?	I don't like shopping centres when I'm jittery. I don't like the noisy food courts. I don't like being on the ward when the other patients are noisy or angry.
Things I might notice when I am getting stressed:	I get jittery and restless – can't stay still. I feel all squirmy inside, and my head gets either all stuffed up or has the voices getting angry.
Things others might notice when I'm starting to get stressed:	My legs bouncing up and down. I walk up and down a lot. Sometimes I hold my head, or talk to the voices.
Ways I can calm myself or make myself feel better when I'm stressed:	Go to the comfort room. Listen to my music. I want to try some relaxation stuff.
Things others can do to make me feel calmer or safer when I'm stressed:	Give me ideas of ways to relax. Walk with me when I'm pacing. Tell me that the voices aren't real. I like when Johnny says "you're stronger than your uncle" when his voice gets annoying.
People who support me and I trust to help me when I'm feeling stressed:	Johnny, my care coordinator. My mum. Jenny, the nurse on night shift.
Things that make it more difficult for me when I'm feeling stressed:	Not being able to go to the comfort room. When I can't get away from the noises.

Consumer Signature: Mike Leggings	**Date Implemented:** 12/6/2012	**Date Reviewed with Consumer:** 30/7/2013

Appendix C

Queensland Government
Queensland Health
The Park – Centre for Mental Health

CONSUMER STRENGTHS ASSESSMENT

Complete Details or Affix Patient Label

Name...Michael Leggings..... Gender. M /F

Address .....

.....

Phone... .....Mob.....

Date of Birth 23/ 8 / 1984 U.R. .....

	Present Moment What are my current strengths? What am I doing now?	Future Desires, aspirations What do I want?	Past Resources – personal, social What have I used in the past?
Mental Health	I use the comfort room when I'm jittery or the voices are annoying. I listen to my music when I'm anxious. I take my medication. I hear some nice voices that make me laugh sometimes.	I want to learn how to relax and stop the jitters when they happen.	Used PRN medication. Avoided stressful places and people. I stayed out of hospital for 9 months.
Physical Health, Nutrition, ADL's	I like to eat good food, and I love fruit and vegies. I have pretty good health, and I don't get sick very often.	I want to feel fit again. My black jeans are too tight. I want to get rid of my smoker's cough in the morning.	Learned to control my asthma when I was a kid. Don't get that anymore. I had a GP that I liked. I was a vegetarian for a while. I used to play AFL that kept me fit.
Daily Living Situation/Financial	I get enough money through my pension to get by. I have somewhere to go when I'm on leave – my brother's place, or my mum's. I can cook and look after a place.	I want to live in a flat with my brother Frank.	I'm pretty good at cooking and housekeeping. I used to live with my brother, after I moved out of mum's place. I usually paid my bills and rent on time, before I got sick the first time.
Vocational/ Educational	I'm good at maths. I like numbers and money. I'm pretty good at using computers.	I would like to work as an accountant one day. I'd like to do some more computer courses.	I got good grades in High School for maths and science. I've had jobs at McDonalds, McGills Bookstore, did some book keeping and reception work for my dad's smash repairs shop. I liked paper work.

Social Supports/ Spirituality	I have my mum and brother, who talk to me a lot and look after me. I am Jewish. I like a lot of the traditions and beliefs. I know a lot of people on the ward and outside.	I'd like to follow my faith and find out more about Judaism. I want to make friends who won't push me back into drugs. I'd like to have a girlfriend.	My mum's Jewish and taught us a lot. I used to know some Hebrew. I had lots of party friends. They liked me because I shared and gave them money. I had a girlfriend in high school.
Leisure/ Recreational	I love the AFL, and go for the Richmond Tigers. Wish they did better. My favourite colours are yellow and black! I'm a good singer. I like listening to music. When I'm happy I like listening to dance & techno. When I'm jittery, I listen to Llor. I like his lyrics. I like movies, especially action and sci-fi.	I'd like to go to Punt Rd in Melbourne and meet the Richmond Tigers. I'd like to go to a live footy game again. I want to go to the movies more often.	I used to play AFL when I was in high school. I used to go to the games, especially when Richmond played in Brisbane. I used to have fun at parties and raves. I liked to get high.
Personal Qualities: Generous; honest; I can be funny sometimes. I'm pretty deep.			
What are my priorities: 1. Learn how to relax & stop the jitters 2. Follow my Jewish faith 3. Go to the movies more often.			

J. C. Lately	Michael Leggings
Care Coordinator signature	Consumer signature
Date Started: 8/3/13	Date Reviewed: 30/7/13
	Date Reviewed:
	Date Reviewed:
	Date Reviewed:

Appendix D

Queensland Government

Mental Health Services

Risk Screening Tool

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date: Time:

Suicide / self harm

Static factors

- ☐ Previous serious attempt
- ☐ History of self harm
- ☐ History of suicide attempt
- ☐ Family history of suicide
- ☐ Long-standing problems (e.g. unemployment, physical illness / pain, mental disorder)

Dynamic factors

- ☐ Intent / plan / thoughts
- ☐ Current suicide attempt
- ☐ Distress / anger
- ☐ Isolated / lonely
- ☐ Hopelessness / perceived lack of control over life
- ☐ Stressors in last 6 months
- ☐ Psychotic symptoms (e.g. command hallucinations)
- ☐ Other: .....

Violence (including sexual violence)

Static factors

- ☐ Under 25 years of age
- ☐ Conduct disorder
- ☐ History of violence / sexual offence / criminal history
- ☐ History of substance abuse

Dynamic factors

- ☐ Impulsivity
- ☐ Anger
- ☐ Intoxication / withdrawal
- ☐ Cognitions supporting violence
- ☐ Carries weapon / access to firearm
- ☐ Recent threats or other aggressive actions / thoughts
- ☐ At risk of sexually abusing others
- ☐ Psychotic symptoms (command hallucinations, threat-control-override and misidentification symptoms, morbid jealousy)

Vulnerability

- ☐ At risk of being sexually abused by others
- ☐ At risk of domestic / family violence
- ☐ At risk of being financially abused by others
- ☐ Deep Vein Thrombosis (DVT) risk
- ☐ Skin integrity risk
- ☐ At risk of being financially abusive to others
- ☐ At risk of self neglect (basic ADLs, complex living skills)
- ☐ Cognitive impairment / intellectual disability
- ☐ Fire risk
- ☐ Falls risk

Absence without approval

- ☐ History of absconding
- ☐ History of Limited Community Treatment breach
- ☐ Treatment refusal
- ☐ Frustration regarding hospitalisation / involuntary treatment

Clinician's name (please print):	Designation:	Signature:	Team:	Date:	Time:

DO NOT WRITE IN THIS BINDING MARGIN

MHS - RISK SCREENING TOOL

v2.00 - 03/2012

SV4201

Queensland Government

Mental Health Services

Risk Screening Tool

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Child protection risk screen

Does the consumer have custody or care responsibilities for children (full time or periodic)? ☐ Yes ☐ No

If yes, the *Mental Health Child Protection form (SW188)* must be completed.

Completed by (print name):	Designation:	Signature:	Date:

Clinical and risk formulation / assessment summary (predisposing historical factors, factors that have precipitated current admission / situation / risk behaviour, factors perpetuating risk and protective factors reducing the risk)

Overall risk summary	Low	Medium	High	Unknown	Comments regarding risk
Suicide	☐	☐	☐	☐	
Other self harm	☐	☐	☐	☐	
Aggression	☐	☐	☐	☐	
Vulnerability	☐	☐	☐	☐	
Absconding	☐	☐	☐	☐	
Dependent children / others?	☐ Yes		☐ No	☐	

Is further risk assessment required? ☐ Yes (if yes, consider full assessment) ☐ No

Clinician's name (please print):	Designation:	Signature:	Team:	Date:	Time:

Page 2 of 2

DO NOT WRITE IN THIS BINDING MARGIN

Appendix E

Queensland Government
Queensland Health

WEST MORETON SOUTH BURNETT HEALTH SERVICE DISTRICT
THE PARK – CENTRE FOR MENTAL HEALTH

(please affix patient label here)
UR Number: xxxxxx
Surname: Leggings
Given Names: Michael Richard
Date of Birth: 24/8/1984 Sex: F ☐ M ☒

CONSENT TO CARER/FAMILY/FRIEND INVOLVEMENT IN CARE

This form provides you with an opportunity to record who you want to be involved in your care. This form will be kept in your clinical file to ensure all members of the treating team are aware of your wishes. Remember, at any time you can change your decision regarding who you wish to be involved in your care and to what extent.

Please note that it is important that you have read and understood the leaflet **"Carers, Family and Friends - Involvement In Care"** before completing this form. If you have not read this leaflet please talk to the Social Worker or your Care Coordinator.

Please tick the relevant box:

☒ Yes, I give consent for the below listed carer/family member/friend(s) to be involved in my care, as specified in my care plan.

Name	Address	Phone Number	Relationship
Annie Leggings	1 Peg Avenue, Johnson Creek Qld 4321	07 5432 1098	Mother
Frank Leggings	Unit 2/26 Wild Street, Juneberry Q 4567	0404 050 060	Brother

☐ No, I do not give consent for my carer/family member/friend(s) to be involved in my care but understand you may share general information with them regarding The Park, mental illness etc.

☐ No, I do not give consent for my carer/family member/friend(s) to be involved in my care and I do not wish them to know that I am being treated at The Park.

Other Special Considerations (eg relationship history, legal issues)		
Michael has previously been acquainted with people who were drug users and dealers. He does not wish to have contact from Mr John Ferner or Miss Jane Olden, and does not want them to know of his whereabouts or treatment.		
Consumer	*Michael Leggings*	8/4/09
	(Signature)	(Date)
Witness (Staff Member)	J.C. Lately R.N.	8/4/09
	(Signature) (Position)	(Date)

- **Please send a copy of this form to the Clinical Initiatives Coordinator (Administration Building)**
- **This form is to be filed in the clinical record behind the 'Individual Treatment Plan' divider.**
- **Please destroy any superseded versions of this form.**

CONSENT TO CARER/FAMILY/FRIEND INVOLVEMENT IN CARE

G:\Everyone\Health Information Services\HIM Forms\Individual treatment forms\Consent Involvement In Care

Appendix F

The Park – Centre for Mental Health
Consumer Information Sheet

Carers, Family and Friends - Involvement in Care

When people are in hospital, often they have family or friends who worry about them and would like to know how they are. Family and friends can be important supports in a person's journey towards recovery.

Some people choose to involve their families, carers or friends in all parts of their care at The Park. Some like them to know a bit. Others prefer them not to be involved in their care at all. This is a choice we would like each person to make.

You might like to think about how you want your family, carers or friends to be involved in your care, while you are here. Some questions you might want to consider are:

- How much you want them to know about your care at The Park
- How much they can take part in decision making with you & the treating team
- If you would like them to stand up for your rights and preferences
- If you would like them to attend Mental Health Review Tribunal hearings with you, or for you (eg speak on your behalf).
- If you would like them to talk to the treating team, and how often.
- If you would like them to help you out in other ways, eg emotional, social, financial support.

It is important that your Care Coordinator knows about your wishes. Then they can record it so all treating team members know.

If you decide that you don't wish certain people to be involved in your care at all, it is important for us to understand this. The treating team highly value maintaining your privacy. Any personal or clinical details that you wish to keep private will not be shared with your carers, family or friends. However, in very rare cases such as an emergency, clinical staff may need to disclose limited information to your family, for example, in a medical emergency or if you are absent without permission.

Family members also have the right to information about mental illness, and other things that may affect them. If your family know that you are receiving care from us, we may share general information with them. This information may include:

- General information about The Park.
- General information about mental illness (we won't disclose your diagnosis if you don't want us to).
- Updates about news in the mental health field, eg research, workshops, events.
- Useful resources and support for carers.

We ask that you indicate your wishes in relation to these matters on a consent form. At any time you can change your decision regarding who you wish to be involved in your care and to what extent. Simply talk to your Care Coordinator.

If you have any questions about this information sheet or the consent form, please talk to your Care Coordinator, Social Worker, the Consumer Advocate or Consumer Consultant.

Attachment 3

The Park Centre for Mental Health

INDIVIDUAL CARE PLAN CHECKLIST - Adolescent -

Affix Patient ID Label Here

- The tools listed below are the required documents that make up the Care Planning Package. These tools need to be **reviewed every three months.** There may be additional tools that are specific to clinical areas or specific patients.
- Indicate in the tick box if each assessment has been completed. If not completed for any reason (eg consumer refusal, consumer unavailable) write the reason in the space below the tick box.
- Ensure all documentation is signed by relevant parties (i.e. Care Coordinator, Doctor & Consumer where possible)

		Date: / /	/ /	/ /	/ /
		Review type: New episode ☐ Standard Review ☐ Ad Hoc Review ☐ End of Episode ☐	Standard Review ☐ Ad Hoc Review ☐ End of Episode ☐	Standard Review ☐ Ad Hoc Review ☐ End of Episode ☐	Standard Review ☐ Ad Hoc Review ☐ End of Episode ☐
Risk	Risk Assessment Profiles:	Rating	Rating	Rating	Rating
		Aggression	Aggression	Aggression	Aggression
		Self Harm	Self Harm	Self Harm	Self Harm
		Absconding	Absconding	Absconding	Absconding
Care	ICW Progress Summary Notes	☐	☐	☐	☐
Recovery Plan	Individual Care Plan	☐	☐	☐	☐
	Crisis Intervention Plan	☐	☐	☐	☐
	Relapse Prevention Plan	☐	☐	☐	☐
Health Outcomes Scales	Health of the Nation Outcome Scales for Children & Adolescents (HoNOSCA)	☐	☐	☐	☐
	Children's Global Assessment Scale (CGAS)	☐	☐	☐	☐
	Factors Influencing Health Status (FIHS)	☐	☐	☐	☐
	Strengths & Difficulties Quest. (SDQ)	Parent ☐ Adolescent ☐ Teacher ☐	Parent ☐ Adolescent ☐ Teacher ☐	Parent ☐ Adolescent ☐ Teacher ☐	Parent ☐ Adolescent ☐ Teacher ☐
Consumer Tools	Consumer Participation Action Plan	☐	☐	☐	☐
	Strengths Assessment Tool	☐	☐	☐	☐
	Consumer Developmental Tasks Questionnaire	☐	☐	☐	☐
MHA	Involuntary / Voluntary Status	Voluntary ☐ Involuntary ☐	Voluntary ☐ Involuntary ☐	Voluntary ☐ Involuntary ☐	Voluntary ☐ Involuntary ☐
	Involuntary Patient Summary (IPS)	☐	☐	☐	☐
	Other Assessments/Clinical Area Tools: *eg. Child Protection Form, LCT, HCR-20*				
Audit	Clinical Chart Audit	☐	☐	☐	☐

Attachment 4

The Park - Centre for Mental Health
Treatment, Research and Education

Together.... Towards Recovery

The Barrett Adolescent Centre

Information for Teenagers

Queensland Government
Queensland Health

Reviewed: 08.09.06

Your rights and responsibilities (continued)

Before you agree to treatment you have a right to:

- have your condition explained in terms you will understand
- know and understand your treatment options
- know how the treatment will affect you
- be able to seek another opinion where this is possible

While you are at the Centre your responsibilities include:

- Everyone respects property, people and individuality
- We value people's safety
- We encourage optimum participation and involvement

THE TYPE OF HELP OFFERED AT BARRETT

Coming to Barrett Adolescent Centre offers help because of several factors:

- experienced, professional staff (eg. What staff will look after me? ...Case Coordinator)
- educational and life skills programs to restore confidence in many areas of teenage life
- a range of recognised therapies
- living and learning with a group of other teenagers
- within an environment comfortable to adolescents.

What staff will look after me?

During your stay you will be cared for by a team including psychiatrists, nurses, social worker, psychologists, speech pathologist, occupational therapists, dieticians, teachers, leisure therapist and others such as clerical, catering and housekeeping staff. All staff wear photographic identity badges including name, photograph and job title.

Case Coordinator

Following admission, adolescents will be assigned a nurse who will be their Case Coordinator. The Case Coordinator will maintain close contact with the adolescent and will oversee all aspects of an adolescent's treatment as decided by the Treatment Team. The Case Coordinator is the primary contact for the adolescent, their family/carers and significant others.

Individual Therapist

All adolescents are assigned an Individual Therapist who is usually a psychologist.

This staff member engages adolescents in therapeutic one-to-one counselling on a weekly basis. These sessions are confidential between the adolescent and therapist.

Family Meeting .

Depending on individual needs adolescents and their families may be involved in family therapy sessions.

A Family Therapist will be assigned for an adolescent (as required) and the Case Coordinator will work closely with this person to run therapy sessions.

Attachment 5

The Park - Centre for Mental Health
Treatment, Research and Education

Together... Towards Recovery

The Barrett Adolescent Centre

Information for Parents and Carers

Queensland Government
Queensland Health

Reviewed: 08.09.06

Prior to an adolescent being admitted to the Barrett Adolescent Centre their parents or carers often ask:

What happens at the Centre?
What do they need to bring?
Who should I talk to?
When can I visit?
and many other similar questions

This booklet has been written to give you some initial answers to these questions and to help you understand more about what happens at the Barrett Adolescent Centre.

If you have any other questions, please do not hesitate to give the Centre a call and one of our staff will be able to help.

We want you and your family to feel more comfortable with accessing our service. We look forward to working with you to bring about the best possible outcome for your adolescent.

WHAT IS THE BARRETT ADOLESCENT CENTRE?

The Barrett Adolescent Centre is a specialised centre situated in the pleasant grounds of The Park - Centre for Mental Health Treatment, Research and Education, at Wacol.

It is the only extended treatment and rehabilitation mental health centre for adolescents in Queensland.

Our mission is ***"to work together with adolescents, their parents or carers and our other partners to provide effective mental health interventions integrated with education and life skills programs that support teenagers in their journey towards recovery"***. For this reason we encourage contact by family members and most adolescents spend their weekends at home following the initial assessment phase of their admission.

The Centre also has a school that caters to the individual's academic needs.

The Centre program is designed to assess and treat adolescents with complex mental health problems. These include depression, schizophrenia, anxiety disorders and anorexia just to name a few.

Admissions may be for a limited assessment period, a longer stay treatment program, or attendance as a day patient. The therapeutic programs include group therapy, individual therapy, family therapy, adventure therapy, psychological assessment, continued education and a life skills program.

Our aim is to bring about suitable improvement in your adolescent's wellbeing, such that other forms of community treatment will be successful following discharge.

WHO CAN I TALK TO?

Prior to your adolescent's admission, our Clinical Liaison Person (Intake Nurse) will be in contact with you. This is the person who sent you this booklet. They will be there when your adolescent is admitted. You are welcome to call this person during normal office hours on [redacted] and ask to be put through to him/her.

Following admission, your adolescent will be assigned a nurse who will be their Case Coordinator. This nurse will oversee all aspects of your adolescent's treatment as decided by the treatment team. The Case Coordinator will work very closely with your adolescent to establish treatment goals and coordinate the implementation of treatment programs. It is important to maintain very regular contact with this person to discuss your adolescent's treatment. Nurses work shifts and can be contacted on either [redacted]

Whenever your adolescent's Case Coordinator is not on duty, you may call and ask for the Clinical Nurse on duty, using these same numbers. They will be able to answer your enquiries.

Throughout their stay, your adolescent will receive treatment from a variety of our multidisciplinary team members. The Treatment Team includes consultant psychiatrist, psychiatry registrar, nursing staff, psychologist, occupational therapist, speech pathologist, social worker, dietitian, teachers, social worker and leisure therapist.

The psychologist works in collaboration with adolescents to develop psychological and behavioural interventions that can be used to help manage problems such as depression, anxiety, anger and poor coping and social skills. The psychologist works with the adolescent in tailoring these to the individual's specific requirements. Some individuals may also require assessment of cognitive functioning, which the psychologist will conduct as part of a comprehensive assessment.

Depending on individual needs, the social worker will work with adolescents and/or significant others to help find other ways of approaching their problems and to plan effective action in areas such as individual casework, family meetings, group work, linking to community organisations, money management, education/schooling, cultural issues, activities of daily living, sports and recreation, and accommodation.

Your adolescent will also have an Individual Therapist who is usually a psychologist. This staff member engages your adolescent in a therapeutic relationship involving one-to-one counselling on a weekly basis. These sessions are confidential between the adolescent and the therapist. Adolescents feel free to open up more in therapy when they know their therapist only talks to them.

For this reason it is preferred that parents do not have contact with the Individual Therapist. Your adolescent's Case Coordinator will be able to advise you on what general topics are being discussed in therapy.

Depending on individual need, teenagers may also be involved in speech pathology sessions. The speech pathologist assists adolescents with communication skills. This can involve assessment, treatment in individual sessions, or group work.

The occupational therapist works with all adolescents to help increase their independence and confidence in daily activities eg self-care, home duties, being a friend, studying, working, and doing leisure, religious and cultural activities.

Developing skills to complete these activities is important for survival, giving meaning to life, contributing to one's sense of self, and promoting health and recovery. Occupational therapy may include assessment, individual therapy, parent/carer consultation, and group work.

The dietitian may also see your adolescent. The dietitian will assist them in ensuring that their nutritional requirements are met and any nutritional or eating issues are addressed.

All adolescents are involved in leisure therapy activities. The leisure therapist assesses age appropriate functioning and development of leisure skills. Leisure activities are utilised as a tool by which to develop life skills and manage the symptoms of mental illness.

Members of the staff may be contacted by calling our reception on **3271 8742.** If you would like to attend an interview with any member of the Treatment Team, it is best to ask your adolescent's Case Coordinator to arrange this.

Of course you may also phone your adolescent while they are at the Centre. Due to the school and activities program conducted at the Centre, the best times to phone are from 7pm until 9pm Monday to Thursday, after 3pm on Friday and any time from 10am until 9pm on weekends. The phone number to call is [redacted]

If you wish to discuss issues relating to academic performance, your adolescent's teacher is available and can be contacted on [redacted]

Most families have the opportunity to attend family meetings. This will involve attendance by the family at regular sessions with the family therapist.

Our Clinical Liaison Person also organises a Parents Support Group, which meets one evening during the week on a monthly basis. This is a valuable opportunity to share your own experience with other parents who face similar issues. It is also an opportunity to meet with staff and discuss issues relating to the Centre.

Attachment 6

CIMHA (Consumer Integrated Mental Health Application) is a consumer-centric clinical information system designed to support mental health clinicians in the provision of safer quality mental health services. CIMHA supports mental health service delivery by providing timely access to up-to-date clinical information across service settings and between Hospital and Health Services in Queensland.

CIMHA users are able to review consumer demographic and clinical information, activity, Mental Health Act 2000 and outcomes in one location and use this to inform treatment plans, evaluate service delivery and assist with service planning.

Consumer information must be entered in CIMHA to comply with the mental health Models of Service, State-wide Policies, and a requirement to keep full and accurate records under the Public Records Act 2002. To support service provider communication and consumer continuity of care, to enable analysis of the impact of clinical activity on consumer outcomes, to support local and state service planning and prioritisation and to support State and the Commonwealth reporting.

All consumer Referral details including, referral status, presenting problems, internal contacts and treating unit information, all Service Episodes including start and end details, internal contacts and treating unit, diagnosis, outcomes and clinical notes (scanned or direct entry) should be recorded/entered into CIMHA. Any data warnings and data discrepancies, demographic details including the current living address and phone numbers, external contacts including the preferred contact, allied person and general practitioner details, alerts, internal contacts, recovery plans / care plans / treatment plans and the Involuntary Patient Summary (IPS) and photo where required should also be recorded and updated in CIMHA.

CIMHA has a Consumer Care and Review Summary clinical note template with the ability to scan and upload external PDF documents. CIMHA has the function to plan, record and report on Consumer Case Review dates via the Provision of Service (POS) module in-line with the National Mental Health Standards.

CIMHA has an End of Discharge Summary clinical note template with the ability to scan and uploaded external PDF documents. This should be completed as per the state Key Performance Indicator and in-line with the Standardised Suite of Clinical Documentation (Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch).

CIMHA is on the Orientation Program and all clinical staff are required to attend the training prior to having access.

Attachment 7

Queensland Health

health • care • people

Procedure

Document ID DDWMProc201000447

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

Custodian/Review Officer:
Executive Director Mental Health

Version no: 1

Applicable To:
Division of Mental Health Staff

Approval Date: 08/11/2010

Effective Date: 08/11/2010

Next Review Date: 01/04/2011

Authority:
Executive Director Mental Health

Approving Officer:
Shirley Wigan
Executive Director Mental Health

Signature:

Supersedes: Nil

Key Words: mental health, transfer, interdistrict, facilities

Accreditation References:
National Mental Health Standards, EQUIP, or relevant standards

EQUIP 6 - 1.16; 1.10
NSMHS 2010 – 04.1.9; 10.6.9

1 Purpose

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

2 Scope

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

PRINCIPLES

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

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

3 Procedure:

Note regarding the transfer of clinical information:

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

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

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

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

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

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

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

Note regarding mandatory steps for any transfer of consumer care:

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

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

1. Transfer of Community Voluntary Mental Health Consumers

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

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

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

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

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

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

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

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

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

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

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

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

2. Transfer of care for involuntary mental health consumers

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

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

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

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

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

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

2.3 Mental Health Act Administrator (MHAA)

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

3. Transfer of care for forensic mental health consumers

3.1 Procedure for forensic consumer under the MHA2000

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

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

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

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

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

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

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

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

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

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

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

4. Transfer of Consumers to a MHS Inpatient Unit

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

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

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

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

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

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

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

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

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

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

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

4.2.2 Pending bed availability, the receiving district will receive the required material for admission and accept the consumer within a two hour period (between 0800hrs and 2300hrs). Transport arrangements are the responsibility of the transferring district. Within rural areas transfers should ideally occur during business hours. The above hours are to be seen as flexible and able to be negotiated between services taking into account the needs of the consumer, the availability of human resources and the ability of the transferring service to maintain the safety of the consumer and staff in the facility prior to transfer.
If for any reason, the rural transferring service is not able to affect the transfer immediately, the "home" mental health service should put in place strategies to assist in maintaining the consumer safely until the transfer can occur. These strategies would include but not be limited to:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Supporting Documents

- See References

5 Definition of terms

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

5 References and Suggested Reading:

The MHA 2000

The MHA 2000 Resource Guide

National Safety Priorities in Mental Health: A National Plan for Reducing Harm

National Standards for Mental Health Services 1996

Queensland's Mental Health Patient Safety Plan 2008 – 2013

Queensland Plan for Mental Health 2007 – 2017

Queensland Health Mental Health Standardised Suites of Clinical Documentation User Guides (2008, 2009)

6 Consultation

Key stakeholders (position and business area) who reviewed this version are:

Southern Qld Health Service Districts Mental Health Network – Working Party and consultation with district based staff.

7 Procedure Revision and Approval History

Version No	Modified by	Amendments authorised by	Approved by

8 Audit Strategy

Level of risk	
Audit strategy	Ongoing review by Southern Qld Health Service Districts Mental Health Network
Audit tool attached	Nil
Audit date	12 months from endorsement
Audit responsibility	Division of Mental Health Clinical Governance
Key Elements / Indicators / Outcomes	Improvement to patient care upon transfer

9 Appendices

APPENDIX A

<u>Cultural considerations when transferring consumers</u>

Cultural factors of consumer transfer between districts include the cultural sensitivity of the transfer/relocation of a consumer. Mental health staff in both the transferring and receiving services must obtain access to cultural expertise and advice.

Factors to be aware of:

- Locality/community

- Transferring service to liaise with Indigenous and culturally and linguistically diverse (CALD) mental health workers
  - Within their team and with the receiving district
- Social and emotional well being considerations
  - links to family, friends, elders

Locality/community – when Aboriginal and Torres Strait Islander people are local to a specific area/town/city/suburb cultural protocol states the mental health service will contact the local Aboriginal or Torres Strait Islander community. There are several ways of contacting and involving the Aboriginal and Torres Strait Islander community:

- Through family connection if the consumer has a relative within that particular community
- Consulting the Indigenous mental health worker in the receiving district.

If the consumer is going to a community that is not well known the indigenous mental health worker must provide orientation for the consumer to the local Aboriginal and Torres Strait Islander community, with the consumer's consent.

Transferring service – It is the responsibility of the clinical team/case manager to notify the Indigenous mental health worker in the receiving district of the transfer of the consumer, whether to private or public follow up care. In the event that there is no mental health service in a community, notification to the Aboriginal Medical Service in that community is recommended. The Indigenous mental health worker from the transferring service needs to be involved / consulted in the transfer of all Indigenous consumers of mental health services.

In addition, the consumer's family, allied person, etc need to be notified of the transfer between districts, with the consumer's permission. Sometimes family exist in both the transferring district and the receiving district.
Consumers need to be orientated to the new district for services and links with Aboriginal and Torres Strait Islander organisations, such as the Aboriginal Medical services; cultural events, activities and meetings; other Queensland Health services and other Queensland Government services.

Social and emotional wellbeing - Following on from this, the consumer's social and emotional needs in the receiving service has to include: family and other relationships; cultural connections/support; other health concerns; housing; income; spirituality; stability of home environment; and, culturally appropriate psycho social interventions in the areas of: further education; diversional activities; fitness activities; clubs etc.

Attachment 8

1a

West Moreton Hospital and Health Service
Procedure

Mental Health Divisional

Inter Hospital and Health Service Transition of Care of Mental Health Consumers from one Hospital and Health Service to another

Document ID:
WMHHS2013274

Custodian / Review Officer:
Nursing Director Community Integration

Version no:
1

Approval Date: 13/05/2014

Next Review Date: 13/05/2017

Approving Officer

Position:
Executive Director, Mental Health and Specialised Services

Name:
Sharon Kelly

Si[redacted]

Su
N/A

Keywords:
Inter Hospital Transfer, Mental Health, transition of care, Transfer

Accreditation References and Key Performance Indicators:

EQuIP National 12.8

1. Purpose

This procedure details the process by which consumers of the Mental Health HHS receive an efficient and safe transition of care between mental health services.

2. Scope

This procedure relates to all staff within West Moreton Hospital and Health Service.

3. Supporting Documents

- The MHA2000
- The MHA2000 Resource Guide
- National safety priorities in mental health: a national plan for reducing harm
- National Standards for Mental Health Services 1996
- National Safety and Quality Standards 2011
- Queensland's Mental Health Patient Safety Plan 2008 – 2013
- Queensland Plan for mental Health 2007 – 2017
- Queensland Health Mental Health Standardised Suites of Clinical Documentation User Guides (2008, 2009)
- Patient Access and Flow Health Service Directive. Inter Hospital Transfer http://www.health.qld.gov.au/directives/docs/ptl/qh-hsdptl-025-3.pdf
- Procedure, Mental Health Divisional, Transport of Mental Health Consumers (WMHHS201000223)
- Workplace Instruction, Mental Health, The Park, HSIS-Queensland Police Escort Assistance (WMHHS2013167)\
- Policy, Procedure and Workplace Instruction Staff Sign Off Sheet http://qheps.health.qld.gov.au/wm/docs/document-signoff.dot

4. References and Suggested Reading

Nil

5. Procedure Process

BACKGROUND

It is well established that mental health consumers are at an increased risk of harm during periods of transition. *South Queensland Mental Health Clinical Cluster Hospital and Health Service* are committed to an agreed set of key principles to ensure the comprehensive and safe transition of consumer care between mental health services. This procedure clarifies and standardises the roles, expectations and responsibilities of both parties in the transition of care of mental health consumers.

For consumer transport considerations refer:-

- Procedure, Mental Health Divisional, Transport of Mental Health Consumers (WMHHS201000223).
- Workplace Instruction, Mental Health, The Park, HSIS-Queensland Police Escort Assistance (WMHHS2013167).

OVERARCHING PRINCIPLES

- Irrespective of an individual's place of residence a consumer **will always** have access to mental health services.
- The clinical documentation must comply with minimum standards as indicated in this procedure to ensure the receiving organisation can provide a safe, timely and appropriate service to the consumer.
- Consumer and carer engagement is an essential component of any transition of care planning.
- A recovery oriented service approach is recommended to ensure a consumer focused transition of care occurs.
- Clinical governance resides with the current HHS until a consultant psychiatrist from the receiving service has accepted the care of the consumer, this must occur within 5 working days of receiving relevant information.
- The cultural needs of the consumer and their carers will be acknowledged and respected (See APPENDIX A).
- Shared care arrangement is to be available during the transition process to ensure engagement and management of identified risks.
- For consumers who are mental health service employees we acknowledge treatment may occur outside of their local HHS.

In order to ensure that these principles are adhered to, **two (2) key processes** have been identified as essential for the safe, timely and appropriate clinical transition of care from one Health and Hospital Service to another.

1. Clinical Handover [1]

When a decision is made to transition a consumer from one service to another, the key principles of clinical handover must be adhered to:

- Clinical handover refers to the process whereby professional responsibility and accountability for some or all aspects of care for a consumer who is transitioning to another person or professional group on a temporary or permanent basis. This should occur at every point of transition.
- Clinical Handover involves the verbal and written communication of critical consumer-care related information between or among members of the healthcare team.
- The purpose of clinical handover is to facilitate continuity of consumer care across care transitions, to promote coordination of care amongst healthcare providers and to maintain high quality, safe consumer care.
- The process of clinical handover is standardised in accordance with five best practice principles:
  - preparation
  - organisation
  - situation and environmental awareness

[1] Standard 6. Australian Commission on Safety and Quality in Health Care. http://www.safetyandquality.gov.au/our-work/accreditation/nsqhss/

- transferred responsibility and accountability
- consumer/carer involvement.

2. Clinical documentation

All clinical documentation must be recorded using the standardized suite of Mental Health clinical forms in the Consumer Integrated Mental Health Application (CIMHA). All consumer documentation must be readily accessible in this information management program.

Clinical Documentation must include:

- ✓ **Consumer demographic information form** (demographic information generated from CIMHA is also acceptable)
- ✓ **Consumer intake form**
- ✓ **Consumer assessment form** (associated assessment modules particularly the Family Developmental History and Social Assessment are highly desirable)
- ✓ **Risk Assessment** including risk mitigation plan.
- ✓ **MHA 2000 documentation** (if applicable)

  Documentation for a Mental Health Act Administrator (MHAA)
  - When receiving notification of a transfer of an ITO via CIMHA email facility, the receiving service MHAA will confer with the Team Leader of the relevant team to establish if the transition handover process has been completed and the consumer has been accepted to the service.
  - When the referral has been accepted the receiving service, the Principal Service Provider (PSP- usually a case manager) will notify the transferring service team and the receiving service MHAA so transfer of the ITO can be arranged.
  - If the transition handover has not occurred, the receiving service MHAA must inform the transferring service that the ITO is to remain with them until the process is completed. If the consumer has been accepted to the receiving service, the ITO must be accepted by the receiving service MHAA.
- ✓ **Consumer End of Episode/ Discharge Summary.**
- ✓ **Transition Plan**
  - What information has been provided by the transitioning service to whom (receiving service) both verbally (including date and time) and written.
  - There is an agreed transition plan including dates and time, this is especially important in regards to consumers under the MHA 2000 and for consumers under Forensic Orders. (Please refer to The MHA2000 Resource Guide, chapter 8 "moving and transfer" http://www.health.qld.gov.au/mha2000/documents/resource_guide_08.pdf
  - The transitioning service has ensured that any information sent by means other than CIMHA has been acknowledged by the receiving service and that this is document in the consumer's record
  - Details regarding follow up appointment have been noted in the consumer's record prior to transfer.

Clinical Transition Procedure:

The following steps required to transfer consumers between services will vary, dependent upon the service type. For transition of consumers between <u>all</u> service types, the following steps are recommended to ensure the best clinical outcome for the consumer.

1. **Consumer has indicated a need to move to another HHS**
2. **Consultant contacts the receiving service in that HHS**
3. **Treating team ensures the relevant documentation is readily accessible;**
   - ☐ **Consumer demographic information form** (demographic information generated from CIMHA is also acceptable)
   - ☐ **Consumer intake form**
   - ☐ **Consumer assessment form** (associated assessment modules particularly the Family Developmental History and Social Assessment are highly desirable)
   - ☐ **Risk Assessment** including risk mitigation plan.
   - ☐ **MHA 2000 documentation** (if applicable)
   - ☐ **Consumer End of Episode/ Discharge Summary.**

   If transitioning from Emergency Department:
   - ☐ Medical Officer R/V notes if initial MH assessment has not been completed
   - ☐ Medical Assessment & Clearance.
   - ☐ Most recent clinical documentation.

   Highly desirable documentation:
   - ☐ **My Recovery Plan** located within the Clinical Note module within CIMHA. The Recovery Plan will include the transition plan ensuring that consumer's from rural and remote areas have ongoing access to their care network if they transitioned out of area.
   - ☐ **Care Review Summary Plan,** this includes the involuntary treatment plan review and case review summary.
4. **Formulate a Transition Plan in collaboration with the consumer/carer and receiving service.**
5. **Transition clinical care** of the consumer to the new Mental Health Service.
6. **With the consent of the consumer, the family/next of kin are to be notified**

Escalation process

If a clinical difference of opinion occurs regarding the transition and ongoing management of a consumer transitioning between HHS, the consultant of the receiving service has the final decision and responsibility for the ongoing care. For involuntary patients the Executive Director of Mental Health and Specialised Services can be approached to assist in resolving disagreements.

6. Definition of Terms

Definitions of key terms are provided below.

Term	Definition / Explanation / Details	Source
MHS	Mental Health Service	
HHS	Hospital and Health Service	
SNFP	Special Notification Forensic Persons	
MHA	Mental Health Act	
CIMHA	Consumer Integrated Mental Health Application	
Queensland Private Health Care Sector	Health Care services which are not Queensland Health provided	

7. Procedure Revision and Approval History

Version No	Modified by	Amendments authorised by
1	Created Michelle Kohlels Cluster Coordinator	South Qld Mental Health Clinical Cluster

8. Audit Strategy

Level of risk	Medium
Audit strategy	Audit of clinical handover processes pertaining to consumers
Audit tool attached	
Audit date	Twice yearly
Audit responsibility	NUMs
Key Elements / Indicators / Outcomes	• preparation • organisation • situation and environmental awareness • transferred responsibility and accountability • consumer/carer involvement.
Endorsing Committee	Clinical Records Committee

9. Appendices

Nil.

APPENDIX A

Cultural considerations when transferring consumers

Cultural factors of consumer transfer between HHSs include the cultural sensitivity of the transfer/relocation of a consumer. Mental health staff in both the transferring and receiving services must obtain access to cultural expertise and advice.

Factors to be aware of:

- Locality/community
- Transferring service to liaise with Indigenous and culturally and linguistically diverse (CALD) mental health workers
  - Within their team and with the receiving HHS
- Social and emotional wellbeing considerations
  - links to family, friends, elders

Locality/community – when Aboriginal and Torres Strait Islander people are local to a specific area/town/city/suburb cultural protocol states the mental health service will contact the local Aboriginal or Torres Strait Islander community. There are several ways of contacting and involving the Aboriginal and Torres Strait Islander community:

- Through family connection if the consumer has a relative within that particular community
- Consulting the Indigenous mental health worker in the receiving HHS.

If the consumer is going to a community that is not well known the Indigenous mental health worker must provide orientation for the consumer to the local Aboriginal and Torres Strait Islander community, with the consumer's consent.

Transferring service – It is the responsibility of the clinical team/case manager to notify the Indigenous mental health worker in the receiving HHS of the transfer of the consumer, whether to private or public follow up care. In the event that there is no mental health service in a community, notification to the Aboriginal Medical Service in that community is recommended. The Indigenous mental health worker from the transferring service needs to be involved / consulted in the transfer of all indigenous consumers of mental health services.

In addition, the consumer's family, allied person, etc. need to be notified of the transfer between HHSs, with the consumer's permission. Sometimes family exist in both the transferring HHS and the receiving HHS.
Consumers need to be orientated to the new HHS for services and links with Aboriginal and Torres Strait Islander organisations, such as the Aboriginal Medical services; cultural events, activities and meetings; other Queensland Health services and other Queensland Government services.

Social and emotional wellbeing - Following on from this, the consumer's social and emotional needs in the receiving service has to include: family and other relationships; cultural connections/support; other health concerns; housing; income; spirituality; stability of home environment; and, culturally appropriate psycho social interventions in the areas of: further education; diversional activities; fitness activities; clubs etc.

Attachment 9

The Park - Centre for Mental Health
Treatment, Research and Education

Together... Towards Recovery

The Barrett Adolescent Centre

Information for Parents and Carers

Queensland Government
Queensland Health

Reviewed: 08.09.06

DISCHARGE PLANNING

Planning for discharge back into the community begins at the time your adolescent is admitted to the Barrett Adolescent Centre. District Mental Health Services are encouraged to maintain close contact with your adolescent and the Centre throughout their admission in an attempt to ensure a smooth transition back into the community service.

District Case Managers are invited to attend team meetings or to discuss any concerns with Barrett Adolescent Centre staff. Assistance, advice, information, training and transitional support is regularly negotiated with particularly complex cases.

WHAT IF I HAVE A COMPLIMENT OR COMPLAINT?

The Centre strives to provide the best quality care for adolescents but there may be times when we do not meet your needs and expectations or we exceed them.

If you have a complaint or would like to pass on a compliment, please do not hesitate to lodge these orally (direct face-to-face, via the telephone or in writing).

To lodge a complaint you can contact:

The Centre Nurse Unit Manager on 3271 8760
The Director of Barrett Adolescent Centre on 3271 8742
The Consumer Advocate on 3271 8567
The Patient and Consumer Advisory Group on 3271 87565
The Service Development Officer on 3271 8537
Community Visitor on 3225 8339 or 1300 653 187 (toll free)

Individuals have the right to independently complain to external agencies at any time.

Staff will take all complaints seriously and will keep you informed of what they are doing to deal with your complaint. All complaints will be handled confidentially.

We trust the information will be of assistance to you, however should you require any further information after reading this booklet, feel free to telephone the Centre on 3271 8760 at any time.

Attachment 10

Queensland Government

West Moreton Hospital and Health Service

Job ad reference:	
Role title:	Nurse Unit Manager
Status:	Temporary Full Time *(up to 9 months)*
Unit/Branch:	Barrett Adolescent Unit
Division/Hospital and Health Service:	The Park - Centre for Mental Health Treatment, Research and Education Division of Mental Health West Moreton Health Service District
Location:	The Park – Centre for Mental Health Wacol
Classification level:	Nurse Grade 7
Salary level:	
Closing date:	
Contact:	Padraig McGrath A/ND
Telephone:	(07) 3271 8293
Online applications:	www.health.qld.gov.au/workforus or www.smartjobs.qld.gov.au If you are unable to apply online, please contact Statewide Recruitment Services or or
Fax application:	
Post application:	West Moreton Recruitment Services, PO Box 2221, Mansfield BC Qld 4122
Deliver application:	West Moreton Recruitment Services, Nexus Building, 96 Mt Gravatt Capalaba Road, Upper Mt Gravatt

About our organisation

Queensland Health's purpose is to provide safe, sustainable, efficient, quality and responsive health services for all Queenslanders. Our behaviour is guided by Queensland Health's commitment to high levels of ethics and integrity and the following **five core values**:

- **Caring for People:** We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.
- **Leadership:** We will exercise leadership in the delivery of health services and in the broader health system by communicating vision, aligning strategy with delivering outcomes, taking responsibility, supporting appropriate governance and demonstrating commitment and consideration for people.
- **Partnership:** Working collaboratively and respectfully with other service providers and partners is fundamental to our success.
- **Accountability, efficiency and effectiveness:** We will measure and communicate our performance to the community and governments. We will use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.
- **Innovation:** We value creativity. We are open to new ideas and different approaches and seek to continually improve our services through our contributions to, and support of, evidence, innovation and research.

.Purpose

- Provide an evidence based and contemporary clinical nursing service within a designated unit via operational management, leadership and the co-ordination of knowledge, skills and resources.
- The Nurse Unit Manager is a Registered Nurse who is an expert practitioner in a specific area of practice. The Nurse Unit Manager is accountable for the planning, coordination, implementation and evaluation of high standards of consumer care in the ward/unit.
- The Nurse Unit Manager in collaboration with the Nursing Director manages the delivery of safe, high quality, cost effective care.

Your key responsibilities

- Fulfil the responsibilities of this role in accordance with Queensland Health's core values, as outlined above.
- Staffing and budget responsibilities:
    - This position supervises: Clinical Nurses, Registered Nurses, Enrolled Nurses, nursing undergraduates, visiting nurses and other delegated nursing staff within the Medium Secure Unit
    - Financial accountability for the nursing stream within the unit including the management of all nursing rosters for the unit.
    - Operational and Administrative staff liaise with the Nurse Unit Manager on daily operational issues
    - The Nurse Unit Manager reports to the Nursing Director.
- Expert knowledge and skills in mental health nursing including in the specialty area of the designated clinical unit of Medium Secure.
- Integrates key objectives from the Strategic Plan into service delivery for the clinical unit through the development unit specific plans in consultation with the Nursing Director.
- Coordinates, formulates and directs evidence based policies relating to the provision of nursing care by integrating consumer care across the continuum of care.
- Supports the strategies for a work based culture that promotes and supports education, learning, research and workforce development by providing training and development opportunities for staff.
- Integrates and prioritises the strategic direction of the service using a quality framework.
- Lead and manage in a multi disciplinary environment utilising the principles of contemporary human, material and financial resource management, incorporating change management principles.
- Achieve optimal consumer outcomes by ensuring that the model of care reflects contemporary practice.
- Coordinate the delivery advanced nursing practice in accordance with legislation and relevant standards of nursing practice, code of ethics for nurses and code of conduct.
- Deputise for the Nursing Director as required.
- Manage human resources according to HRM framework, including rostering, leave planning, team building, change management, recruitment, education, performance management and counselling.
- Act in accordance and ensure compliance with workplace health and safety, equal employment opportunity and anti-discrimination requirements.

Qualifications/Professional registration/Other requirements

- Appointment to this position requires proof of qualification and registration or membership with the appropriate registration authority or association within Australia. Certified copies of the required information must be provided to the appropriate supervisor/manager, prior to the commencement of clinical duties.
- Relevant clinical experience an advantage.
- **The successful completion of, or the ability to complete, the Qld Health sponsored Aggressive Behaviour Management (ABM) Course on appointment is mandatory.**
- Expectation to be involved in and participate in Clinical Supervision.
- Post Graduate qualifications and experience in the forensic mental health field are also highly desirable.

Are you the right person for the job?
You will be assessed on your ability to demonstrate the following key attributes. Within the context of the responsibilities described above, the ideal applicant will be someone who can demonstrate the following:

Specialist Knowledge	Demonstrated specialist knowledge of mental health service associated with the management of complex consumer care.
Consumer Focus	Delivers and sets standards for high levels of consumer service, demonstrating a logical approach and remaining solutions focused when resolving issues for customers.
Staff Management	Manages staff effectively by providing clear direction, support and respecting diversity, considering the impacts of actions and motivating the achievement of positive outcomes.
Operational Management	Manages resources within designated controls to ensure highest levels of service delivery through the application of sound risk management and rostering practices.
Leadership	Inspires staff and colleagues to participate in solutions that support organisational objectives and removes perceived obstacles to positive change.
Continuous Improvement	Evaluates and assesses the effectiveness and efficiency of the operational environment through proactively reviewing and implementing processes and managing resources to support major objectives.
Continuous Learning	Proactively develops self and others, supporting learning and sharing information with others.
	Demonstrates honesty, integrity and respect for all consumers, carers and staff.
Problem Solving	Demonstrated ability to anticipate, identify and initiate or coordinate solutions to problems that are effective and appropriate with a systematic approach

How to apply
Please provide the following information to the panel to assess your suitability:

- **Your current CV or resume, including referees.** You must seek approval prior to nominating a person as a referee. Referees should have a thorough knowledge of your work performance and conduct, and it is preferable to include your current/immediate past supervisor. By providing the names and contact details of your referee/s you consent for these people to be contacted by the selection panel. If you do not wish for a referee to be contacted, please indicate this on your resume and contact the selection panel chair to discuss.
- **A short response (maximum 1–2 pages)** on how your experience, abilities, knowledge and personal qualities would enable you to achieve the key responsibilities and meet the key attributes.
- **Application form** (only required if not applying online).

About the Health Service Division/Branch/Unit
West Moreton Hospital and Health Service (WMHHS) comprises of four local government areas, Scenic Rim Regional Council, Lockyer Valley Regional Council, Somerset Regional Council and Ipswich City Council.

Ipswich is the major city of the region. Esk, Laidley, Gatton, Boonah and Wacol are townships spread throughout the service area.

The WMHHS services a population of approximately 249,000 people. The region's demographics are diverse and include metropolitan and small rural community settings.

WMHHS is home to one medium size hospital, Ipswich Hospital, four rural facilities, Boonah Rural Health Service (RHS), Esk RHS, Gatton RHS and Laidley RHS.

Based at Gailes are The Brisbane Youth Dentition Centre Health Service and The Park –Centre for Mental Health, Treatment, Research and Education which also hosts the state- wide service of Queensland Centre for Mental Health Learning and Queensland Centre for Mental Health Research.

Community Health Services operate from both the Ipswich Health Plaza and Goodna Community Health Centre and provides an outreach service to the rural area. Brisbane Women's Offender Health Services (including Helana Jones at Albion) and Brisbane Offender Health Service became apart of the Community Health Division on 1 July 2012 as part of the state- wide health reform.

Oral Health services are provided in 18 fixed clinics and 12 mobile dental clinics across the region, coordinated to provide comprehensive adult and school based services. The main oral health clinic is the Ipswich Community Dental Clinic based at Limestone Street Centre.

By 2031 it is projected that the WMHHS population will more than double to approximately 580,000 making the Hospital and Health Service the fastest growing in the state.

The Park – Centre for Mental Health has a Model of Service Delivery which embraces the principles of Recovery, Consumer and Carer Involvement, Consumer Centred Service Delivery, Evidence Based Practice, Outcome Based Services, Managing Risks, Accommodation and Practices that reflect Community Living, Services as Partners in a Network of Mental Health Services and Skilled Staff.

The Park –Centre for Mental Health is the State's major Forensic Mental Health Centre. Presently it comprises Supra District services of:
Extended Treatment and Rehabilitation/ Dual Diagnosis Clinical Program (45 beds)
Medium Secure Clinical Program (34 beds)
High Security Clinical Program (70 beds)
Adolescent Unit (15 beds)

Additional information on the District is available on QHEPS site via www.health.qld.gov.au

Pre-employment screening
Pre-employment screening, including criminal history and discipline history checks, may be undertaken on persons recommended for employment. The recommended applicant will be required to disclose any serious disciplinary action taken against them in public sector employment, as well as any other availability information that could preclude them from undertaking the role.

Roles providing health, counselling and support services mainly to children will require a Blue Card. Please refer to the Information Package for Applicants for details of employment screening and other employment requirements.

Health professional roles involving delivery of health services to children and youth
All relevant health professional (including registered nurses and medical officers) who in the course of their duties formulate a reasonable suspicion that a child or youth has been abused or neglected in their home/community environment, have a legislative and a duty of care obligation to immediately report such concerns to Child Safety Services, Department of Communities.

All relevant health professional are also responsible for the maintenance of their level of capability in the provision of health care and their reporting obligations in this regard.

Salary Packaging
To confirm your eligibility for the Public Hospital Fringe Benefits Tax (FBT) Exemption Cap please contact the Queensland Health Salary Packaging Bureau Service Provider – RemServ via telephone 1300 30 40 10 or http://www.remserv.com.au.

Disclosure of Previous Employment as a Lobbyist
Applicants will be required to give a statement of their employment as a lobbyist within one (1) month of taking up the appointment. Details are available at http://www.psc.qld.gov.au/library/document/policy/lobbyist-disclosure-policy.pdf

Probation
Employees who are permanently appointed to Queensland Health may be required to undertake a period of probation appropriate to the appointment. For further information, refer to Probation HR Policy B2 http://www.health.qld.gov.au/hrpolicies/resourcing/b_2.pdf

Attachment 11

Queensland Government
Queensland Health

DARLING DOWNS-WEST MORETON
HEALTH SERVICE DISTRICT

Job ad reference:	H09WM01712
Role title:	Clinical Nurse Consultant
Status:	Temporary Full Time for up to12 months
Unit/Branch:	Medium Secure / Dual Diagnosis, The Park - Centre for Mental Health, Treatment, Research and Education
Division/District:	Darling Downs - West Moreton Health Service District
Location:	Wacol
Classification level:	Nurse Grade 7
Salary level:	$3091.20 - $3312.30 per fortnight
Closing date:	Monday, 16 February 2009 (Applications will remain current for the duration of the vacancy)
Contact:	Terry Clancy
Telephone:	
E-mail applications:	
Fax application:	
Post application:	Darling Downs-West Moreton Recruitment Services, PO Box 2221, Mansfield BC Qld 4122
Deliver application:	Darling Downs-West Moreton Recruitment Services, Nexus Building, 96 Mt Gravatt Capalaba Road, Upper Mt Gravatt

About our organisation

Queensland Health's mission is 'creating dependable health care and better health for all Queenslanders'. Within the context of this organisation, there are **four core values** that guide our behaviour:

- **Caring for People:** Demonstrating commitment and consideration for people in the way we work.
- **Leadership:** We all have a role to play in leadership by communicating a vision, taking responsibility and building trust among colleagues.
- **Respect:** Showing due regard for the feelings and rights of others.
- **Integrity:** Using official positions and power properly.

Purpose of role

- To provide advanced clinical nursing care to consumers of the Medium Secure and Dual Diagnosis Units inpatient service.
- To provide expert professional support and guidance to nursing staff working within the service in the area of clinical practice.

Staffing and budget responsibilities

- This role reports operationally and professionally to the Nursing Director, Extended Treatment and Rehabilitation Unit

Key accountabilities

- Fulfil the accountabilities of this role in accordance with Queensland Health's core values, as outlined above.
- Provide high quality recovery orientated clinical care, within scope of practice, to both clinical units
- Establish and maintain clinical and operational liaison with nursing, medical and allied health staff
- Clinical guideline development to ensure an evidence based recovery orientated service
- Establish and maintain clinical and operational liaison with nursing, medical and allied health staff in the integrated mental health services of client Districts and non-government organisations to ensure effective pre assessment, admission, and discharge processes for consumers
- In collaboration with the Nursing Director and Nurse Unit Managers participate in relevant human resource management processes including orientation, performance appraisal, professional development planning and clinical supervision of nursing staff
- In collaboration with the Nursing Director and Nursing Director, Education develop and coordinate an ongoing program of professional development relevant to the needs of nursing staff and others within the service
- Take a lead role in the ongoing development, coordination of and use of the formal care planning package.
- Develop, facilitate and participate in nursing relevant research activities
- Promotes a collaborative ,team based model of care within the service
- Enthusiastically leads and manages a team in collaboration with the unit NUM by planning for the unit, involving staff in decision making, setting clear expectations for staff, providing an example to others and delegating appropriately

Qualifications/Professional Registration/Other requirements

- Registration as a Registered Nurse under the Queensland Nursing Act 1992 with a current annual practicing certificate is essential.
- Endorsement with the Queensland Nursing Council as a Mental Health Nurse is desirable.
- 'C' class drivers licence

Key skill requirements/competencies

Clinical Expertise	Advanced clinical skills in the areas of clinical practise, research and education in a recovery based service
Continuous Improvement	Flexible, open to change, actively maintains awareness of relevant research, utilises data as basis of service improvement and advanced problem solving
Continuous Learning	Proactively manages own and others continuous learning and development, identifying training needs and conducting or coordinating coaching, mentoring and inservice training for continuous learning in the team.
Patient Focus	Promotes a patient focus in the service by building rapport, effective communication with patients and staff and high level clinical problem solving, whilst promoting a positive environment.
Problem Solving	Proactively finds solutions and uses tact, diplomacy and sensitivity to solve problems.
Work Values	Demonstrates honesty, integrity, respect and caring for all patients, carers and staff.

How to apply

Please provide the following information for the panel to assess your suitability:

- **A short response** (maximum 1–3 pages) on how your experience, abilities, knowledge and personal qualities would enable you to achieve the key accountabilities and meet the key skill requirements.
- **Your current CV or résumé, including referees.** Referees should have a thorough knowledge of your work performance and conduct, and it is preferable to include your current/immediate past supervisor. Referees will only be contacted with your consent.
- **Application form** (only required if not applying online).

About the Health Service Area/District/Area/Division/Branch/Unit

Darling Downs-West Moreton Health Service District offers exciting employment and professional development opportunities. Whether you are interested in administrative, allied health, medical, nursing or operational, we offer a family friendly environment committed to accommodating the needs of workers with family responsibilities and the requirements of Queensland Health. It has a major teaching role providing both undergraduate and postgraduate clinical experience for members of the healthcare team.

The West Moreton South Burnett District covers approximately 19,460km2 to the West of Brisbane and extends from the New South Wales border to Proston in the North. The District population has grown from 200 558 in 2001 to 218,172 in 2006, and is projected to increase to 240,875 in 2011, constantly remaining at approximately 5.5% of the total Queensland population.

Toowoomba & Darling Downs District comprises 17 Health Services, and three Outpatient Clinics and provides a comprehensive clinical services to approximately 243 000 people across 91 000 square kilometres. The District's demographics are diverse and include city, large rural town and small rural community settings.

The Darling Downs-West Moreton Health Service District employs approximately 5700 staff with an annual budget of $670m.

Working for the Darling Downs-West Moreton Health Service District provides unique and valuable experiences, such as working within Ipswich Hospital, community health, mental health (including a tertiary mental health facility), oral health or at one of our many rural facilities.

If you are looking for a challenging and supportive working environment, we encourage you to consider progressing your career with us.

Pre-Employment screening

Pre-employment screening, including a criminal history check, may be undertaken on persons recommended for employment. Please refer to the Information Package for Applicants for details of employment screening and other employment requirements.

Health professional roles involving delivery of health services to children and young people

All relevant health professionals (including registered nurses and medical officers) who in the course of their duties formulate a reasonable suspicion that a child or young person has been abused or neglected in their home/community environment, have a legislative and a duty of care obligation to immediately report such concerns to the Department of Child Safety.
All relevant health professionals are also responsible for the maintenance of their level of capability in the provision of health care and their reporting obligations in this regard.

Attachment 12

West Moreton Hospital and Health Service
BAC STAFF COMMUNIQUE 1

Barrett Adolescent Centre

Welcome to our first Barrett Adolescent Centre Staff Communiqué. I hope this communiqué helps keep you informed about what is happening and how it will impact on yourselves as staff at the BAC.

Barrett Adolescent Centre Building
To provide certainty to both our current consumers and our staff, we continue to work toward the end of January 2014 to cease services from the Barrett Adolescent Centre (BAC) building. This is a flexible date that will be responsive to the needs of our consumer group and as previously stated, will depend on the availability of ongoing care options for each and every young person currently at BAC. The closure of the building is not the end of services for young people. WMHHS will ensure that all young people have alternative options in place before the closure of the BAC building.

Clinical Care Transition Panels
Clinical Care Transition Panels have been planned for each individual young person at BAC, to review individual care needs and support transition to alternative service options when they are available. The Panels will be chaired by Dr Anne Brennan, and will consist of a core group of BAC clinicians and a BAC school representative. Other key stakeholders (HHS's, government departments and NGOs) will be invited to join the Panel as is appropriate to the particular needs of the individual consumer case that is being discussed at the time.

Admissions to BAC
WMHHS is committed to safe and smooth transitions of care for each young person currently attending BAC. These transitions will occur in a manner and time frame that is specifically tailored to the clinical care needs of each individual young person. In order to meet this goal, there will be no more admissions to BAC services from this date forward. For adolescents currently on the waiting list, we will work closely with their referring service to identify their options for care.

Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy
The statewide project for the Adolescent Extended Treatment and Rehabilitation (SW AETR) Implementation Strategy has commenced under the governance of Children's Health Queensland, and the Steering Committee has met three times since 26 August 2013. As part of the statewide project, two Working Groups have been defined to deliver on various aspects of this initiative. Working Group one is the SW AETR Service Options Implementation Working Group, which will build on the work surrounding service models completed by the Expert Clinical Reference Group earlier this year. Working Group two will focus on the financial and staffing requirements of any future service options that are developed.

SW ATER Service Options Implementation Working Group
The SW AETR Service Options Implementation Working Group met for the first time on 1 October 2013 for a half-day Forum. This Forum was attended by a range of multi-disciplinary clinicians and service leaders from Child and Youth Mental Health Services (CYMHS) across Queensland, a BAC staff member (Vanessa Clayworth), a carer representative, and non government organisation (NGO) representation. Feedback suggests that the Forum was a very successful and productive day. A second Forum will be held within the next month to further progress the work on service models. Families and carers have also been invited to provide written submissions on the development of the new service options moving forward for the consideration of this working group.

Date: Thursday, 3 October 2013

Queensland Government

Acting Nurse Unit Manager (NUM)
Mr Alex Bryce will be commencing as the Acting NUM at BAC from Monday 14 October 2013. Alex is a senior nurse with extensive experience in nursing management. This will allow Vanessa Clayworth to move into the Acting CNC role, and directly support the clinical needs of the young people at BAC and the progress of the Clinical Care Transition Panels.

HR
Discussions have commenced with HR regarding processes, options and issues for yourselves. HR and Senior clinical staff will soon commence work with each of you individually to identify your individual employment options.

Support available
The Employee Assistance Service (EAS) is available for you to access at any time. This service is completely confidential and self referral. For more information on EAS please visit: http://qheps.health.qld.gov.au/eap/html/WestMortHSD.htm. Please also be reminded that your line managers are available to discuss any concerns or queries you may have.

Communication to Families and Carers
Fast Facts 8 will soon be going out to all BAC families, carers and staff to ensure they receive the most update information on what is happening with BAC.

Communication with Department of Education, Training and Employment (DETE)
WMHHS continues to liaise directly with DETE on a regular basis, keeping them up-to-date with changes and plans regarding BAC. DETE is committed to responding to the educational needs of each young person at BAC, and will work with us on the Clinical Care Transition Panels.

Kind regards
Sharon Kelly
Executive Director Mental Health & Specialised Services
West Moreton Hospital and Health Service

Children's HHS – LD

Queensland Government

Children's Health Queensland
Hospital and Health Service

Enquiries To: Ingrid Adamson
Project Manager, AMHETI
Child and Youth Mental Health Service
Children's Health Queensland

Telephone:
File Number:

Ms Kristi Geddes
Minter Ellison
PO Box 7844
Waterfront Place QLD 4001

Dear Ms Geddes

Re: Health Service Investigation – Barrett Adolescent Centre

As per the letter of request for information dated 11th September, Children's Health Queensland Hospital and Health Service (CHQHHS) submits the attached documents in regard to:

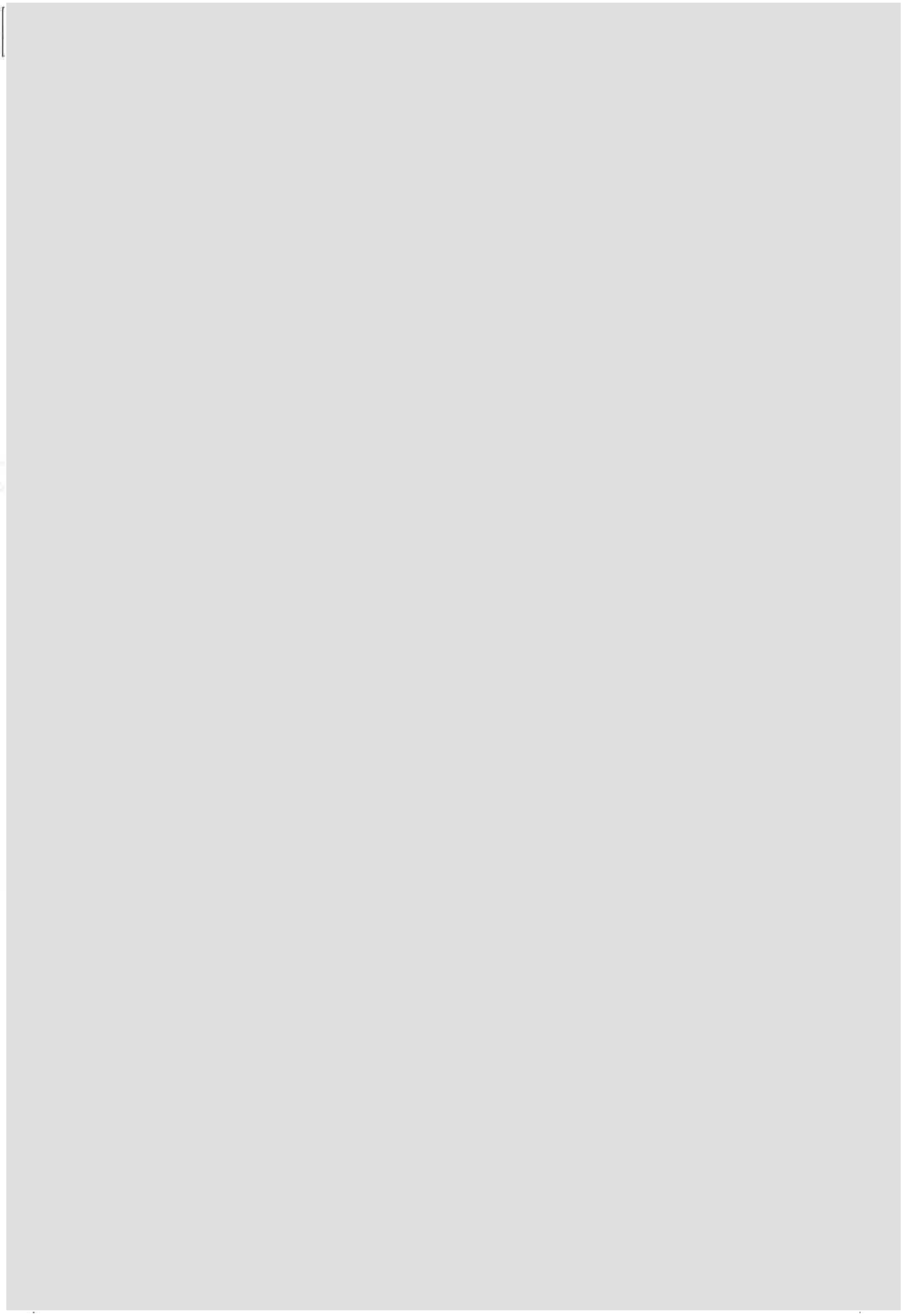
1. Records held by CYMHS (North West) fc regarding the care received and relating to transition there; and
2. Further information generally about the service provided by the CYMHS (North West), including any policies and/or procedures about intake of patients.

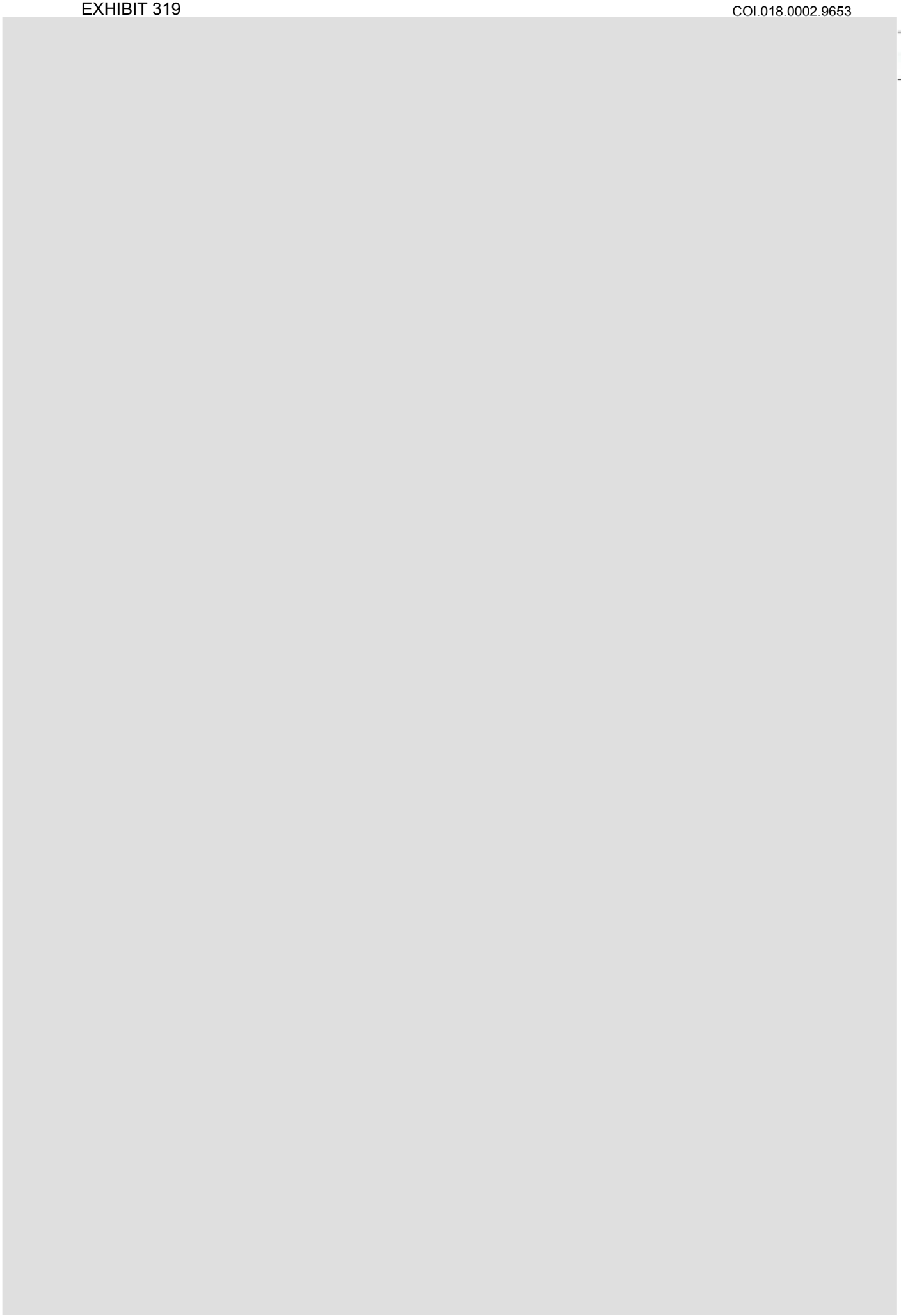
Should you require any further information in relation to this matter, I have arranged for Ms Ingrid Adamson, Project Manager, Child and Youth Mental Health Service, CHQHHS, on telephone or via email a to be available to assist you.

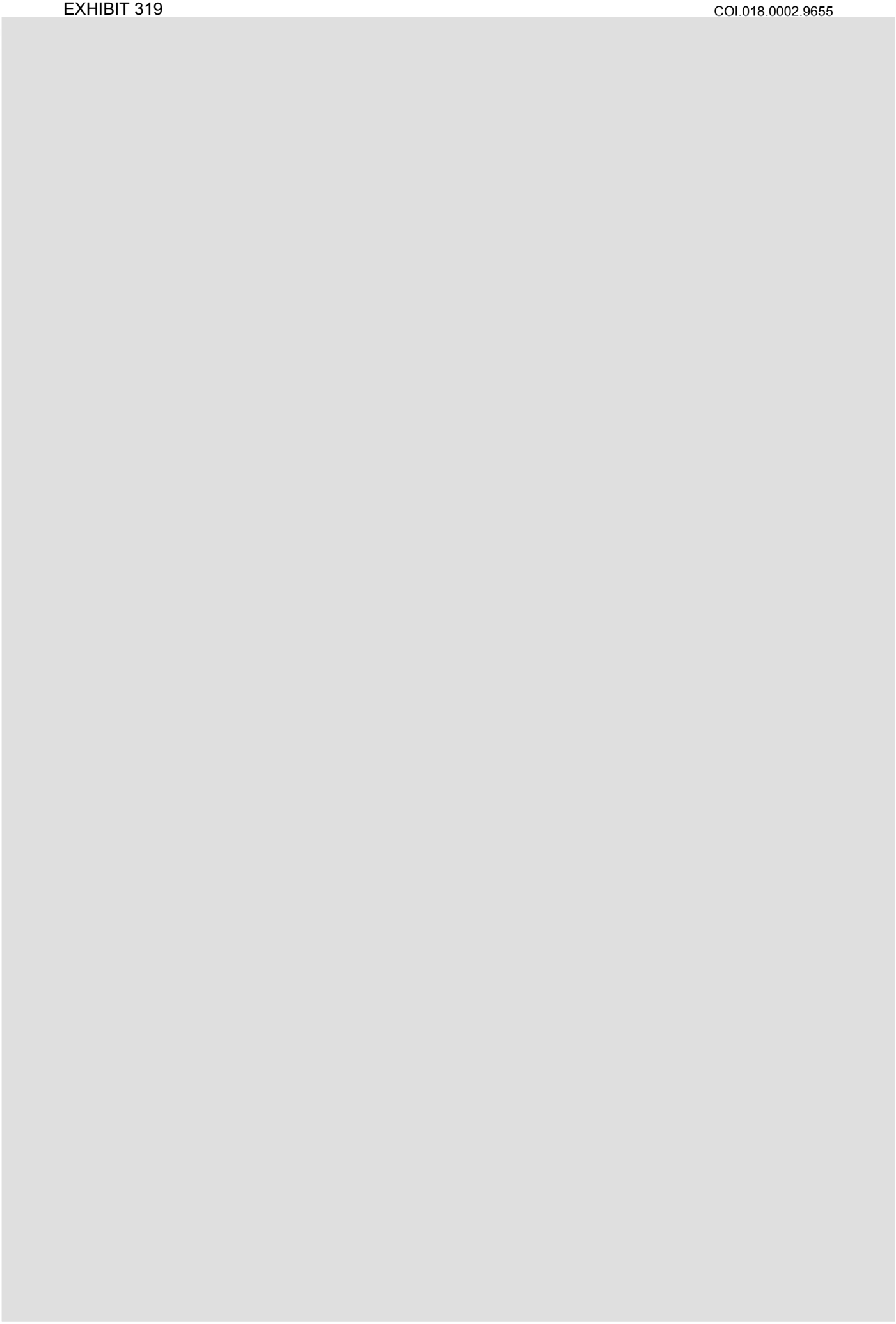
Yours sincerely

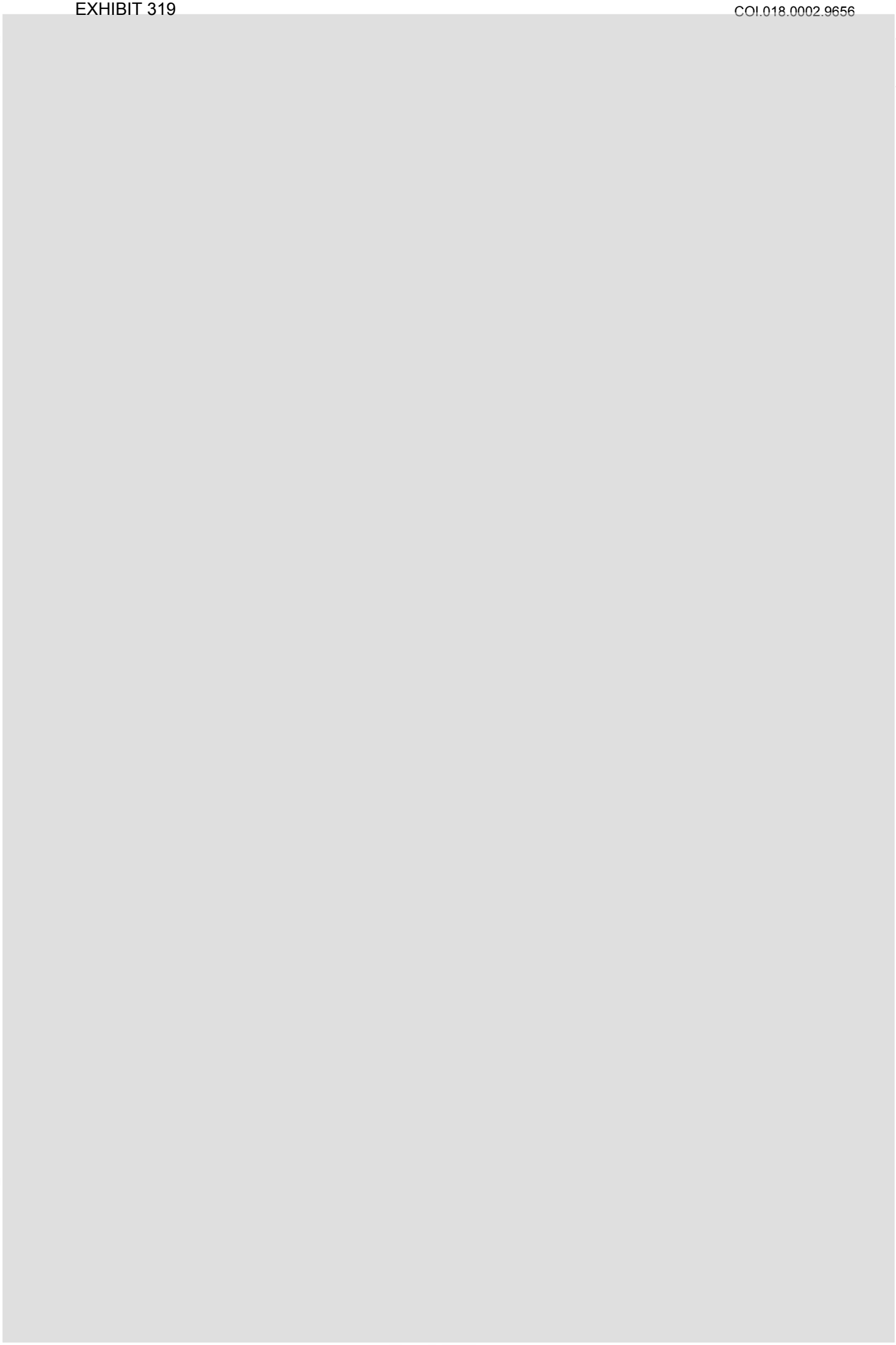
Health Service Chief Executive
Children's Health Queensland
Hospital and Health Service
19.12.14

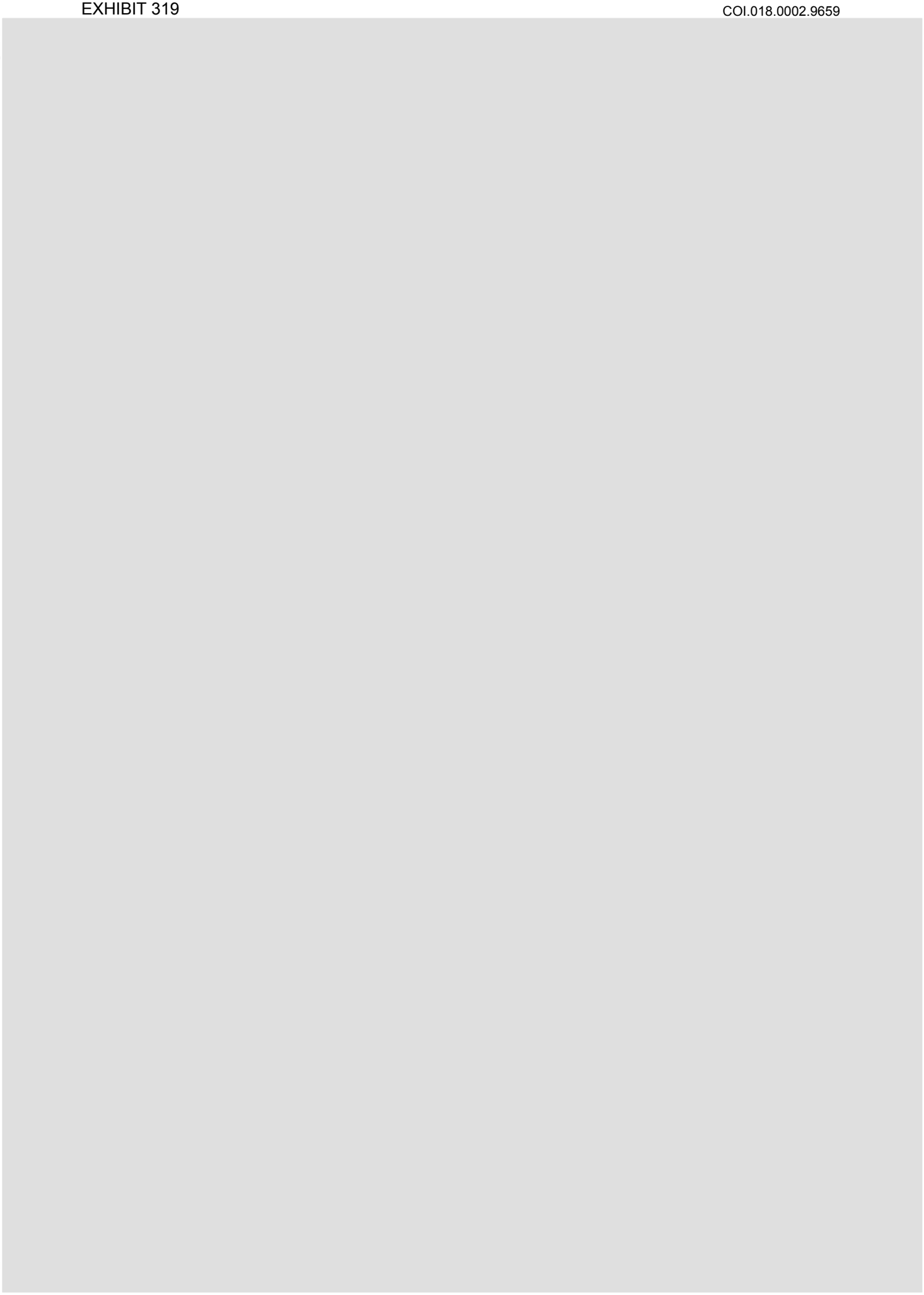
Level 1, North Tower
Royal Children's Hospital
Herston QLD 4029
GPO Box 48, Brisbane Q 4001

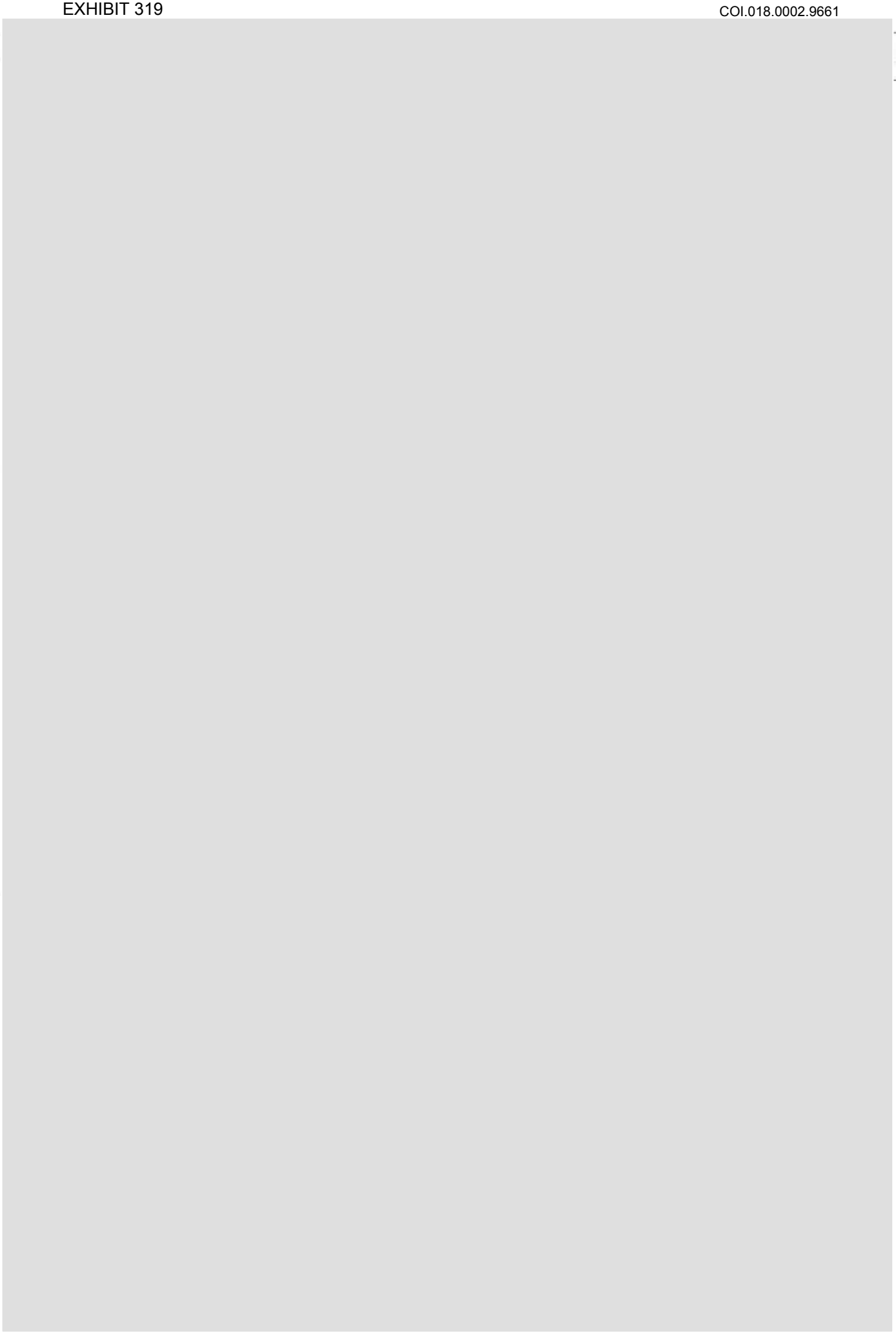


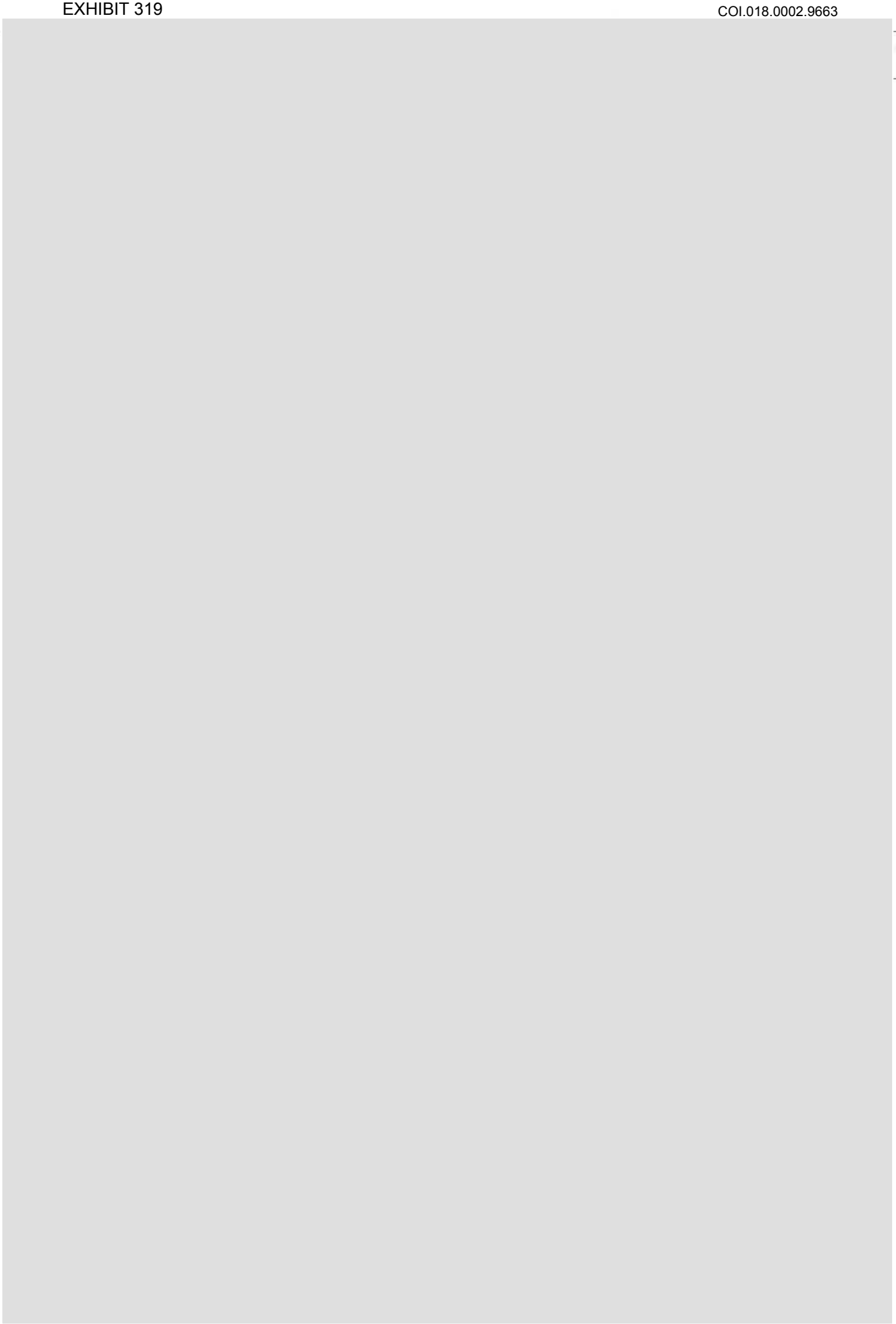












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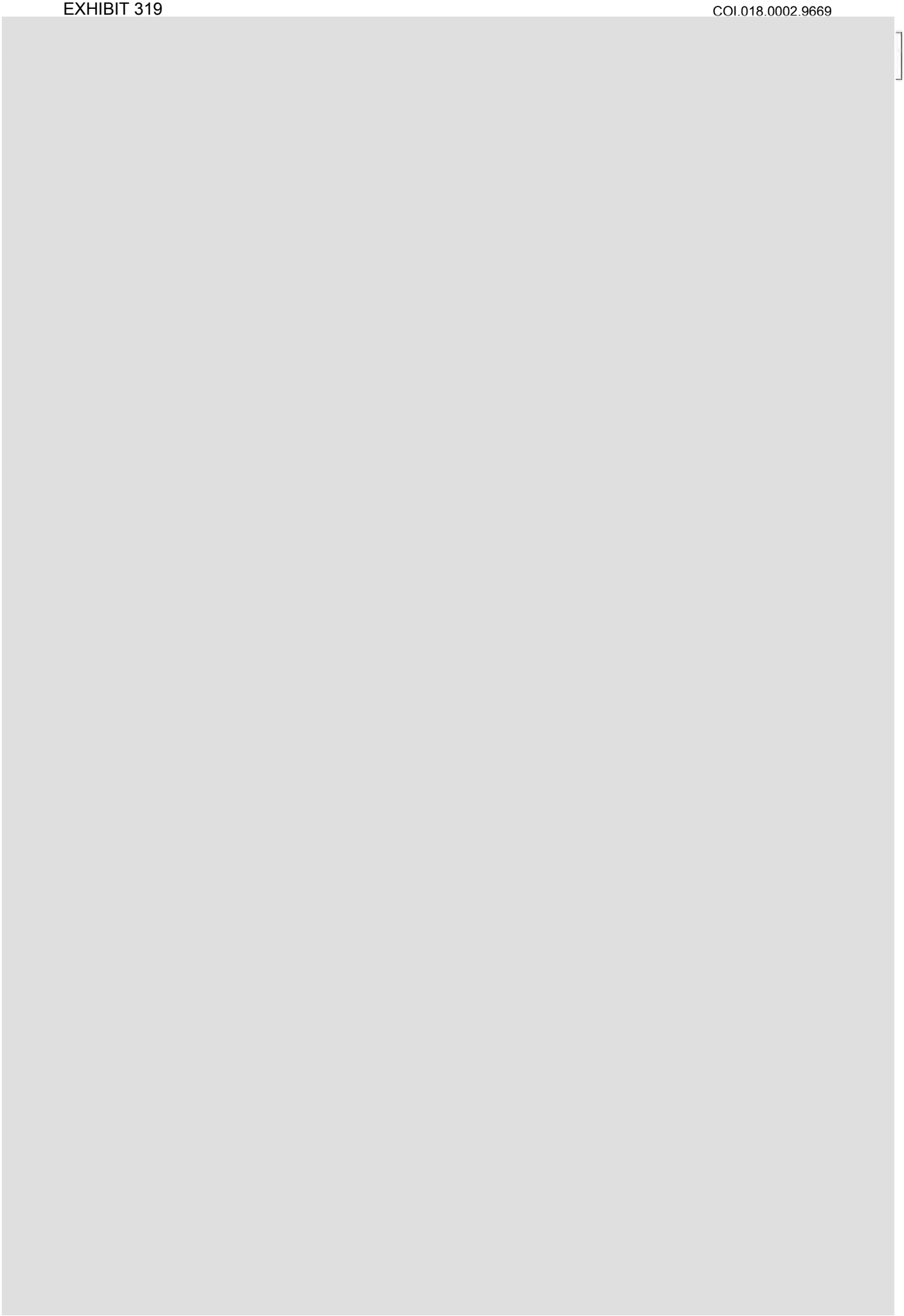

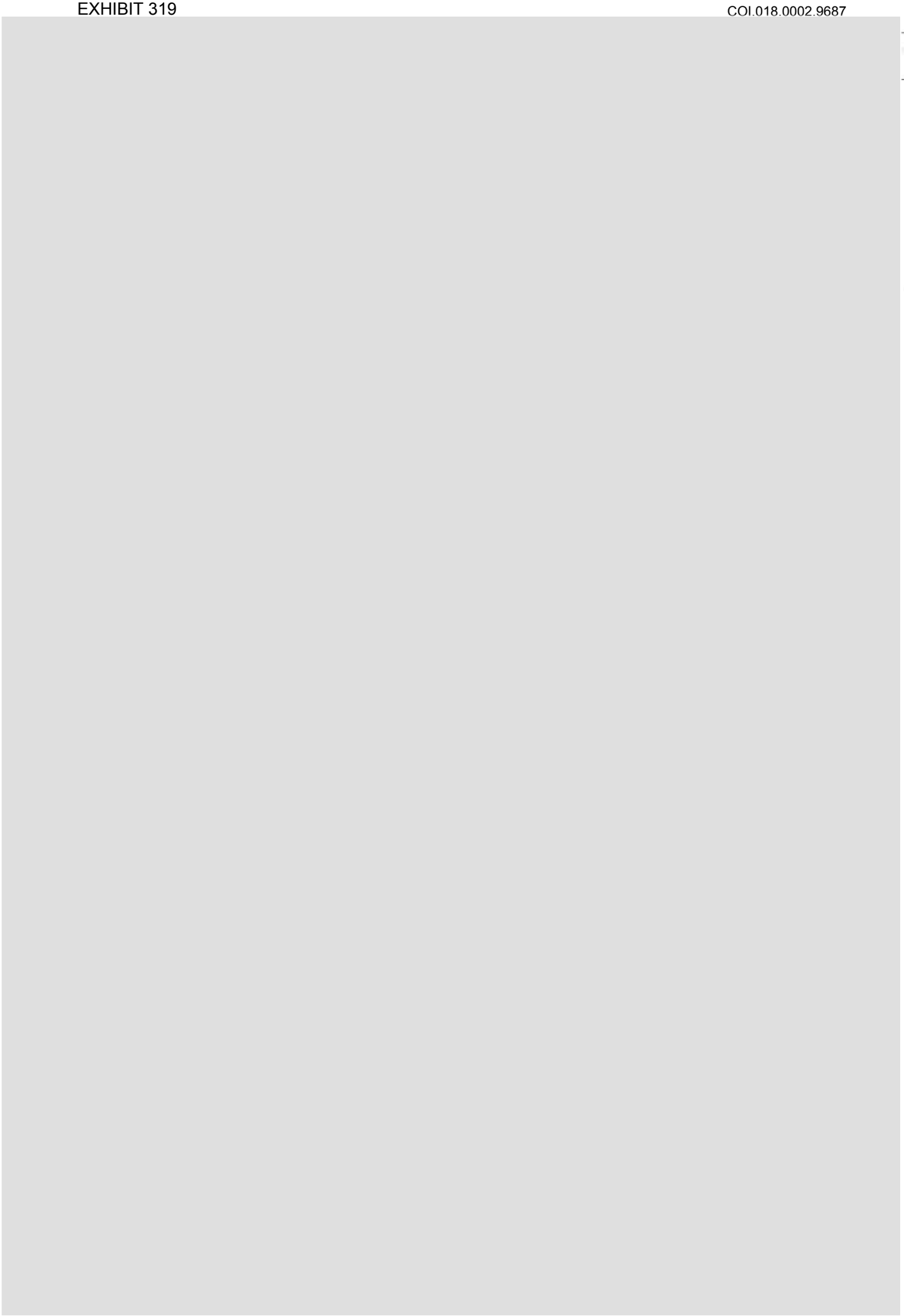

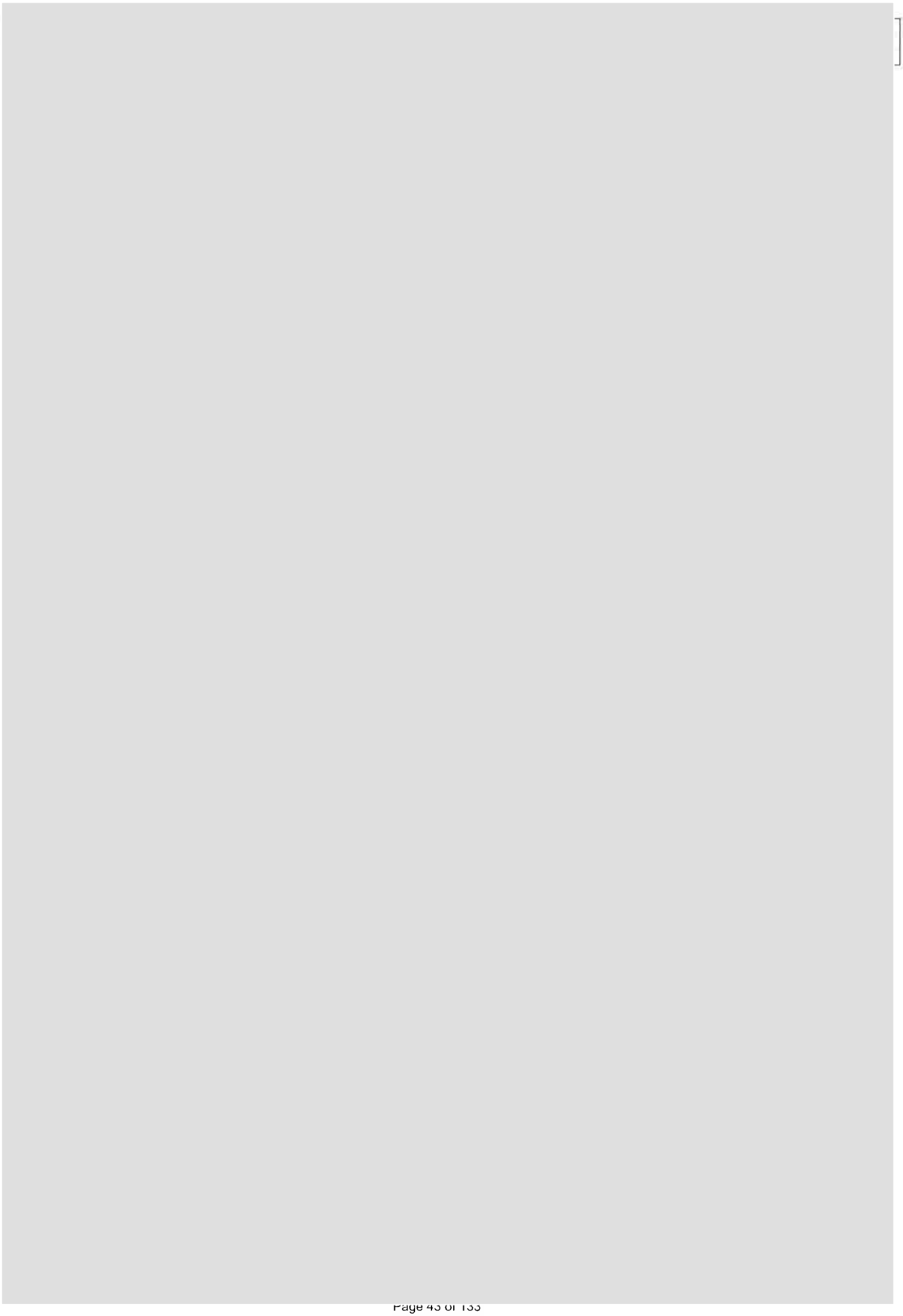

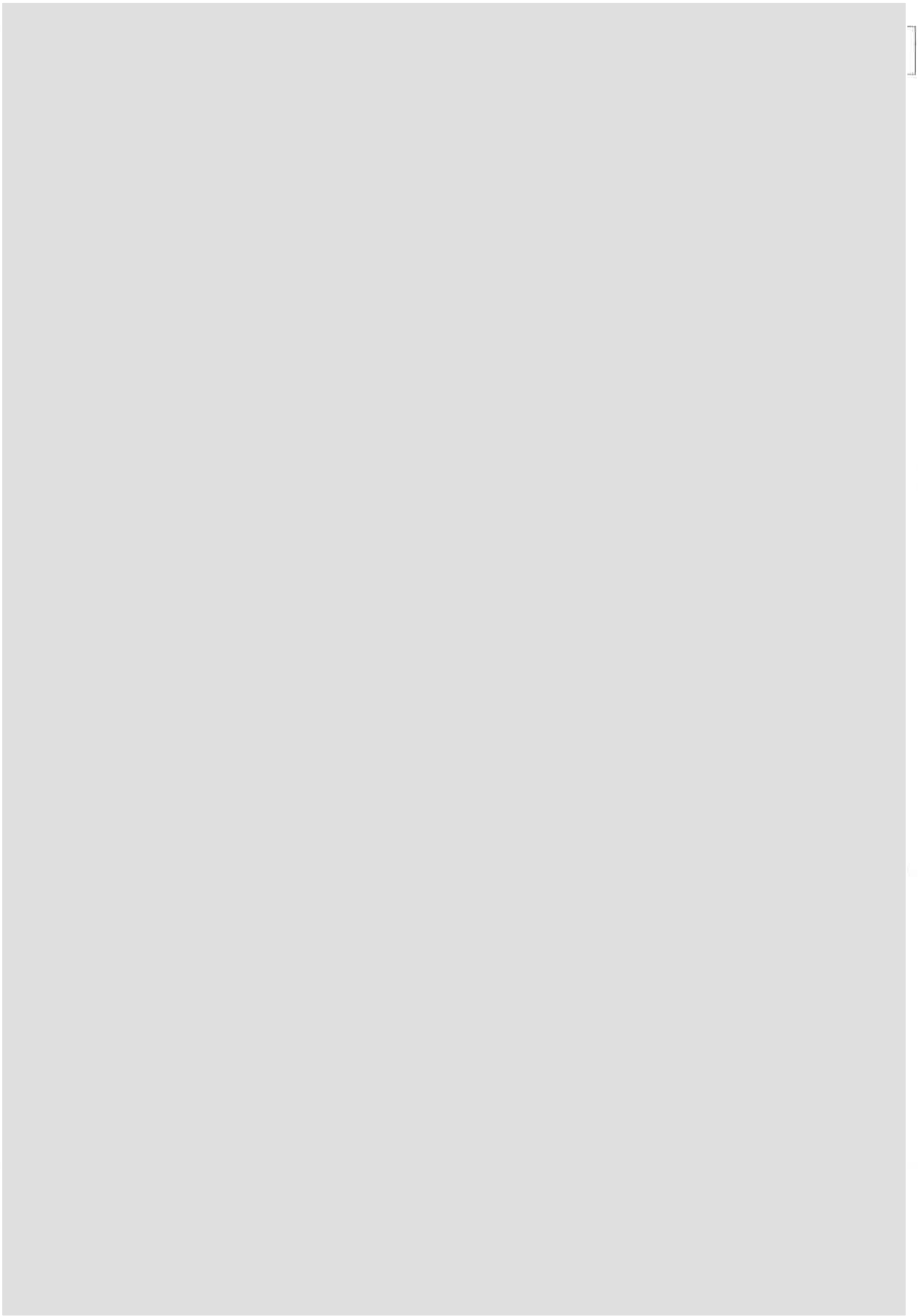

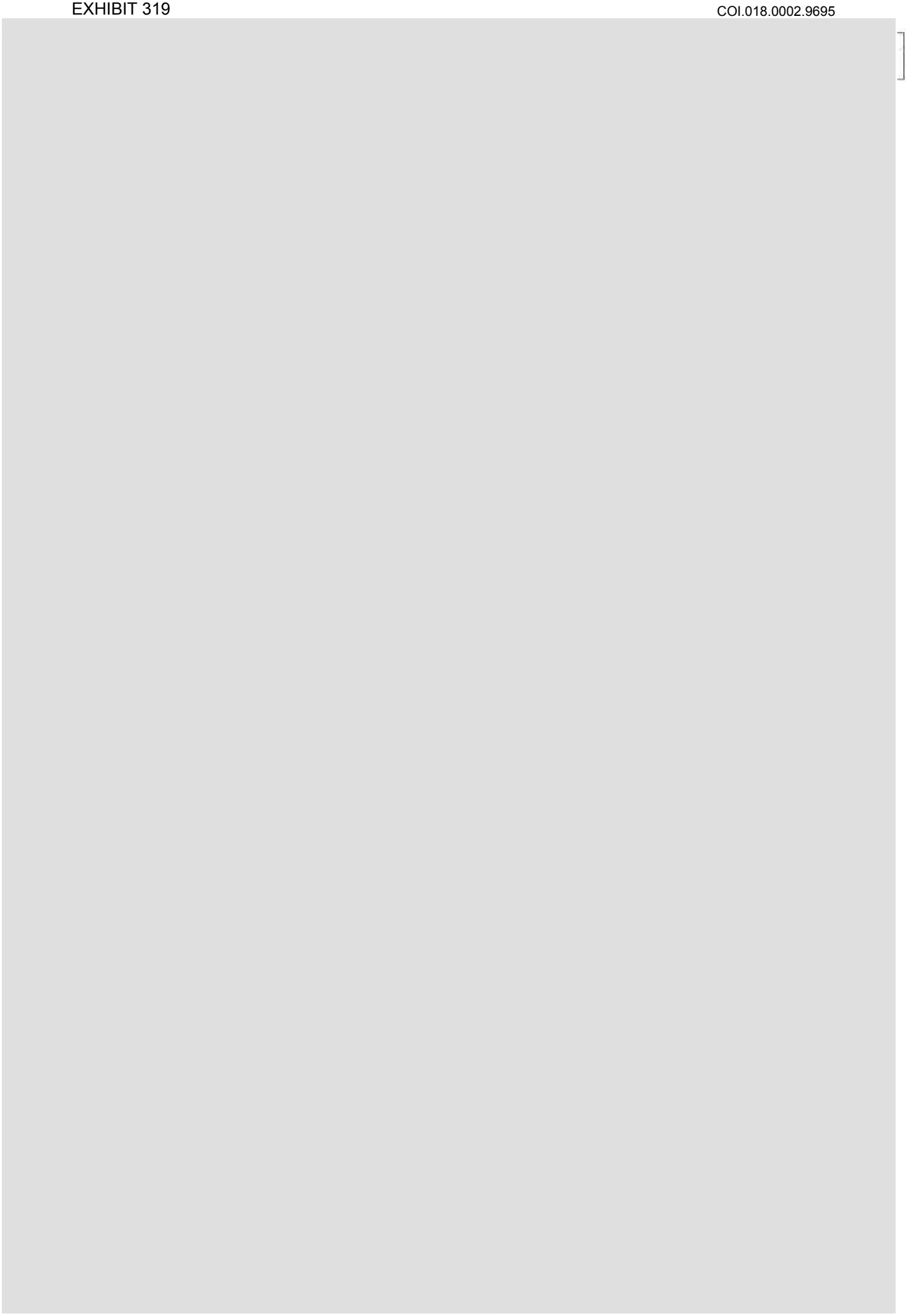

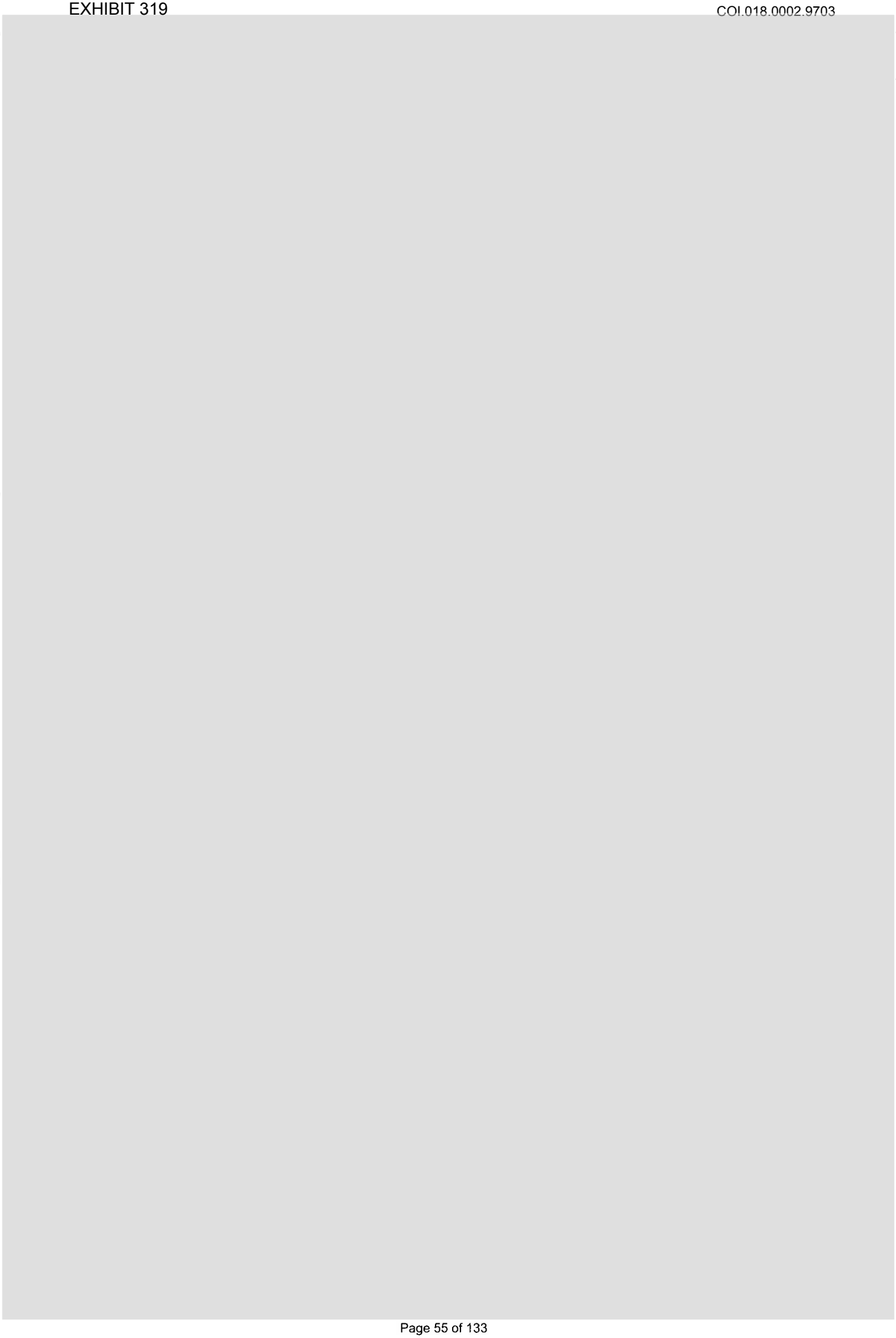

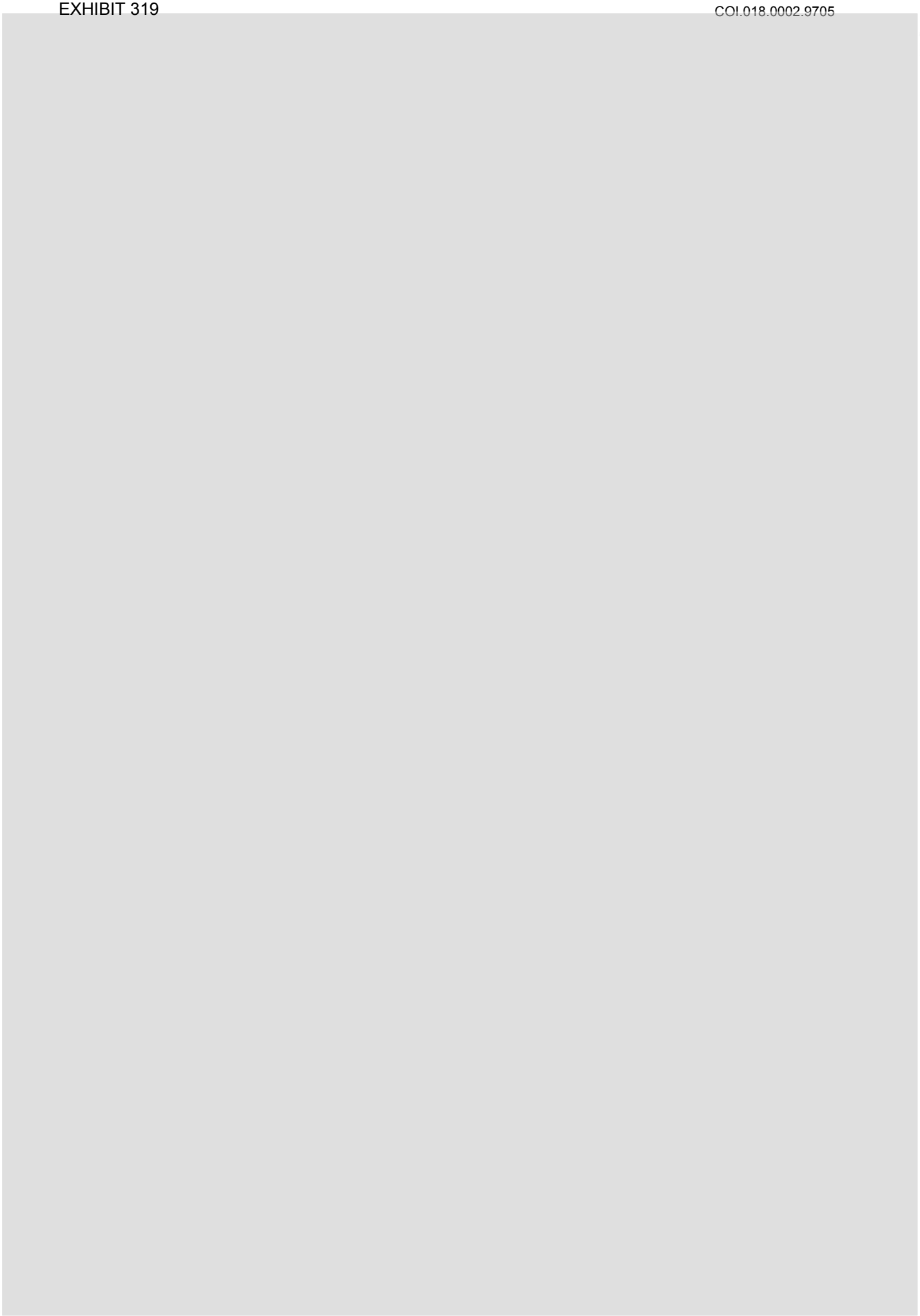

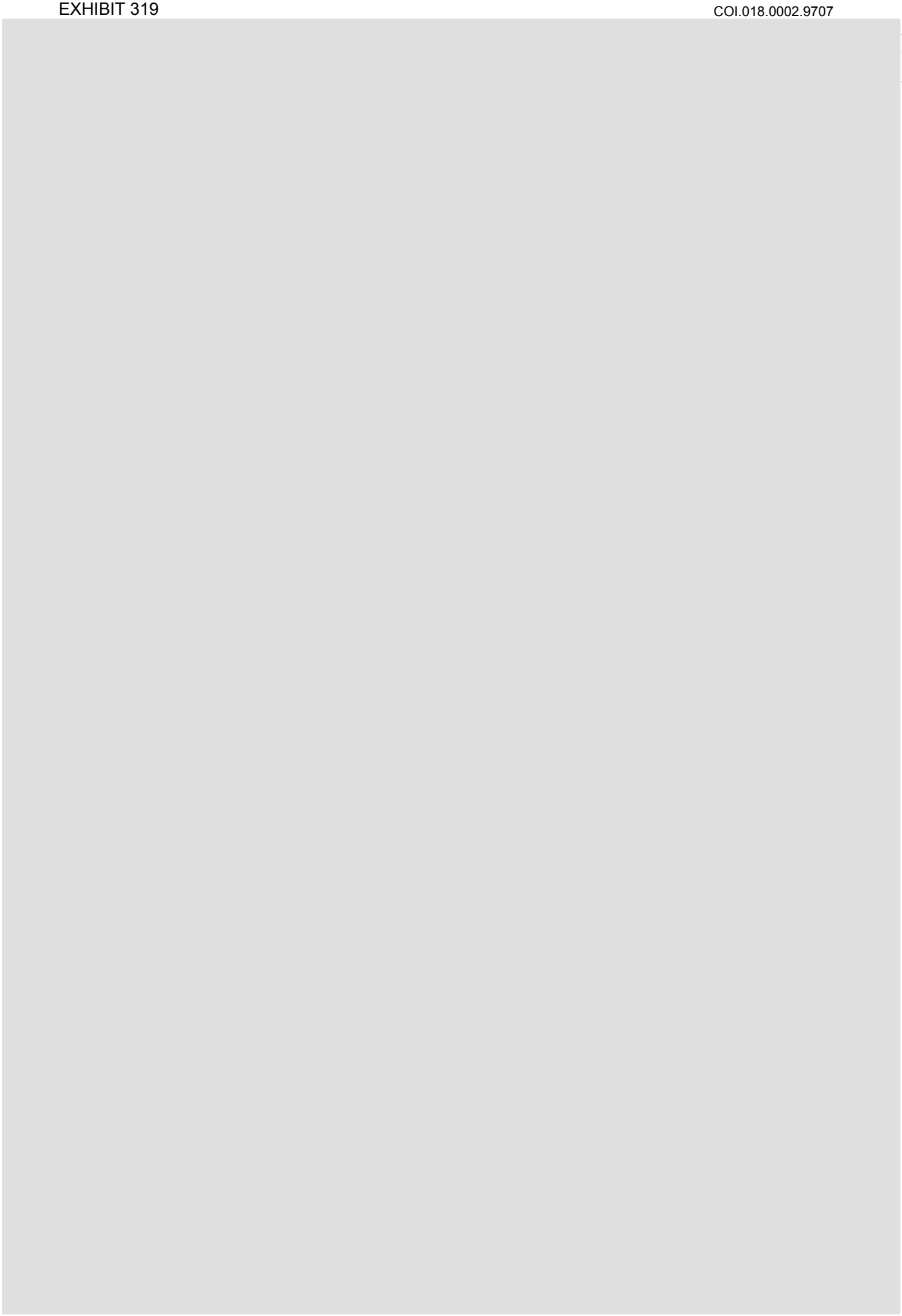

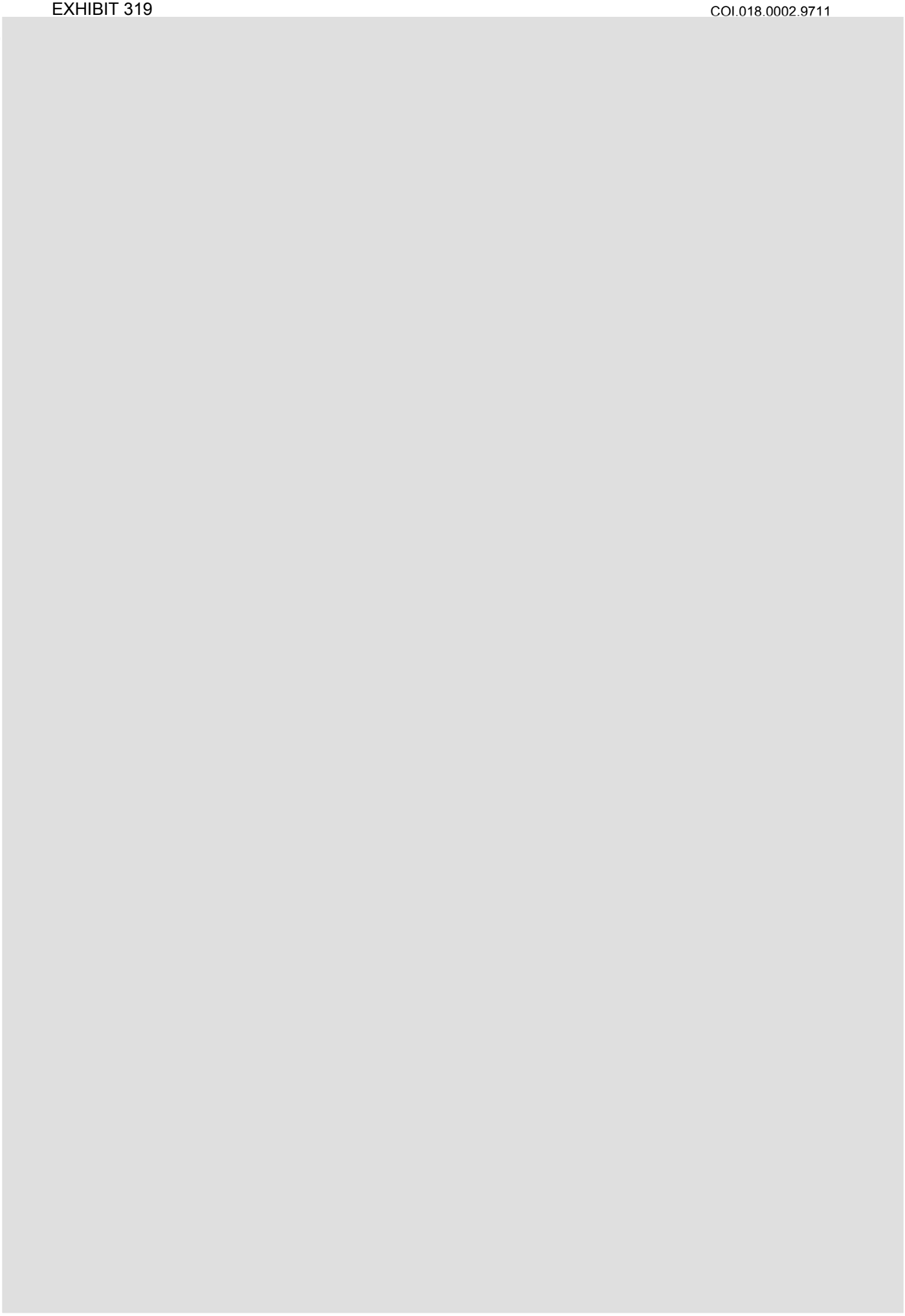

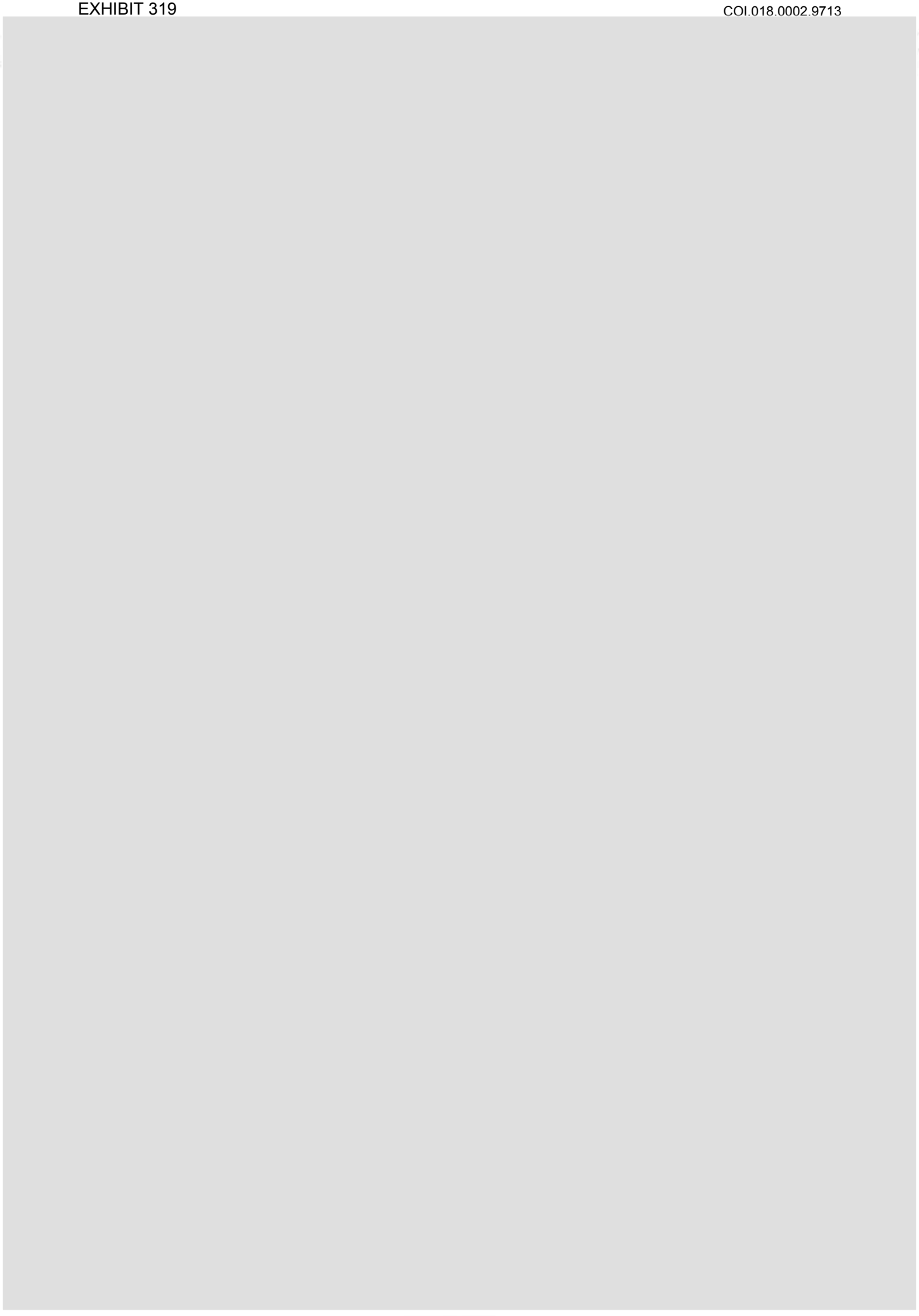

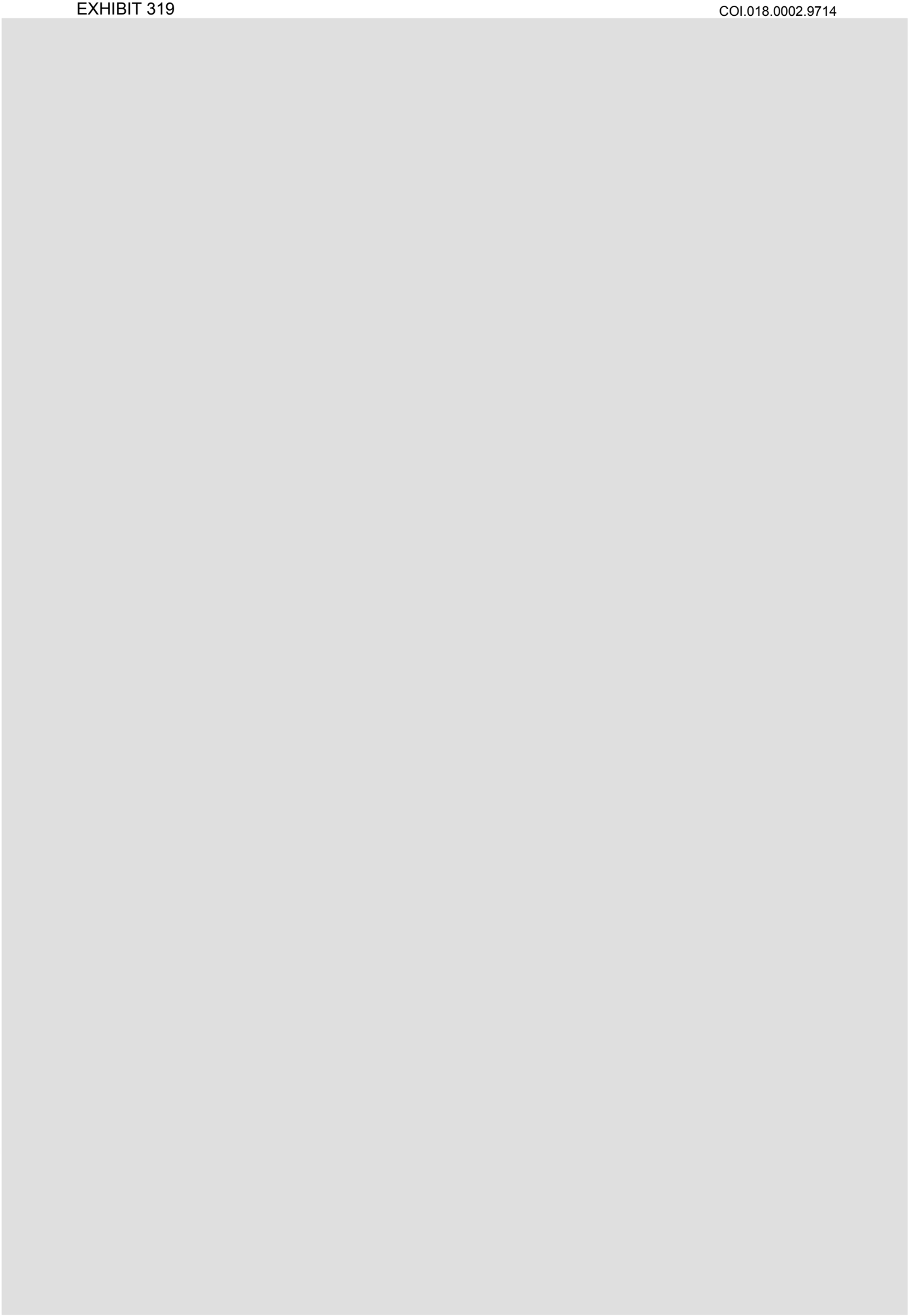

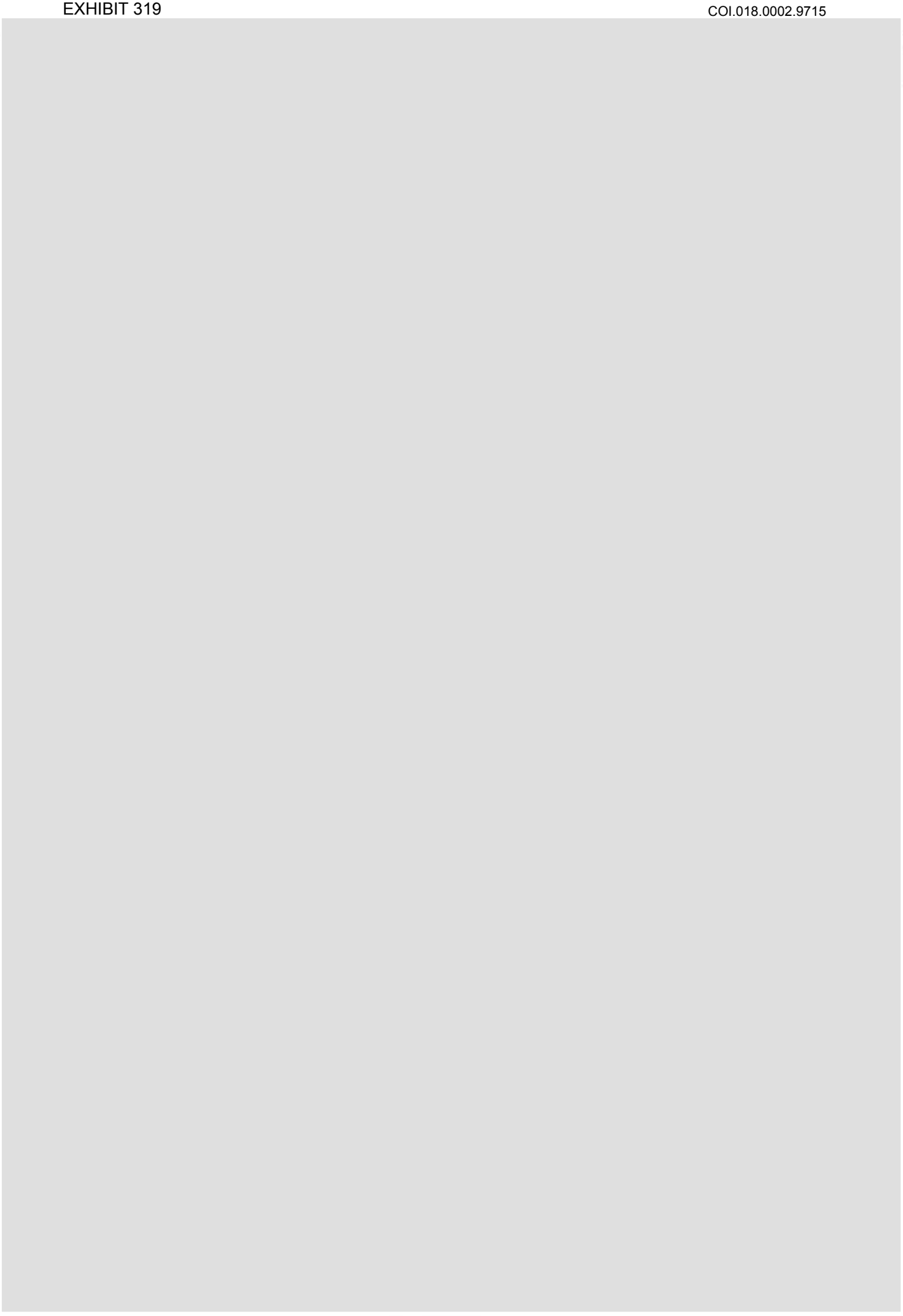

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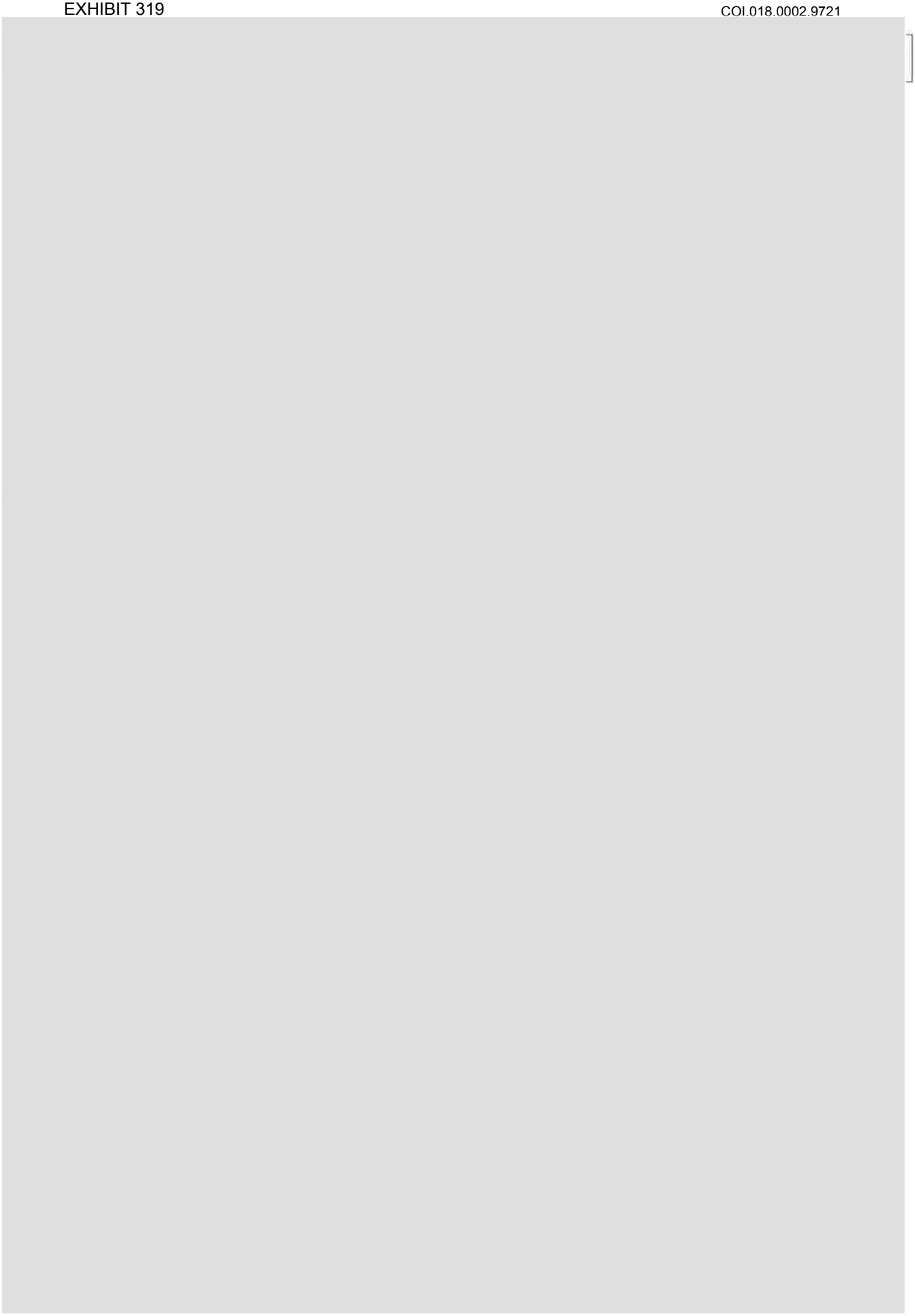

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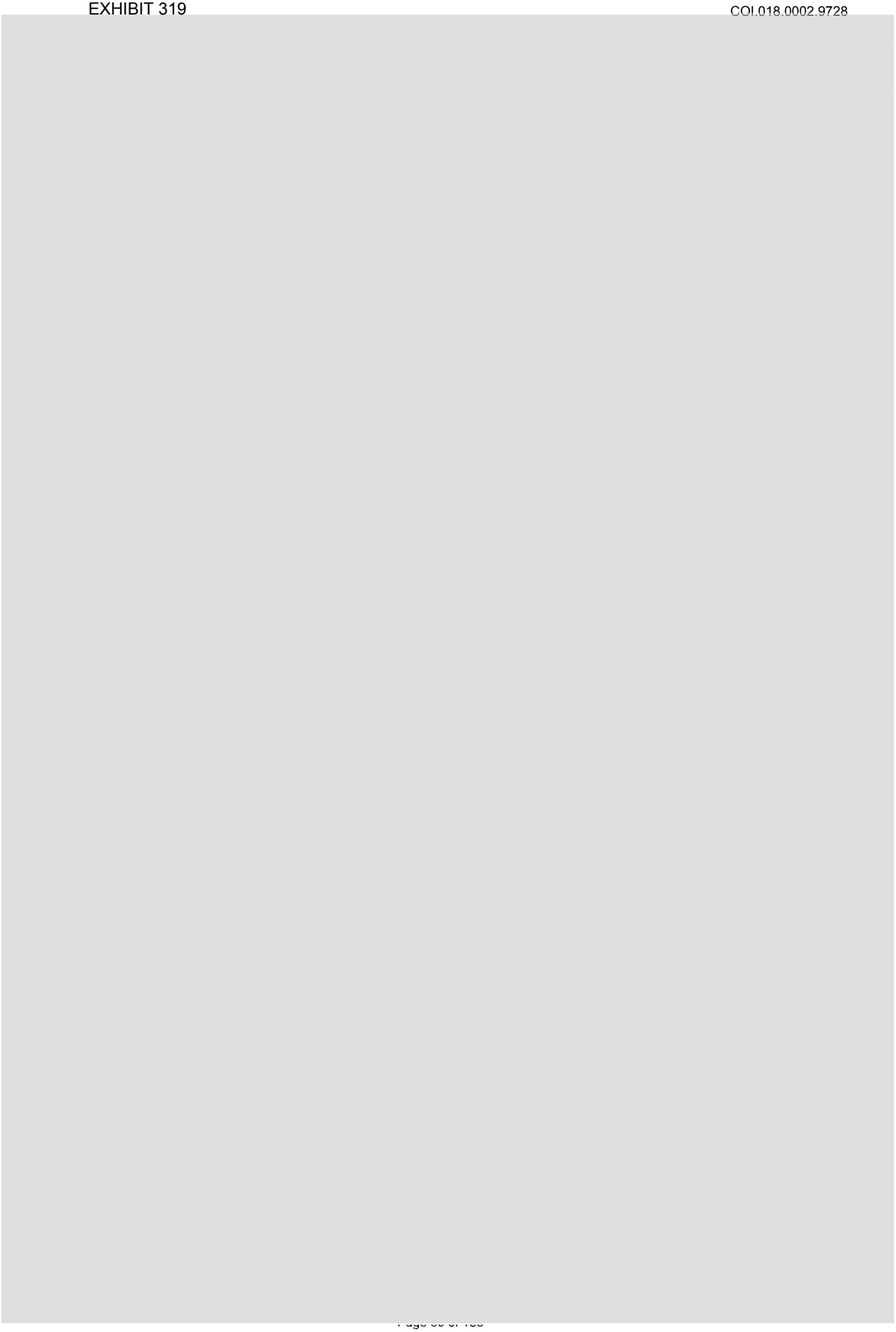

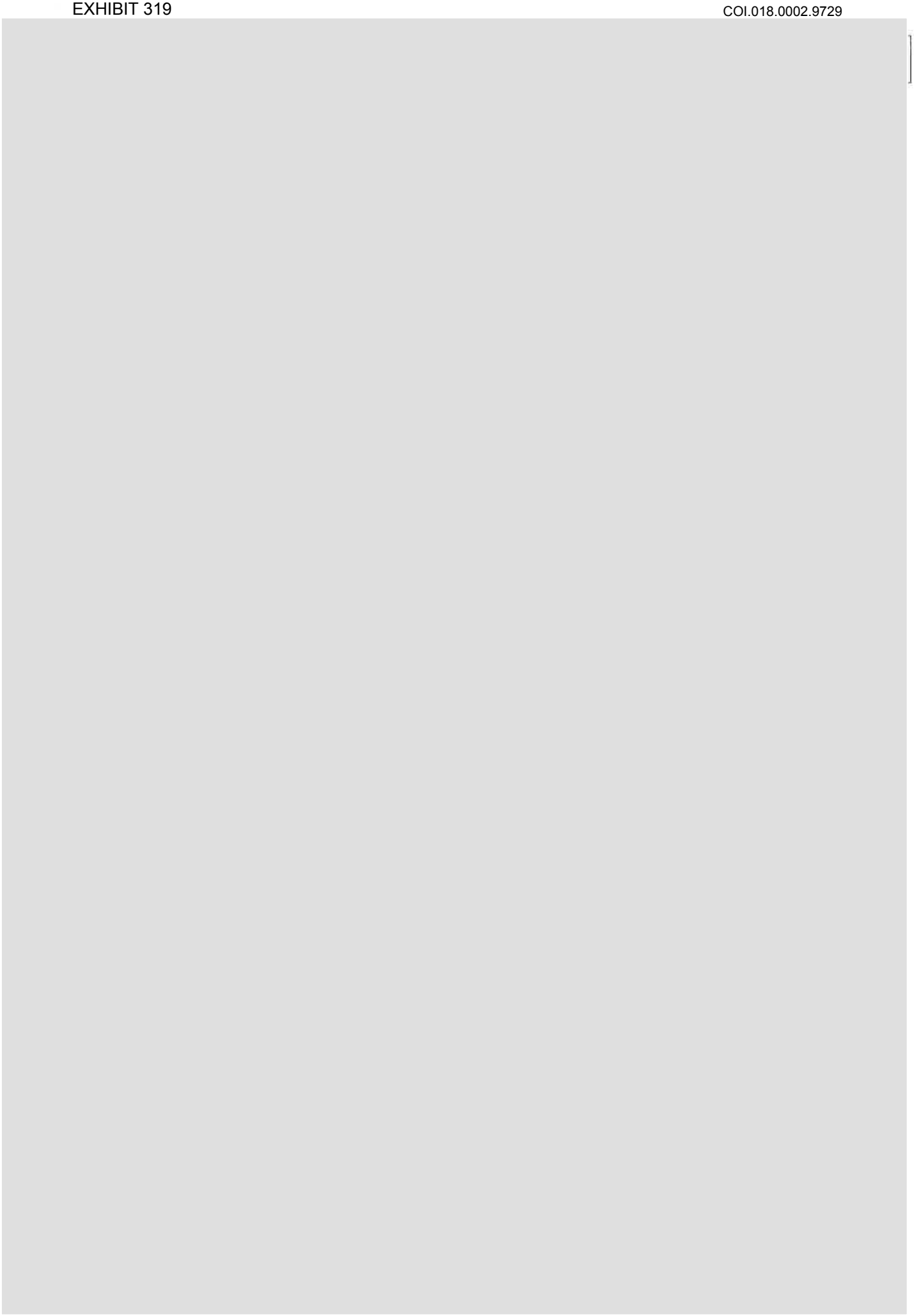

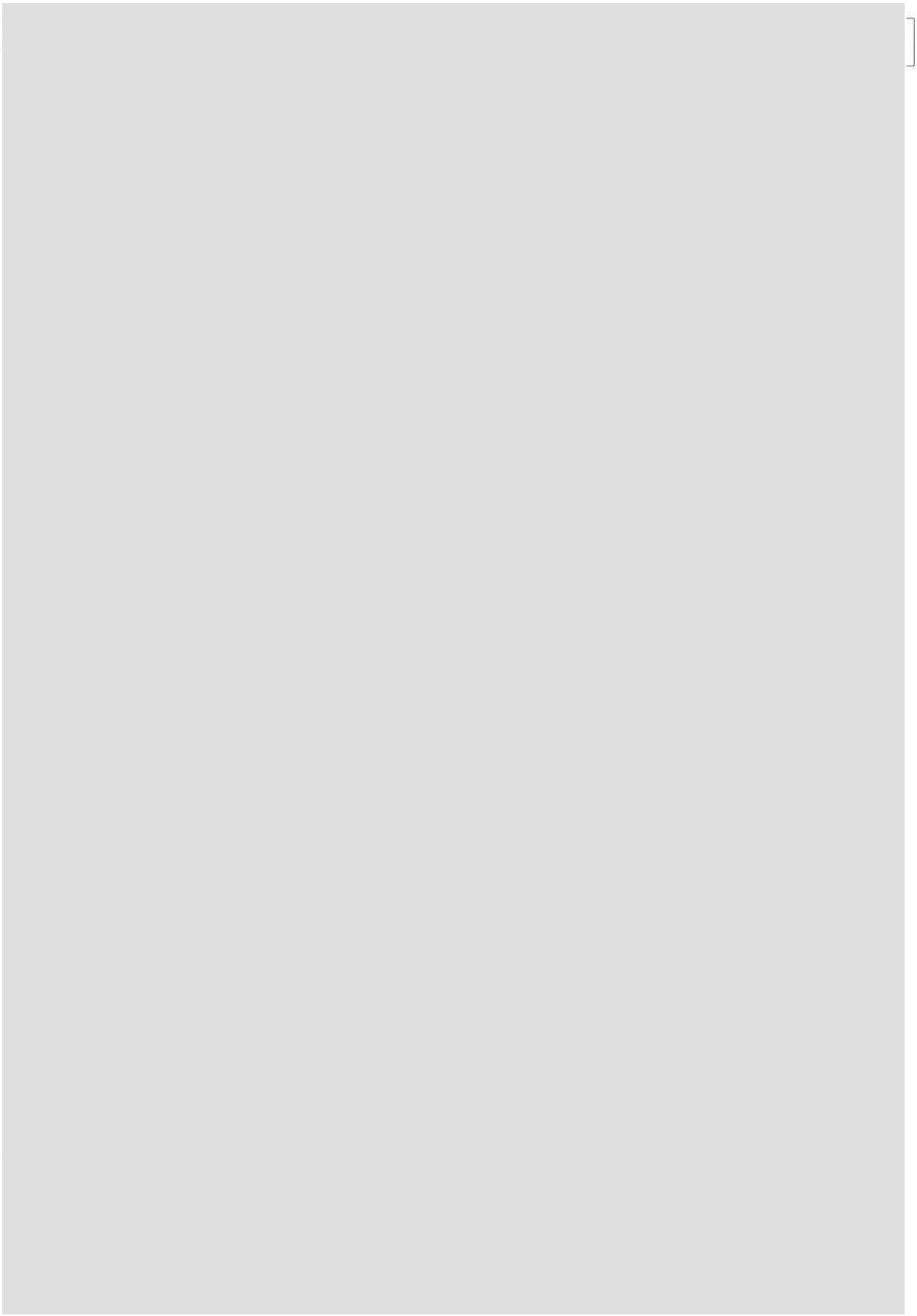

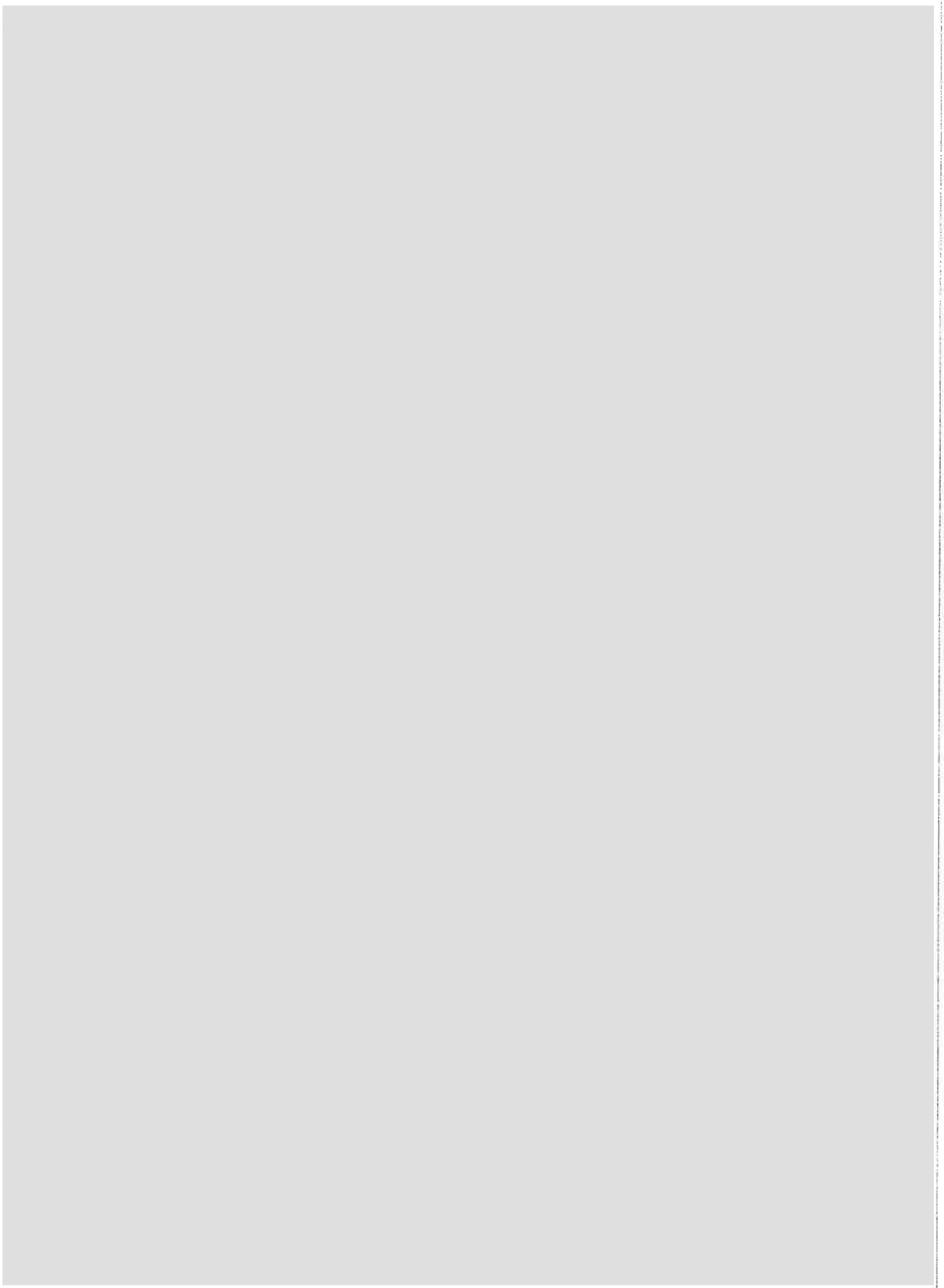

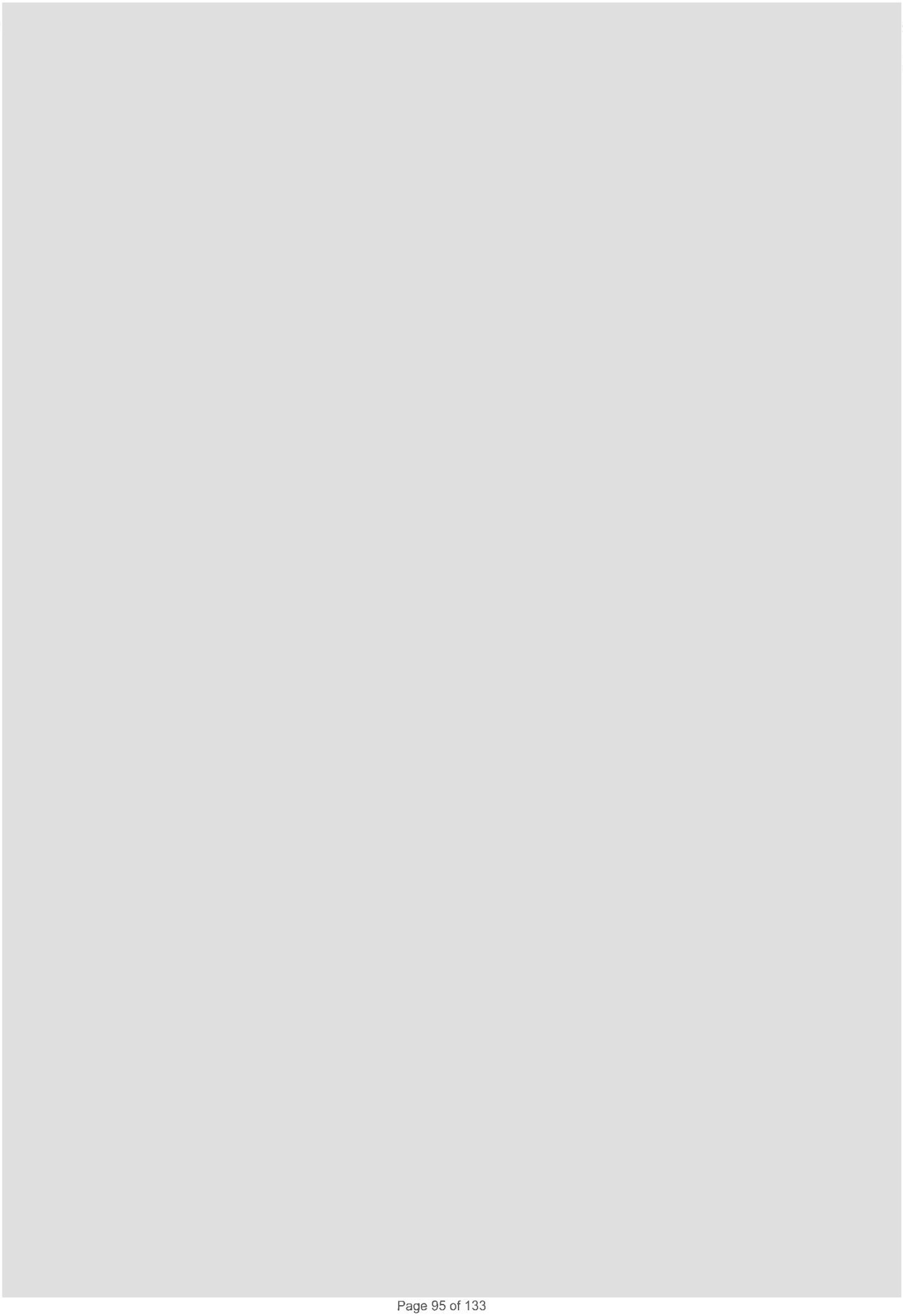

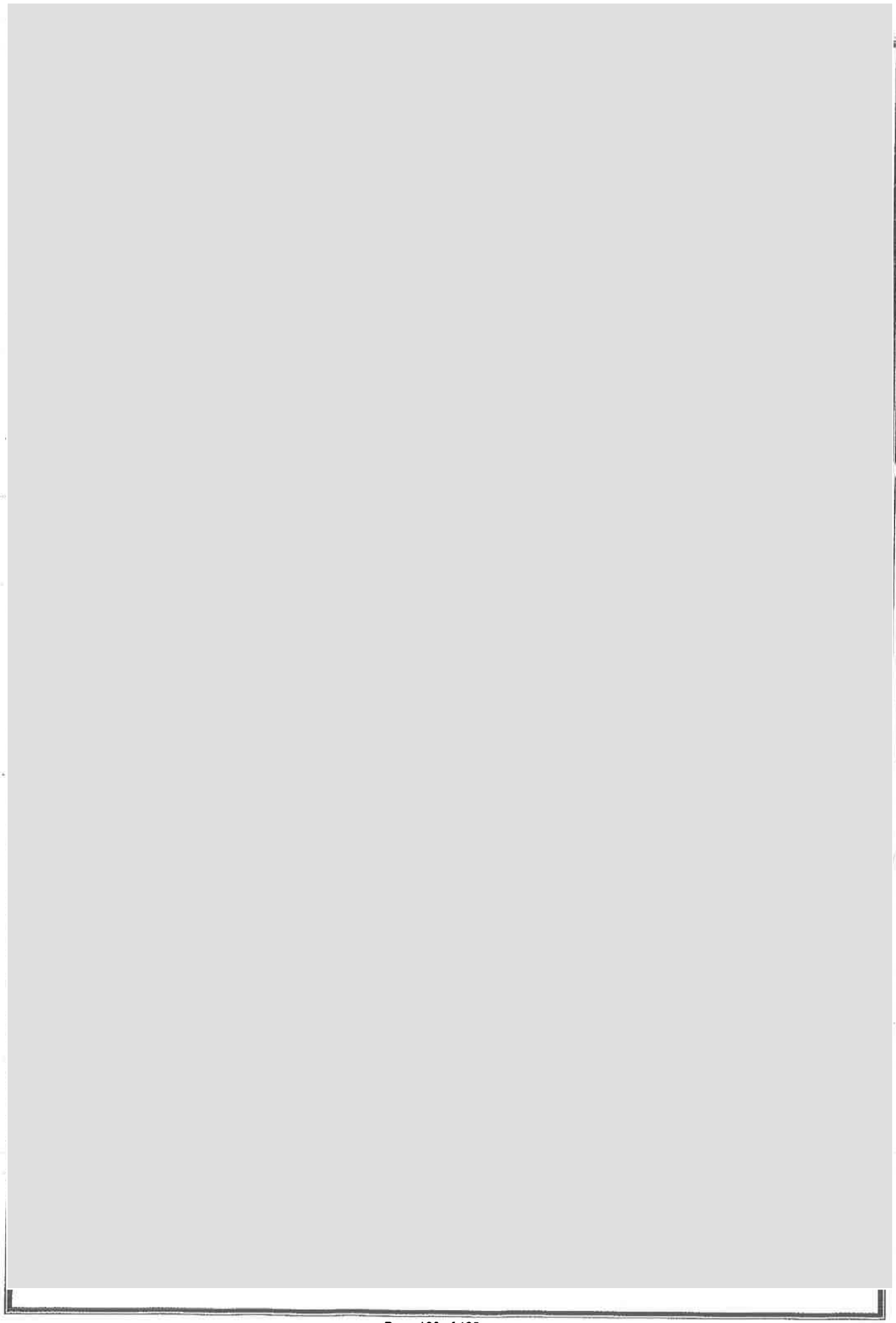

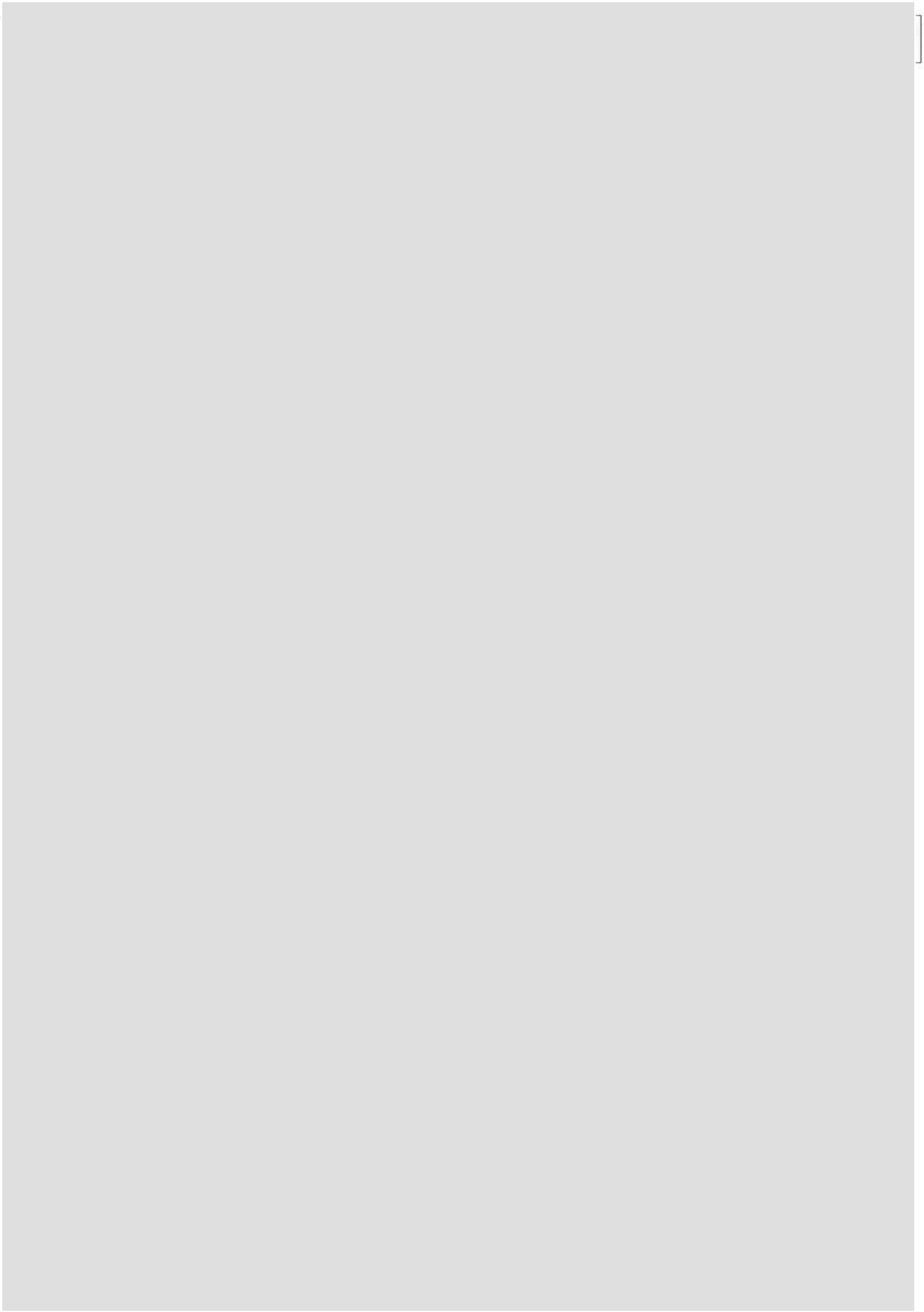

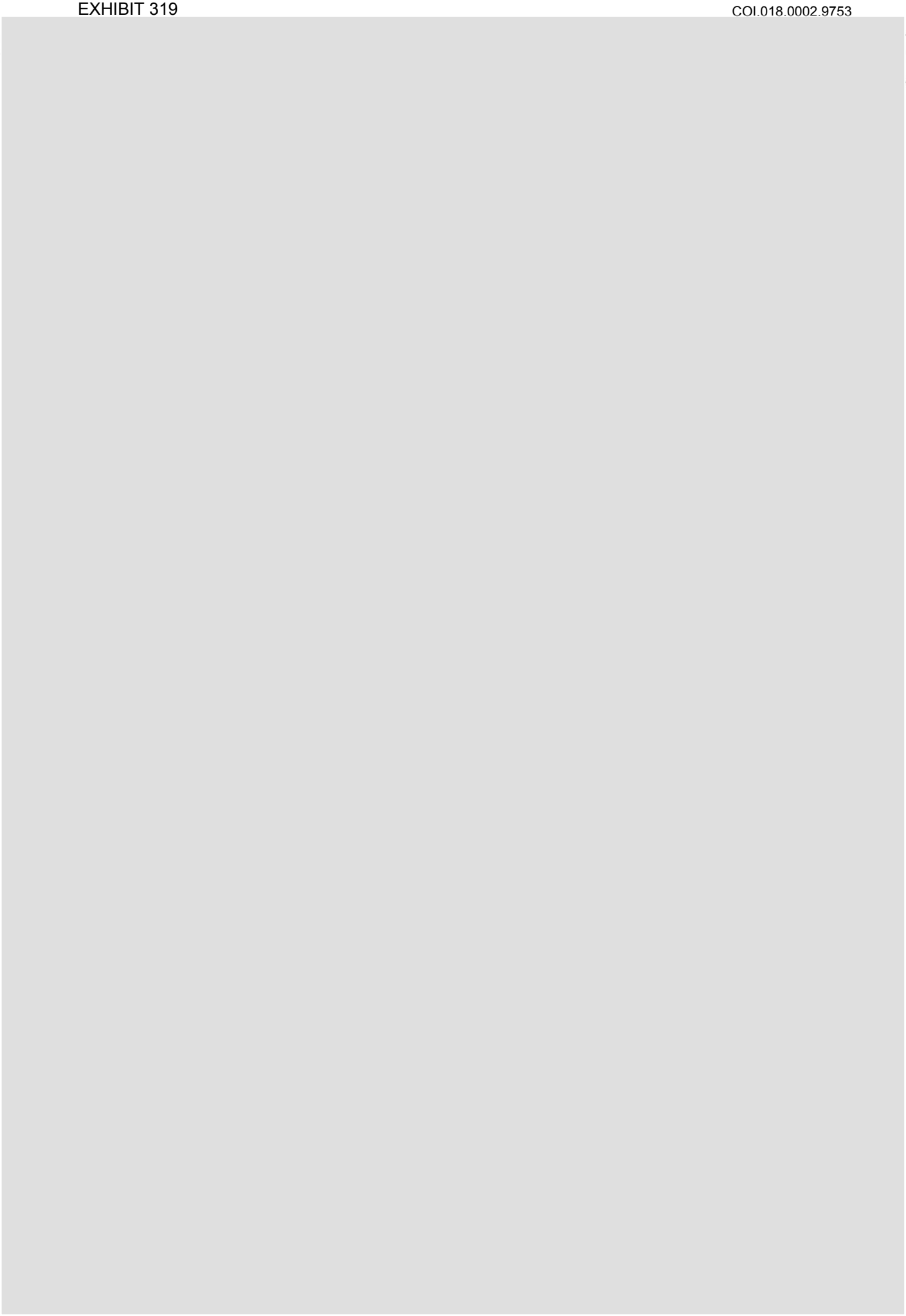

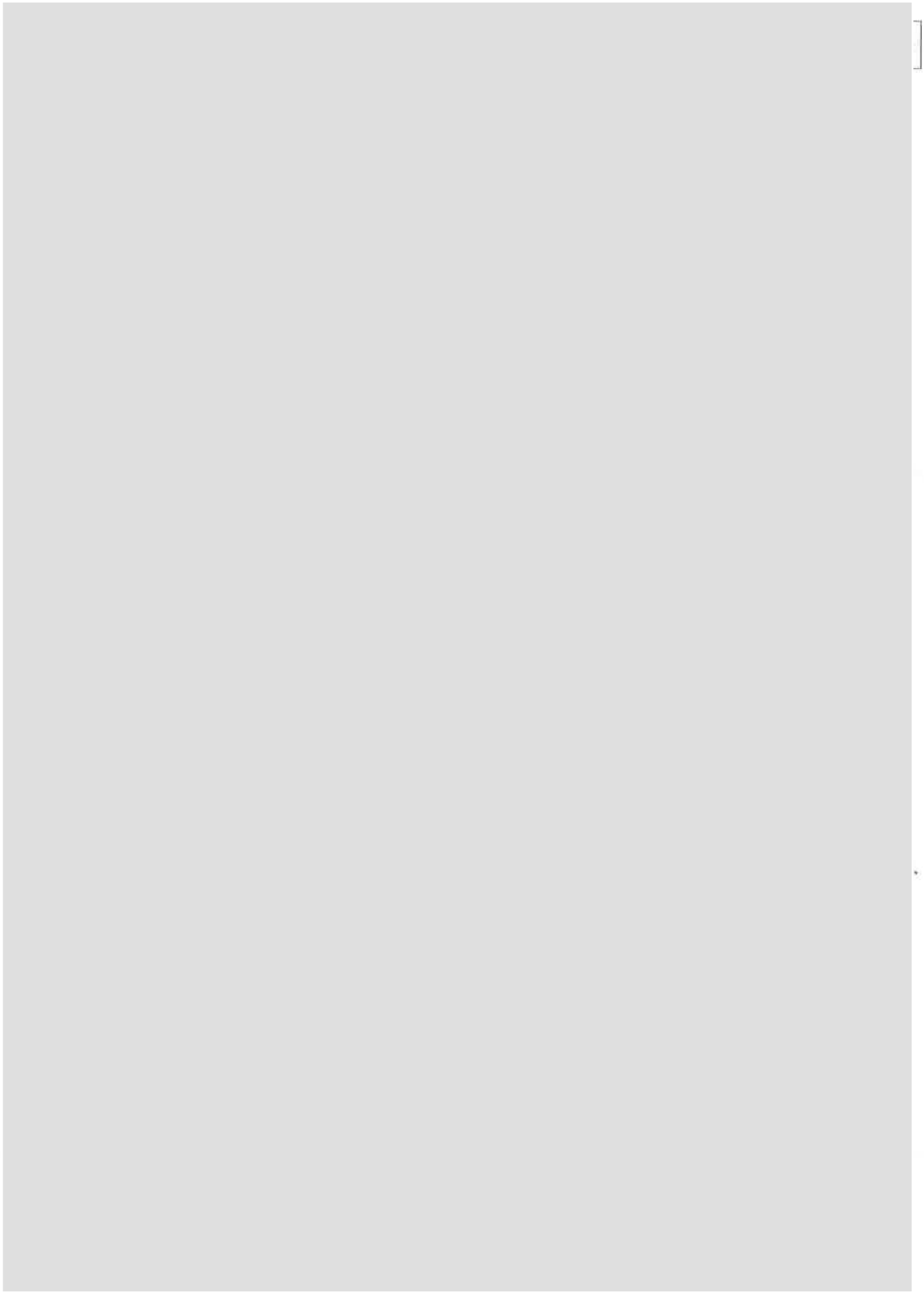

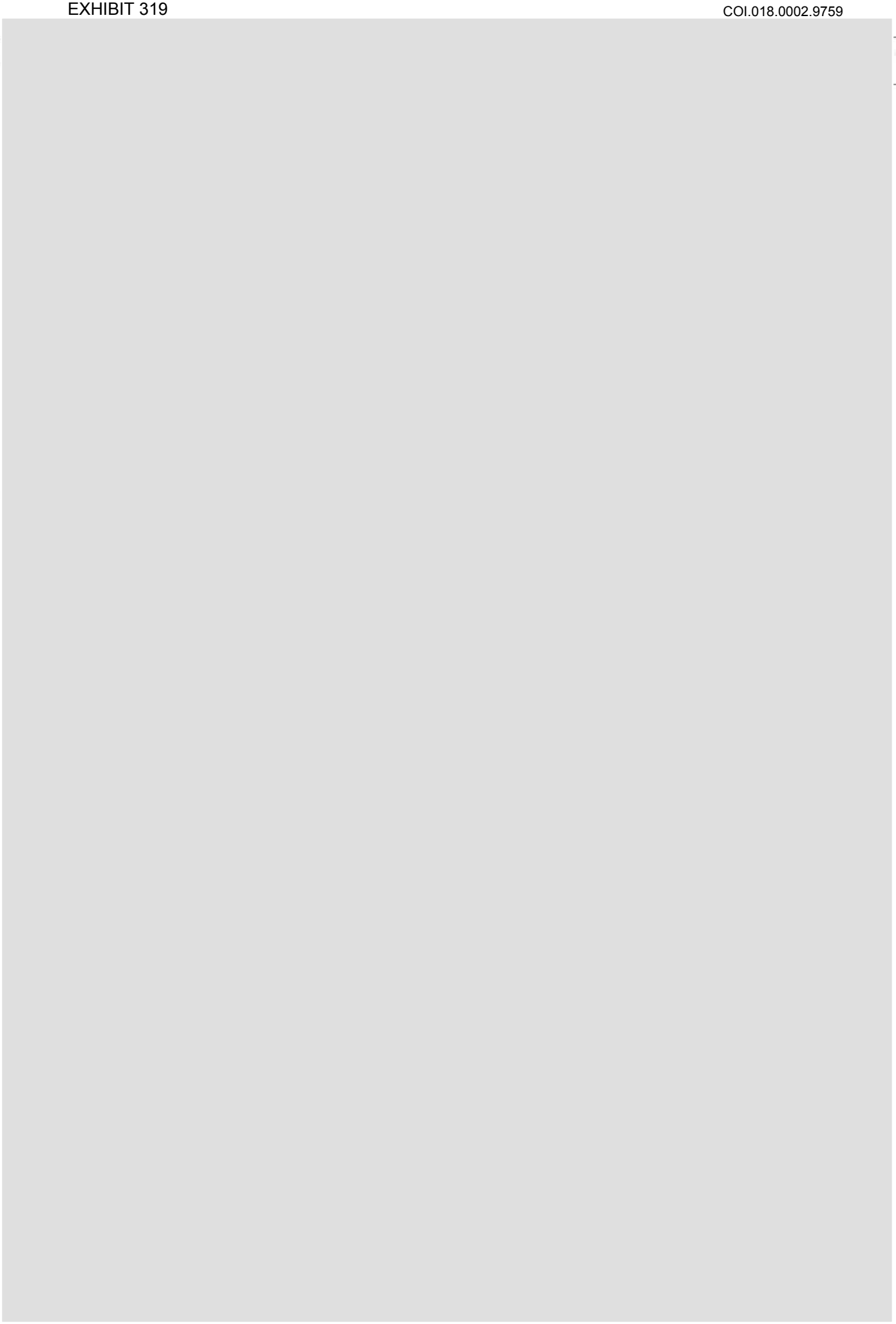

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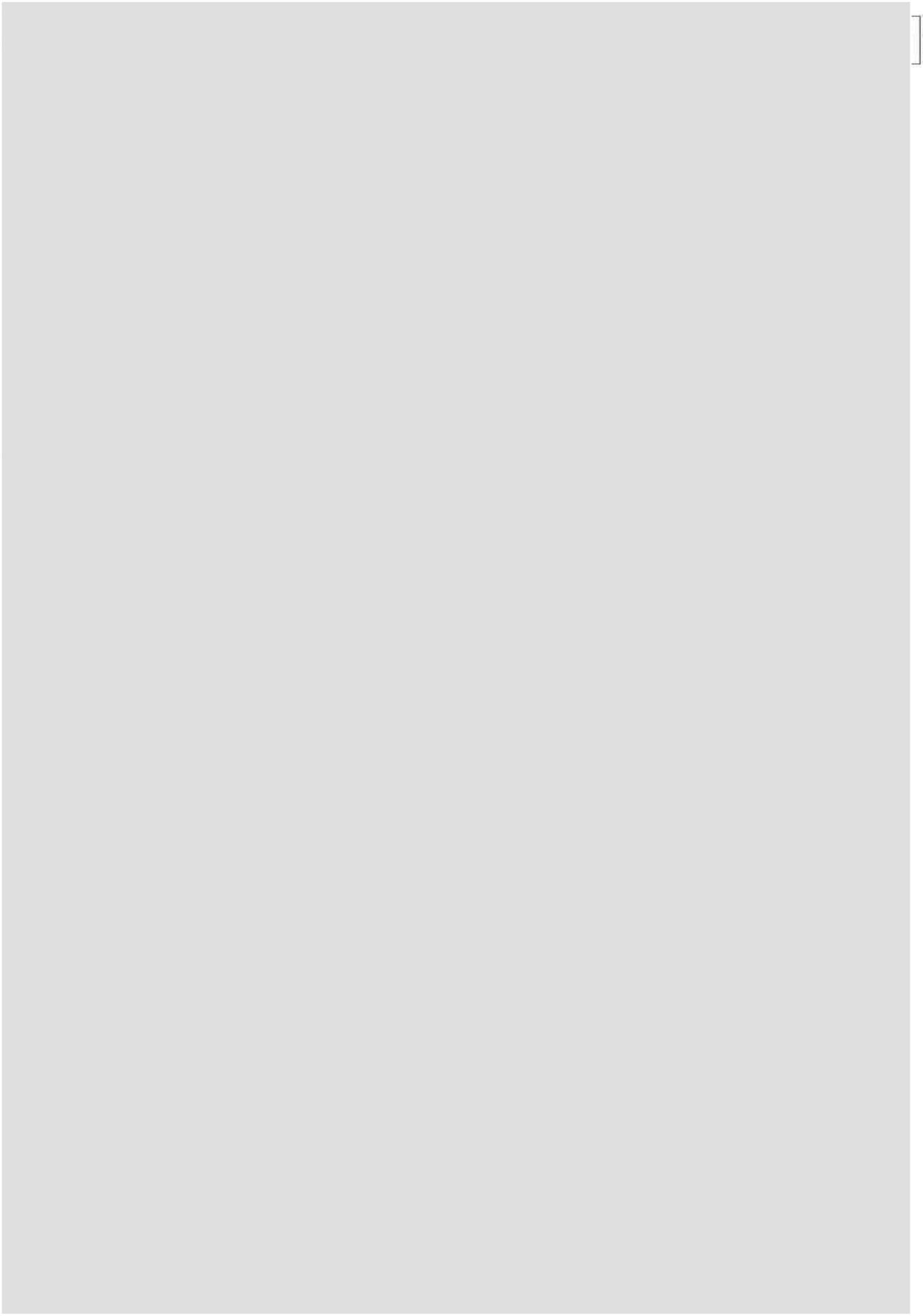
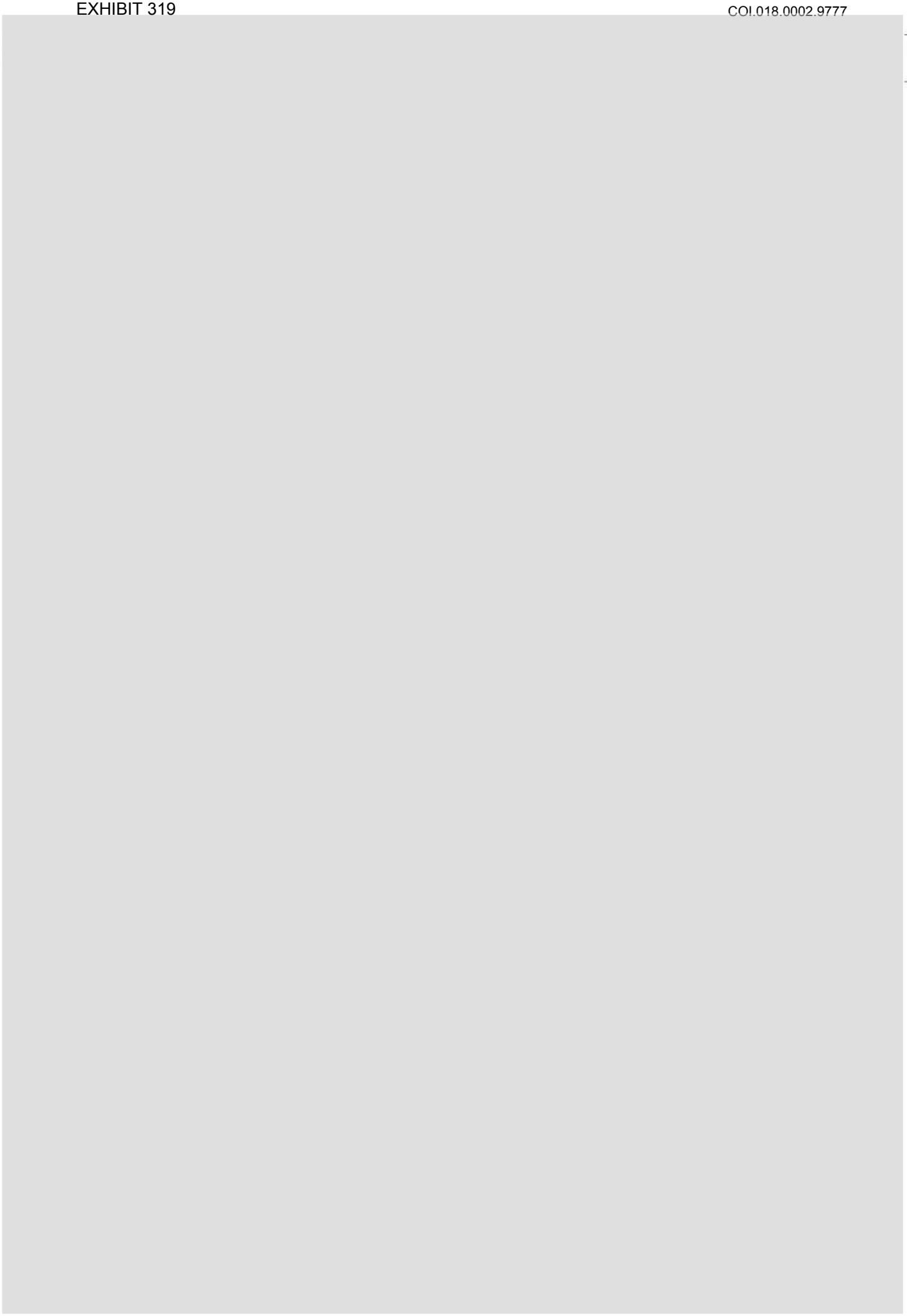
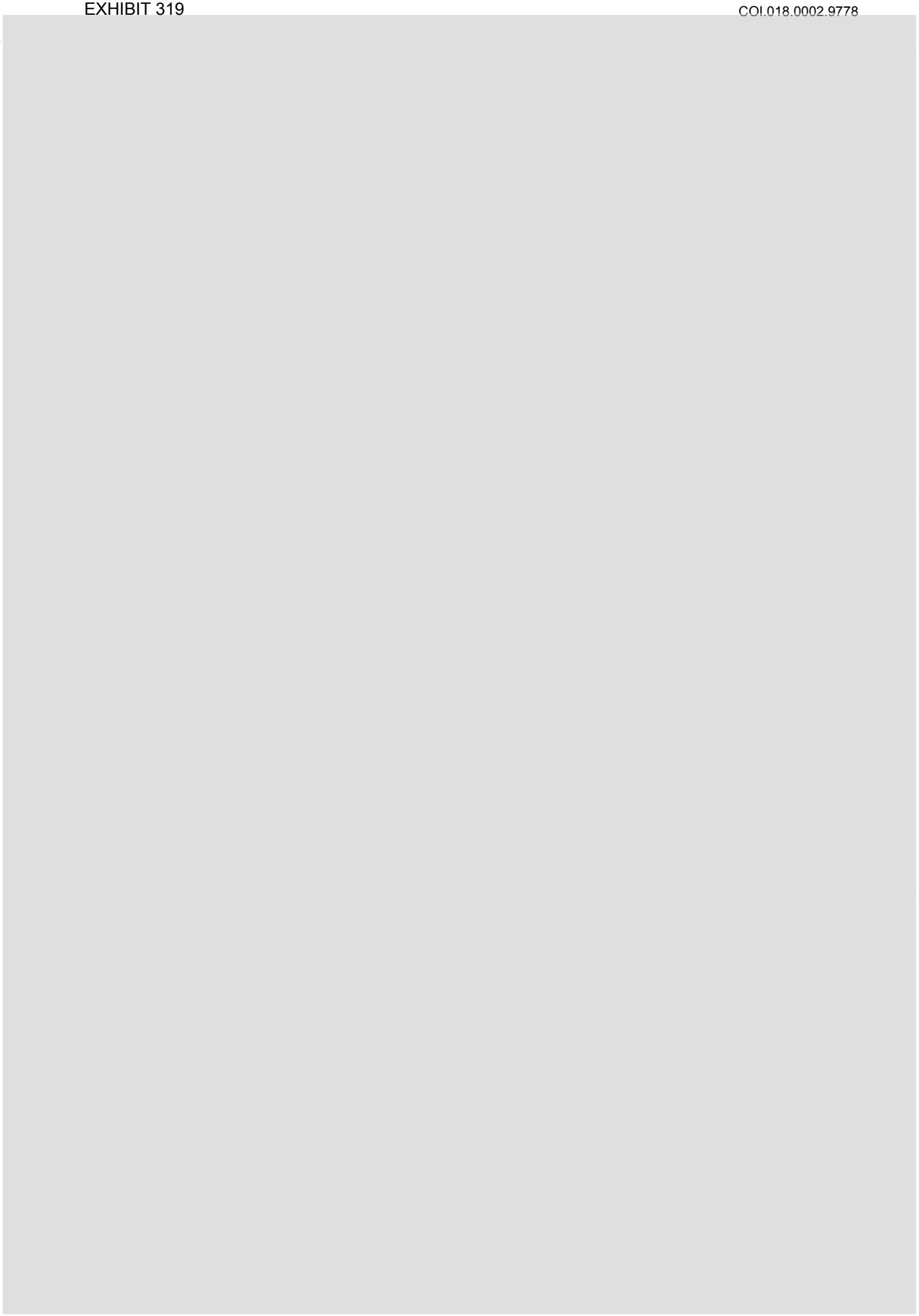
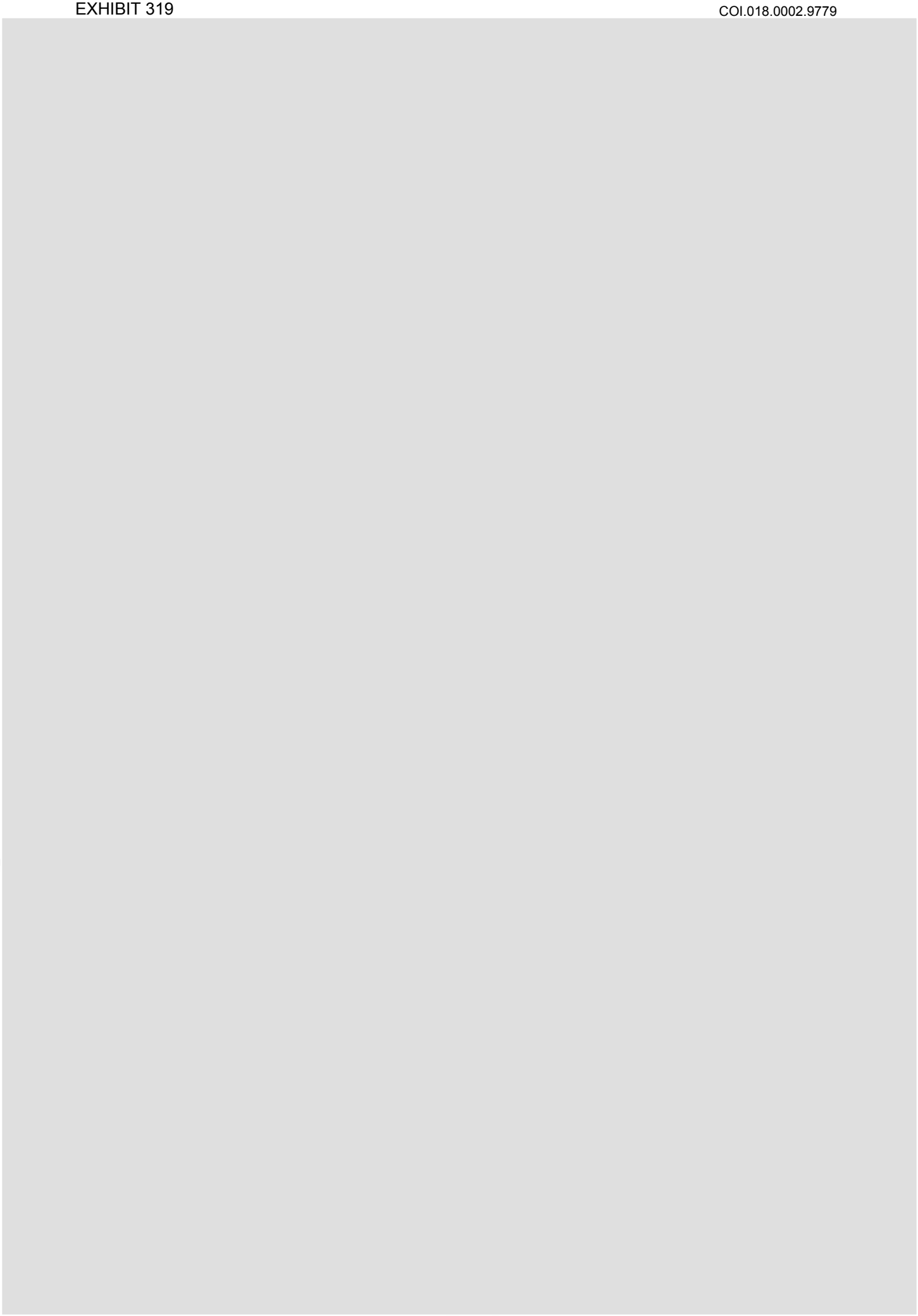








CYMHS Access Manual

Brief overview of service

CYMHS provides a service for people up to the age of 18 (or potentially older if consumer is still in school) with severe and complex mental health issues. All referrals go through a process of intake where it is decided if CYMHS is the most appropriate service for that young person. This is a multidisciplinary team decision. If CYMHS is appropriate, an appointment will be offered with a clinician. If CYMHS in not appropriate, suggestions will be made for more appropriate services. During the process of decision making a one off mental health assessment may be offered to clarify mental health issues or to assess and contain risk. Referrals are not taken for specific discipline groups (e.g. psychology), for psychiatry review, for medication review and for psychometric/speech and language assessment purposes.

Administrative Issues

Morning Meeting

A morning meeting is held every day at 8.45am. This is to review current referrals that are being processed by Access and for multidisciplinary team decision making. Morning meetings are usually conducted over the phone due to the team working across CYMHS sites.
The morning meeting is chaired and hosted by Team Leader unless otherwise advised.

Referrals to be presented at morning meeting should be organised the day before or early the same day. Referrals are presented in groups according to which clinic they belong to (i.e. Nundah or North West). Referrals to be presented are as follows:

- New referrals taken the previous day.
- Any referrals that require allocation to a Community Team.
- Any referrals that require allocation to the Access Team for Mental Health Assessment.
- Any referrals that are to be closed and referred on elsewhere.

The morning meeting is documented on the "Intake Team POS Sheet" which is saved electronically on the Nundah CYMHS G drive (G:\CYMHS-Team\Access Team - Nundah\Forms and Templates). Each clinic requires a separate form for each morning meeting. The form documents which clients are presented, if the client was a new referral from the previous day and the action that the team has decided on (i.e. allocate to community, MHAx, end referral).

After the morning meeting the details entered on the Intake POS Sheet need to be entered into CIMHA "Intake/Triage" form under the subsection "Intake Summary, Discussion and Follow up". The electronic entries need to be dated, the team discussion summarised, plan updated and be signed by the clinician amending the form. An example is as follows:

- **21/09/2009 I/M** 12 year old girl with anxiety symptoms. Holdover to contact family to offer an in person assessment. **Plan: Call family (Clinician's name and position).**

Once all entries have been entered in CIMHA, a copy of the Intake Team POS Sheet needs to be emailed to the relevant community team AO and a read only copy remains on file in G drive as record.

Action List

The action list is a list of all clients who Access are currently working with regardless of status. The electronic copy of this is located on the Nundah G Drive at: (G:\CYMHS-Team\Access Team – (clinic name)\Action List). The list is to be co-ordinated at the beginning and at the end of the day by one person to ensure consistency and planning. All clinicians are responsible for updating the list as they work through referrals.

- The action list is to be updated on a daily basis to reflect the work that has been done and also the work that is required to be done.
- The list is organised in date order from oldest to newest.
- Items on the list are highlighted in yellow and bold if they need priority follow up and the need for priority is specifically noted on the list.
- Items on the list are highlighted in purple if they need to be flagged for presentation at morning meeting the next day.

Email

Each community team site has a generic email address that should be used to communicate with the Access Team. It is important that these email addresses are checked on a regular basis and particularly important for Wednesday handovers to and from the community team. All team members should have proxy access to each email address. The team can negotiate who will be responsible for this each day. The email addresses are:

- Nundah
- North W

Keeping Track of Referrals

To keep track of referrals and ensure that none are lost, the following procedures are in place.

- Check faxes and generic emails regularly.

<u>When taking a new referral:</u>

- Take referral.
- Enter on CIMHA as soon as possible and make sure ALL details are entered. Be particularly mindful of adding phone numbers and external contacts. Enter OK and save consumer!
- Referral details to be entered on action list.
- Referral details to be entered on to the next day's Intake POS sheet

When finalising a referral

- You will have presented the referral at morning meeting.
- Update the action list on G drive to reflect team decision.
- Process *CIMHA notes* according to decision made (see following).

Allocated Clients to the Community

- You will have presented at morning meeting and completed appropriate admin.
- Send a copy of the Intake/Triage form to the Team Leader via CIMHA Message. In the body of the message write the name, age and a brief summary of the reasons for referral.
- The team leader will then allocate a community clinician to the client and advise Access of the time, date and clinician. They will do this via email to the clinician who sent the allocation to them and also via the generic clinic email.
- The team leader will update the community diary.
- The Access team will then contact the client to confirm the appointment time.
- If the client is able to make the appointment, complete the appropriate section of the "Intake/Triage" form and save and sign the form.
- The completed "Intake/Triage" form is now sent via CIMHA message to the admin officer for that clinic. The admin officer will complete the paperwork and organise charts to be made up for the client.
- The Access team then needs to email the community clinician to confirm that the appointment has been made with date, time and name of client noted.
- If the client is unable to make the appointment, refer back to the appropriate Team Leader who will re-allocate another time.
- **It is noted in Action list and also on triage doc in appropriate place**
- If there are URGENT clients that need allocation the Access team is able to allocate to the next available clinician in the diary if the community team leader is not contactable. However, before doing so, attempt to contact the community team leader and speak to them – either in person or on the phone. **Note in cimha triage doc the priority level.**

Allocated Clients to the Access Team - MHAx

- At morning meeting, this will be put through as an allocated client to the Access clinician and reasons for allocation noted in the "Intake Summary, Discussion and Follow Up" section of the "Intake/Triage" form.

- It will be noted in the action list that the client has been allocated for MHAx, the Access clinician's initials will be recorded as will the date of allocation.
- The Access clinician will make an appointment time with the client and record this as part of the "Intake Summary, Discussion and Follow up" section.
- The Access clinician will send a message via CIMHA to the clinic admin officer to advise them that a MHAx has been booked so that a chart can be created when the client arrives and a room booked, place into clinicians electronic calendar.
- The Access clinician conducts the MHAx then writes up the assessment on CIMHA in a "CYMHS Consumer Assessment " form.
- The assessment is then presented at clinical review on Wednesday or discussed at the daily IM where a decision will be made about the outcome of assessment.
- The "Intake/Triage" form will be finalised at clinical review based on the decision made. The paperwork will be sent to admin officers as per normal processes for closing a referral or allocating a referral to community team.

Allocated Clients to the Access Team – Brief Interventions

- A decision will have been made at clinical review to conduct a brief intervention with a client post MHAx.
- Clinicians will book sessions as per clinical need.
- Clients will need to be reviewed periodically at clinical review (frequency will be decided at review).
- When brief interventions are reviewed, a "Care Review Summary" will need to be completed PRIOR to review and saved as a draft. The draft will need to be sent and shared with the person designated as managing CIMHA entries for that review. This clinician will update the form according to the team discussion.
- At the final session of a brief intervention the client/carer will need to complete an end of episode SDQ and the clinician will need to complete the Outcomes suite of forms.
- When brief interventions are finalised, a "Care Review Summary" and a "End of Episode/Discharge Summary" will need to be completed. After presentation at review, a discharge letter will need to be written to the client/carer to confirm discharged. The chart then needs to be given to the clinic admin officer to close.

Not Accepted Clients

- You will have presented at morning meeting and completed appropriate admin (i.e. fill in all sections of form).
- A letter will be sent out to the family and cc-ed to the referrer outlining the reasons for the decision and containing information of more appropriate support agencies
- You then send the "Intake/Triage" form to the clinic admin officer via CIMHA message and advise them that the referral is to be closed.

Clinical Issues

Taking a New Referral

- Ensure that the child is in our age range (0 to 17, 18 if the child is in school) and ensure that the child is in our catchment area (see catchment suburbs list).
- If the child is primary school age, they will need a referral from a GP, school etc. Adolescents can self refer.
- Make sure that the referrer has consent to make the referral from the child/parent/legal guardian.
- Check if there is already a treating clinician (e.g. private) and find out why the referral is not being made back to them (as appropriate).
- Take referral information. The "Intake/Triage" form has a range of prompts regarding what type of information to collect. Ensure that a risk assessment is completed as well. .
- When finishing a call, advise the referrer that a team decision will be made about whether CYMHS is the most suitable service and that the Access Team will advise of the outcome of the referral.

Clinical Information/Documenting a New Referral

- Enter referral on CIMHA as per CIMHA process.
- The clinical note is "Intake/Triage Form" then you select "CYMHS Consumer Intake".
- Ensure you **obtain and document** the following:

- **Specific** mental health symptoms (e.g. Joe reports experiencing panic attacks – increased HR, sweaty, hyperventilation, shaking, sudden onset with nil apparent trigger).
- Onset (time and context).
- Frequency, duration, severity and intensity of symptoms.
- Context in which symptoms occur.
- Context in which symptoms do not occur.
- **Specific risk factors and clear plan.** This includes risk of self harm, suicide, substance use issues, child protection issues, homelessness etc.
- Family history including mental health and drug and alcohol history. Make sure you obtain names and contact details of family/carers.
- Developmental history.
- Current/Past treatment and/or treating clinicians.

- Ensure that you specify the next plan of action in your clinical note so that the referral can be easily followed up.

Following Up New referrals

- All new referrals will be offered a in person assessment

Urgent Referrals

- Make a clinical decision regarding level of risk and how urgent the presentation is.
- Seek support if necessary from consultants, psychiatry registrars, other team members. **Always discuss with T/L or senior clinician on team**
- If you are able to assess risk on the phone and contain the situation do so. Ensure that you provide the consumer/family with a safety plan.
- If you are not able to assess risk on the phone or if the situation is urgent enough to warrant an in person assessment your options are to firstly, ask the person to come into the clinic where you will conduct an in person risk assessment and secondly, if it is late in the day (e.g. 3.30pm or later) request that the person present to hospital for assessment and advise Extended Hours. Be sure to request support as needed and advise Team Leaders/Consultants when there is an urgent or risky case.
- If the Mental Health Act needs to be used – look for a doctor or an authorised mental health practitioner. Refer to relevant folders and QHEPS for information and forms.

Queensland Government

Child and Youth Mental Health Services (CYMHS), Children's Health Services

CYMHS provides specialist mental health consultation, assessment and treatment services for infants, children, and young people (0-18 years) and assistance to their families or carers through combination of hospital and community-based facilities.

Referrals are considered on an individual basis, with priority entry given to the likely psychiatric nature of the presenting problem, extent of functional impairment in a range of settings, and level of distress experienced by the infant/child/ young person and family.

Provision of named referrals is preferred

Mental health problems in infants, children, and adolescents

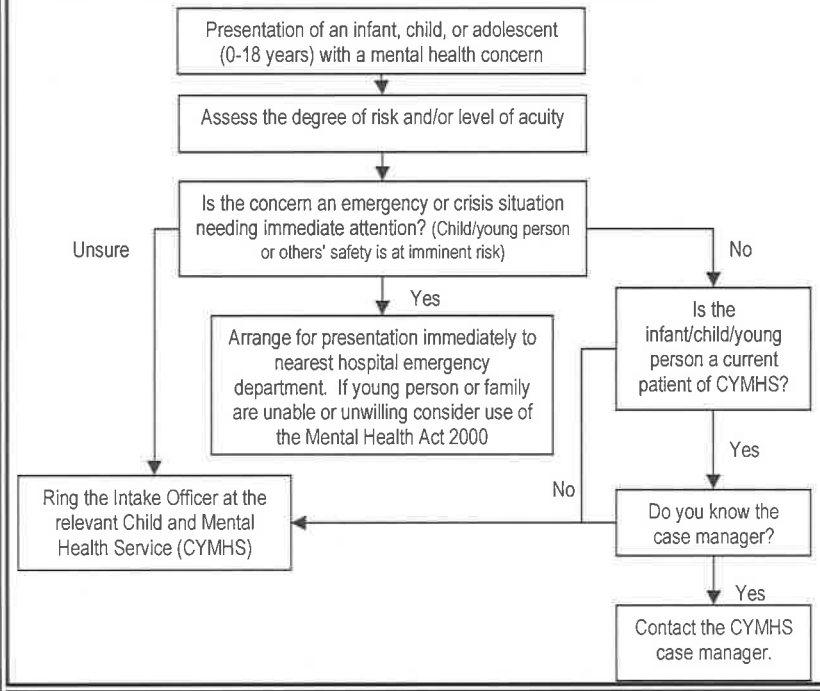
May include:

Complicated ADHD	Depression	Psychosis
Anxiety	Eating disorders	Trauma
Co-morbid conditions	Obsessive compulsive disorder	Attachment difficulties
Complex behavioural problems	Post-traumatic stress disorder	Severe relationship difficulties

Initial work-up is essential

Obtain psychiatric and developmental history from young person/ parents/ carers regarding onset and course of mental health problems, family history, and collateral information from school or other relevant sources if available.

Consider using the Strengths and Difficulties Questionnaire (SDQ) as a way of eliciting concerns from parents http://www.youthinmind.info/Aus/sdqonline/Parent/StartParent.php and young person http://www.youthinmind.info/Aus/sdqonline/Self/StartSelf.php.



Refer when

Emotional and behavioural disorders are severe or complex; or at risk of becoming so; and these needs cannot be met by other services.

Specific consideration given to infants, children, and young people with mental health problems from an Aboriginal and Torres Strait Islander background, homeless or have had multiple out of home placements.

Consider early intervention for infants, children, or young people who are:

- Living with family members who have mental illness or substance use issues
- Engaging in substance use
- Under 3 years of age requiring infant mental health intervention See: http://www.health.qld.gov.au/rch/families/cymhs_fut_fam.asp
- In statutory care or in contact with the law
- Living with a chronic physical illness or disability including sensory impairment.

Data needed in referral

Consent from young person/ parents/ carer for referral to CYMHS.

Basic demographic information including identity of legal guardian, any current legal orders, indigenous status, Medicare number etc.

Reason for referral including outline of mental health symptoms.

Relevant history including family history, past/ current psychiatric history, medical history and current/ recent treatment.

Relevant social history and supports including other agencies involvement.

Any recent investigations or reports from medical specialists or agencies including allied health or school.

Mental Status Examination and any relevant physical examination results.

Clinical Advice: Ring INTAKE OFFICER in Community CYMHS (see contacts) or Extended Hours Team after hours on [redacted] In a psychiatric emergency present to the nearest hospital.

For further Information and Fact Sheets see: http://www.health.qld.gov.au/rch/professionals/cymhs.asp

See final page for references, copyright, disclaimer and further contact details.

Queensland Government

Contact us

Extended Hours Service
Child and Family Therapy Unit
Future Families – Infant Mental Health Service
Child Development Program Intake Officer
Community Child Health Service general enquiries (via Primary Care Program Central Intake)
RCH Admission Enquiries
RCH ED Admission Enquiries
RCH Admission Enquiries After Hours (via the RCH Main Switch)
Poisons Information Centre
Seriously Unwell Child: RCH Emergency Department

Copyright and disclaimer

These guidelines were reviewed and developed by specialists at the Royal Children's Hospital and reviewed by a working group of metropolitan general practitioners in Queensland.

Feedback or suggestions welcomed. Contact the **Patient Safety and Quality Unit:**

Last reviewed: October 2010

Provision of named referrals is preferred

Clinical Advice: INTAKE OFFICER in Community CYMHS (see contacts) or Extended Hours Team after hours on or nearest hospital in a psychiatric emergency.

For further Information and Fact Sheets see: http://www.health.qld.gov.au/rch/professionals/cymhs.asp

DSQ Ipswich – WF

Kristi Geddes

From: Tammy A Myles [redacted]
Sent: Monday 15 September 2014 04:09 pm
To: Kristi Geddes
Subject: Disability Services: Intake Policy and Procedures
Attachments: needs-assessment.pdf; eligibility.pdf

Good afternoon Kristi

In response to your request for information from the Department of Communities, Child Safety and Disability Services regarding our involvement with [redacted]

I understand you spoke with Mark Healey, General Counsel , Legal Services and I confirm that, as discussed, the department cannot provide the information sought in item 1 of your letter as this would contravene the confidentiality provision in section 228 of the Disability Services Act 2006.

Please see attached however two documents relating to your request for "further information generally about the service provided by Disability Services Queensland, including any policies and/or procedures about intake of patients".

Please do not hesitate to contact me should you require further clarification of the intake and assessment processes

Regards

Tammy E Myles | A/Regional Director
Disability and Community Services | Brisbane Region | Department of Communities, Child Safety and Disability Services

Level1 Cnr Russell and Edmonstone Street South Brisbane Q 4101
[redacted]

Disability and Community Care Services
POLICY

Title: Needs assessment

Disability and Community Care Services (DCCS) is committed to a sustainable service system that delivers specialist disability services in an easy to use, responsive and fair way, and achieves improved outcomes for people with a disability, their families and carers, while delivering improved value for government.

Specialist disability services aim to support a person to live as independently as possible. Access to specialist disability services (provided and funded by DCCS) is determined through a comprehensive process that sees a person's eligibility checked, their assessment completed, their prioritisation conducted, and an indication made about the type and level of funded support that would meet their assessed need. Following this, a person may be offered and then linked to an available service or support.

Part of the way we will support people to achieve and/or retain as much independence as possible, is to also consider appropriate supports beyond the funded disability services system to assist in meeting a person's needs.

Policy statement:

DCCS is committed to understanding a person's needs in order to assist them to live as independently as possible in the community, and best inform the appropriate allocation of specialist disability services and the effective use of finite resources.

Policy detail

DCCS will assess the needs and function of a person who applies for specialist disability services. Only people who require more than informal support and mainstream services will progress to a formal assessment.

The assessment gathers and reviews information about a person, their skills and abilities and existing services and supports, their goals, their environment, life circumstances, strengths,

capabilities, risk and the role of a person's carer in order to make a determination about their needs. Information gathered is used to recommend the services that may respond to those needs.

The completion of a needs assessment does not entitle a person to support. Rather, access to specialist disability services depends on eligibility, the outcome of assessment and prioritisation processes, and available resources.

Eligibility is confirmed during the needs assessment.

DCCS will obtain written consent from a person during the assessment to share their information in order to obtain or provide services. Written consent enables personal information to be disclosed to other agencies or government departments for the purpose of obtaining services.

Where required, DCCS will arrange alternative communication or interpreter services. Costs associated with such services are met by DCCS.

Scheduling assessments

A person applying for specialist disability services will be scheduled for the first available needs assessment or at a time agreed between a person and DCCS (refer to Intake Policy).

Where it is identified that a person has been referred to the Mental Health Court through a judicial process in relation to an indictable offence, an assessment will be urgently scheduled so that it can be completed prior to the person's appearance.

The time and location of an assessment is negotiated with a person based on their circumstances. Wherever possible this will be at a DCCS Centre, however in some instances or areas, such as rural and remote areas, this may occur at the person's residence or at a venue closer to the person's residence.

A person who does not attend an assessment is rescheduled for the next suitable assessment time as determined by DCCS.

Assessment method

An assessment is conducted by a DCCS trained assessor using a consistent, standard assessment process and tools. The assessment process is adapted to be responsive to individual circumstances.

Standardised assessment tools are used to assess a person's functional need and to screen for risk, including risk of harm to self or others, and risk to the person's current care arrangements.

DCCS will understand the role of the carer, where a person, their family or carer is seeking services to support the carer, or where it is recognised that services to support the carer in their caring role would be beneficial.

Additional clinical assessments

Where DCCS conducts an assessment for a person prior to their appearance before the Mental Health Court, or for a person beginning to transition into the community from the Forensic Disability Service or an Authorised Mental Health Service through extended Limited Community Treatment, a separate clinical assessment will be obtained, for example from a psychologist, to inform the needs assessment.

In these circumstances, a clinical assessment will be used along with the standardised assessment process to determine a person's needs and to recommend services that may respond to these needs. Needs assessment outcomes will be used to inform prioritisation and any future planning subject to the availability of resources.

Compensation

During the assessment DCCS confirms if a person is receiving financial compensation or is the subject of a case that may result in financial compensation being paid, and whether this compensation will include an amount that relates to future care. This information is considered when a person participates in the planning and linking to services process (refer to Planning, Offering and Linking to Services Policy).

Identifying service options

Service options, including the amount and duration of each service option, are based on the assessment results, informed by a person's stated preferences and goals and developed using a standardised approach.

Service options include only those identified on the department's Service Catalogue, which describes the services and supports that DCCS provides or funds.

A service option and the amount of that option that may be provided is only identified where it responds to a person's assessed need and will benefit a person in meeting their identified goals. Where more than one service may meet a person's assessed needs this is also identified.

Case management may be considered as a service option where the needs assessment indicates it is necessary to support a person to effectively identify, engage with, negotiate and maintain informal, mainstream and specialist disability support in a sustainable way. This may include where a person is in contact with the Mental Health Court of Queensland, where a young person is exiting the care of the state, or where a person is accessing a time-limited response.

In determining the amount of each service option that may be provided, DCCS also considers if:

- more than one person is required to provide the support due to a person's level of function
- additional equipment is required to support a person
- a person resides in a rural or remote area and/or the service provider requires a longer travel time.

An identified service option is provided only where it is available based on a person's relative need.

On completion of the assessment, priority ratings are determined, and the person participates in planning and linking to services (refer to Prioritisation Policy and Planning, Offering and Linking to Services Policy).

This policy does not apply to community care services or to community mental health services.

Reassessment

A reassessment occurs where a review of a person's circumstances has confirmed these have changed significantly, and this change is likely to affect the type and level of specialist disability services that will respond to a person's needs, and/or the person's prioritisation ratings (refer to Review Policy).

A person is scheduled for the first available time for reassessment. The standardised assessment tools used to reassess a person are determined by DCCS and depend on the changes in a person's circumstances.

Where a review identifies that a person's circumstances have changed significantly and the person has been referred to the Mental Health Court through a judicial process in relation to an indictable offence, a reassessment will be urgently scheduled so that it can be completed prior to the person's appearance.

A person will continue to receive the specialist disability services they have been accessing until they are re-prioritised for other services and are offered services through the planning and linking to services process.

Communicating the assessment outcome

Assessment results will be provided to a person on request. Information will include service options that have been identified as meeting a person's assessed need, and will be provided to the person as a written assessment report.

DCCS will also discuss and explain the assessment report with a person where this is requested.

Review of decisions

A person can request a review of the assessment process and the outcome of the assessment following completion of the assessment (refer to Review of Decisions Policy).

Principles:

The principles underpinning this policy are:

- the participation of a person in the assessment process is essential
- a person is required to provide information once and this is used as necessary

- an understanding of the person's circumstances is gained through the assessment process without a person needing to focus on the worst case scenario.
- the assessment process is sensitive to cultural, communication and other individual differences.

Objectives:

This policy aims to ensure that:

- the process used to assess a person's needs is fair, consistent and transparent
- sufficient information is gathered to confirm a person's eligibility for specialist disability services and to determine the person's support needs
- needs assessment outcomes can be used to inform prioritisation and the allocation of specialist disability services (such as speech or occupational therapy).

Scope:

Reference to 'a person' means a person with a disability, and includes the person's family, carer, guardian or substitute decision maker, as and when appropriate.

Reference to a person's 'needs' means a person's disability support needs.

Specialist disability services are those services defined by the *Disability Services Act 2006* and includes: accommodation support services, respite services, community support services, and community access.

This policy applies to a person who is seeking ongoing specialist disability services or a person seeking one-off specialist disability services, such as aids and equipment.

This policy applies to all assessments that are undertaken by DCCS for the purpose of determining access to services.

This policy does not apply to specialist assessments that are carried out to inform the delivery of a specific specialist disability service.

This policy does not apply to community care services or to community mental health services.

Roles and responsibilities:

Service Access Teams:

Members of Service Access Teams are responsible for:

- applying and adhering to the Needs Assessment Policy when undertaking an assessment
- conducting each assessment consistently and fairly, using standardised tools and professional practice framework
- resolving any concerns that may arise during the needs assessment process

- ensuring the assessment information reflects a realistic representation of the person and their circumstances
- explaining assessment results to a person where necessary
- advising a person of the process to request that a decision be reviewed where a person disagrees with the assessment
- documenting any discrepancies between the services that a person requests and the service options recommended
- responding appropriately to each person seeking assistance, including Aboriginal or Torres Strait Islander peoples, people from a culturally or linguistically diverse background, or people with communication difficulties
- recording the information collected so that it can be used to best effect in delivering responsive services; for decision-making purposes by DCCS; and to inform the department's policy, program and budget advice and development.

Service Access Team Manager or Service Centre Manager:

The Service Access Team Manager or Service Centre Manager is responsible for:

- supporting staff to apply the Needs Assessment Policy
- ensuring assessors are trained in the use of assessment tools to successfully apply the methodology and to document the person's needs
- managing workflows to ensure that assessments are completed within prescribed timeframes
- assisting to resolve any concerns that may arise during the needs assessment process.

Office of the Chief Practitioner Disability:

The Office of the Chief Practitioner Disability is responsible for:

- identifying a person that has been referred to the Mental Health Court through a judicial process
- notifying the Service Access Team that a clinical assessment and needs assessment or reassessment is required where a person is attending a Mental Health Court hearing.

Policy and Performance:

The Policy and Performance Team is responsible for:

- custodianship of this policy, including its intent
- providing support and guidance as required to apply this policy
- reviewing this policy to ensure its continued accuracy, currency and relevance.

Authority:

Disability Services Act 2006
Forensic Disability Act 2011
Mental Health Act 2000
Queensland Disability Service Standard – Standard 3: Decision making and choice
Queensland Disability Service Standard – Standard 5: Participation and integration

Delegations:

Regional Directors

Regional Directors are delegated to implement this policy within the Department of Communities' regions and are accountable for ensuring that appropriately skilled staff deliver services under this policy.

Records File No.:	DDS/09683
Date of approval:	November 2011
Date of operation:	November 2011
Date to be reviewed:	July 2013

Office:	Policy and Performance, DCCS
Help Contact:	Director, Policy Development and Coordination, 340 43011

Links:

Related policies

- Department of Communities (DCCS) Intake Policy (approved July 2011)
- Department of Communities (DCCS) Eligibility Policy (approved July 2011)
- Department of Communities (DCCS) Time-Limited Response Policy (approved July 2011)
- Department of Communities (DCCS) Prioritisation Policy (approved July 2011)
- Department of Communities (DCCS) Planning, Offering and Linking to Services Policy (approved July 2011)
- Department of Communities (DCCS) Review of Decisions Policy (approved July 2010)
- Queensland Government Language Services Policy (included in the Queensland Government Multicultural Policy 2004)
- Communication Support for People with Complex Communication Needs Policy (approved 10 May 2005)
- Responding to Sensitive or Life Changing Information Communicated by Methods Other than Speech (approved 10 May 2005)
- Preventing and Responding to Abuse Neglect and Exploitation of People with a Disability Policy (approved 13 June 2007)
- Substitute Decision Makers Policy (approved 5 January 2006)
- Critical Incident Reporting Policy (revised 11 November 2008)
- Complaints Management Policy (April 2011)
- Code of Conduct for the Queensland Public Service (released January 2011)

Strategic context

- Department of Communities 2011-15 Strategic Plan (in particular the strategic objective of Better Services and Pathways for our Customers and Clients)

Related legislation or standard

- *Disability Services Act 2006*
- Queensland Disability Service Standards November 2005
- *Right to Information Act 2009*
- *Information Privacy Act 2009*
- *Public Service Act 2008*
- *Public Sector Ethics Act 1994*

Rescinded policies

Disability Services Queensland Eligibility Policy August 2006

Linda A Apelt

Director-General

Department of Communities

Disability and Community Care Services
POLICY

Title: Eligibility

Disability and Community Care Services (DCCS) is committed to a sustainable service system that delivers specialist disability services in an easy to use, responsive and fair way, and achieves improved outcomes for people with a disability, their families and carers, while delivering improved value for government.

Specialist disability services aim to support a person to live as independently as possible. Access to specialist disability services (provided and funded by DCCS) is determined through a comprehensive process that sees a person's eligibility checked, their assessment completed, their prioritisation conducted, and an indication made about the type and level of funded support that would meet their assessed need. Following this, a person may be offered and then linked to an available service or support.

Part of the way we will support people to achieve and/or retain as much independence as possible, is to also consider appropriate supports beyond the funded disability services system to assist in meeting a person's needs.

Policy statement:

DCCS is committed to applying a fair, consistent and transparent approach for each person applying for specialist disability services, and managing finite resources effectively and equitably.

Policy detail:

Eligibility criteria are the minimum requirements to be met by a person applying for specialist disability services. DCCS may gather a range of evidence to determine eligibility, the method for gathering and the evidence required will be informed by the person's circumstances.

Eligibility alone does not entitle a person to receive specialist disability services. Rather, access to specialist disability services will depend on eligibility, the outcome of assessment and prioritisation processes, and available resources.

Eligibility will be confirmed during needs assessment.

Eligibility criteria

To be eligible for specialist disability services, a person will meet the following criteria:

1. The person must be one of the following:
   - an Australian citizen **or**
   - a holder of a visa that gives permanent residency rights **or**
   - a New Zealand citizen who arrived in Australia prior to 26 February 2001

   The person must also be:
   - a Queensland resident, **and**
   - under 65 years of age.

   AND

2. The person has a disability that is:
   - attributable to an intellectual, psychiatric, cognitive (including both congenital and acquired impairments), neurological, sensory or physical impairment or a combination of impairments, **and**
   - permanent or likely to be permanent (and may or may not be of a chronic episodic nature)

   AND

3. The disability results in the person:
   - having substantial reduction in one or more of the following areas: communication; social interaction; learning; mobility; or self care/management, **and**
   - needing ongoing specialist disability support.

Children under six years of age

A child under six years of age is eligible for specialist disability services where they meet criteria one, **and**:

- have a significant developmental delay, **or**
- have a disability that is attributable to an intellectual, psychiatric, cognitive (including both congenital and acquired impairments), neurological, sensory or physical impairment or a combination of impairments.

To be eligible for specialist disability services a child six years of age and over must meet all eligibility criteria, even where they have previously received services while under six years of age. A child is reassessed at six years of age where it is necessary to confirm they have a

disability consistent with criteria 2 and 3 above. In circumstances where this has been confirmed prior to a child turning six years of age the child does not need to have their eligibility reconfirmed.

Determining eligibility

A person will be advised of the evidence required by DCCS to determine eligibility. It is a person's responsibility to source and fund this information.

In instances where DCCS determines that information to verify eligibility is conflicting, DCCS will source any supplementary assessment required.

Once a person has provided all necessary information to determine their eligibility, DCCS will make a determination and advise the person in writing within 10 working days of receipt of this information.

Conditional eligibility

A person may be determined as conditionally eligible for specialist services where they:

- require a critical, time-limited response and it appears from available information that they are likely to meet eligibility criteria
- have a disability where early therapeutic interventions would improve long-term functional capacity to a point where the person no longer has a substantial reduction in capacity
- have a disability where the permanency of the disability is not clear but it is likely to be permanent.

Where the permanency of a disability is unclear, a review date of no longer than two years from assessment is set to confirm ongoing eligibility for specialist disability services.

Where a person in receipt of a time-limited response is determined as ineligible, DCCS will support the person to access other appropriate informal supports and mainstream services. Ongoing specialist disability services cannot be offered.

Review of decisions

A person can request a review of the eligibility decision once the eligibility decision is confirmed in writing (refer to Review of Decisions Policy).

Principles:

The principles underpinning this policy are:

- the process to determine eligibility will place as minimal a burden as possible on the person seeking specialist disability services
- a person's eligibility for specialist disability services is determined and communicated at the earliest possible point

- eligibility confirmation does not by itself confer entitlement to specialist disability services. Allocation of services is based on assessment and prioritisation results and on service availability.

Objectives:

This policy aims to ensure that:

- the decision making process to determine eligibility is simple, clear and transparent
- eligibility decisions are made consistently
- only people determined as eligible are able to access specialist disability services.

Scope:

Reference to 'a person' means a person with a disability, and includes the person's family, carer, guardian or substitute decision maker as and when appropriate.

Reference to a person's 'needs' means a person's disability support needs.

Specialist disability services are those services defined by the *Disability Services Act 2006* and includes: accommodation support services, respite services, community support services, and community access.

This policy applies to a person who is seeking ongoing specialist disability services or a person seeking one-off specialist disability services, such as aids and equipment.

This policy does not apply to community care services or to community mental health services.

Roles and responsibilities:

Service Access Teams

Members of Service Access Teams are responsible for:

- applying and adhering to the Eligibility Policy
- applying a consistent process for people seeking access to specialist disability services.
- ensuring the eligibility information reflects a realistic representation of the person and their circumstances
- advising a person of the process to request a review of the eligibility decision where a person is determined as ineligible
- resolving any concerns as they arise
- responding appropriately to each person seeking assistance, including Aboriginal or Torres Strait Islander peoples, people from a culturally or linguistically diverse background, or people with communication difficulties

- recording the information collected so that it can be used to best effect in delivering responsive services; for decision-making purposes by DCCS; and to inform the department's policy, program and budget advice and development.

Service Access Team Manager or Service Centre Manager:

The Service Access Team Manager or Service Centre Manager is responsible for:

- supporting and assisting staff to make consistent decisions about a person's eligibility
- providing staff with requisite information and assisting to resolve any concerns or complaints that may arise.

Policy and Performance

The Policy and Performance Team is responsible for:

- ongoing custodianship of this policy, including its intent
- providing support and guidance as required to apply this policy
- reviewing this policy to ensure its continued accuracy, currency and relevance.

Authority:

Disability Services Act 2006
Queensland Disability Service Standard – Standard 1: Service access

Delegations:

Regional Directors

Regional Directors are delegated to implement this policy within the Department of Communities' regions and are accountable for ensuring that appropriately skilled staff deliver services under this policy.

Records File No.:	DDS/09683
Date of approval:	July 2011
Date of operation:	July 2011
Date to be reviewed:	July 2013

Office:	Policy and Performance, DCCS
Help Contact:	Director, Policy Development and Coordination, 340 43011

Links:

Related policies

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- Department of Communities (DCCS) Needs Assessment Policy (approved July 2011)
- Department of Communities (DCCS) Time-Limited Response Policy (approved July 2011)
- Department of Communities (DCCS) Prioritisation Policy (approved July 2011)
- Department of Communities (DCCS) Review of Decisions Policy (approved July 2010)
- Queensland Government Language Services Policy (included in the Queensland Government Multicultural Policy 2004)
- Communication Support for People with Complex Communication Needs Policy (approved 10 May 2005)
- Responding to Sensitive or Life Changing Information Communicated by Methods Other than Speech (approved 10 May 2005)
- Preventing and Responding to Abuse Neglect and Exploitation of People with a Disability Policy (approved 5 January 2006)
- Substitute Decision Makers Policy (approved 5 January 2006)
- Critical Incident Reporting Policy (revised 11 November 2008)
- Complaints Management Policy (April 2011)
- Code of Conduct for the Queensland Public Service (released January 2011)

Strategic context

- Department of Communities 2011-15 Strategic Plan (in particular the strategic objective of Better Services and Pathways for our Customers and Clients)

Related legislation or standard

- *Disability Services Act 2006*
- Queensland Disability Service Standards November 2005
- *Right to Information Act 2009*
- *Information Privacy Act 2009*
- *Public Service Act 2008*
- *Public Sector Ethics Act 1994*

Rescinded policies

Disability Services Queensland Eligibility Policy August 2006

Linda A Apelt

Director-General

Headspace Ipswich – WF

headspace Ipswich

[redacted]

headspace.org.au

Date: 19th September 2014

To Whom It May Concern,

Health Service Investigation – Barrett Adolescent Psychiatric Centre

I am writing in response to your letter dated: 11th September 2014 requesting the provision of documents and information in order to assist with investigations in relation to the closure of the Barrett Adolescent Psychiatric Centre in January 2014.

Please find enclosed the following records:

[redacted]

Please let us know if you require any further information.

Kind Regards,

[redacted]

Aftercare | Headspace Ipswich | Service Manager

26 East Street
Ipswich Qld 4305

[redacted]

aftercare

headspace

ABN 58 000 020 146
headspace National Youth Mental Health Foundation Ltd is funded by the Australian Government Department of Health and Ageing under the Youth Mental Health Initiative Program.

Encounters

[redacted]

SOFAS= 42

K10= 20/50

Kym Dann

From: Kym Dann
Sent: Wednesday, 16 July 2014 1:36 PM
To: Sarah Gilman
Cc: Kym Dann
Subject: FW: [redacted]

Importance: High

Can you upload this to [redacted] file please

Kym Dann
Aftercare | Headspace Ipswich | Clinical Team Leader

26 East Street
Ipswich Qld 4305

[redacted]

W www.aftercare.com.au
W www.headspace.org.au
www.facebook.com/aftercareaustralia

As a Gamilaroy Woman on country of the Yagara People *("Ugerapul, Yuggera and Jagera")*,
I wish to pay my respects and acknowledge them as the Traditional Custodians of this land.

[redacted]

26 East Street
Ipswich Qld 4305

[redacted]

[redacted]
w www.headspace.org.au
www.facebook.com/aftercareaustralia

As a Gamilaroy Woman on country of the Yagara People *("Ugarapul, Yuggera and Jagera")*,
I wish to pay my respects and acknowledge them as the Traditional Custodians of this land.

[redacted]

[redacted]

[redacted]

26 East Street
Ipswich Qld 4305

[redacted]

w www.aftercare.com.au
w www.headspace.org.au
www.facebook.com/aftercareaustralia

aftercare
together for social and emotional wellbeing

From: Casey Irwin
Sent: Wednesday, 19 February 2014 12:56 PM

[redacted]

[redacted]

What do you think I should do?

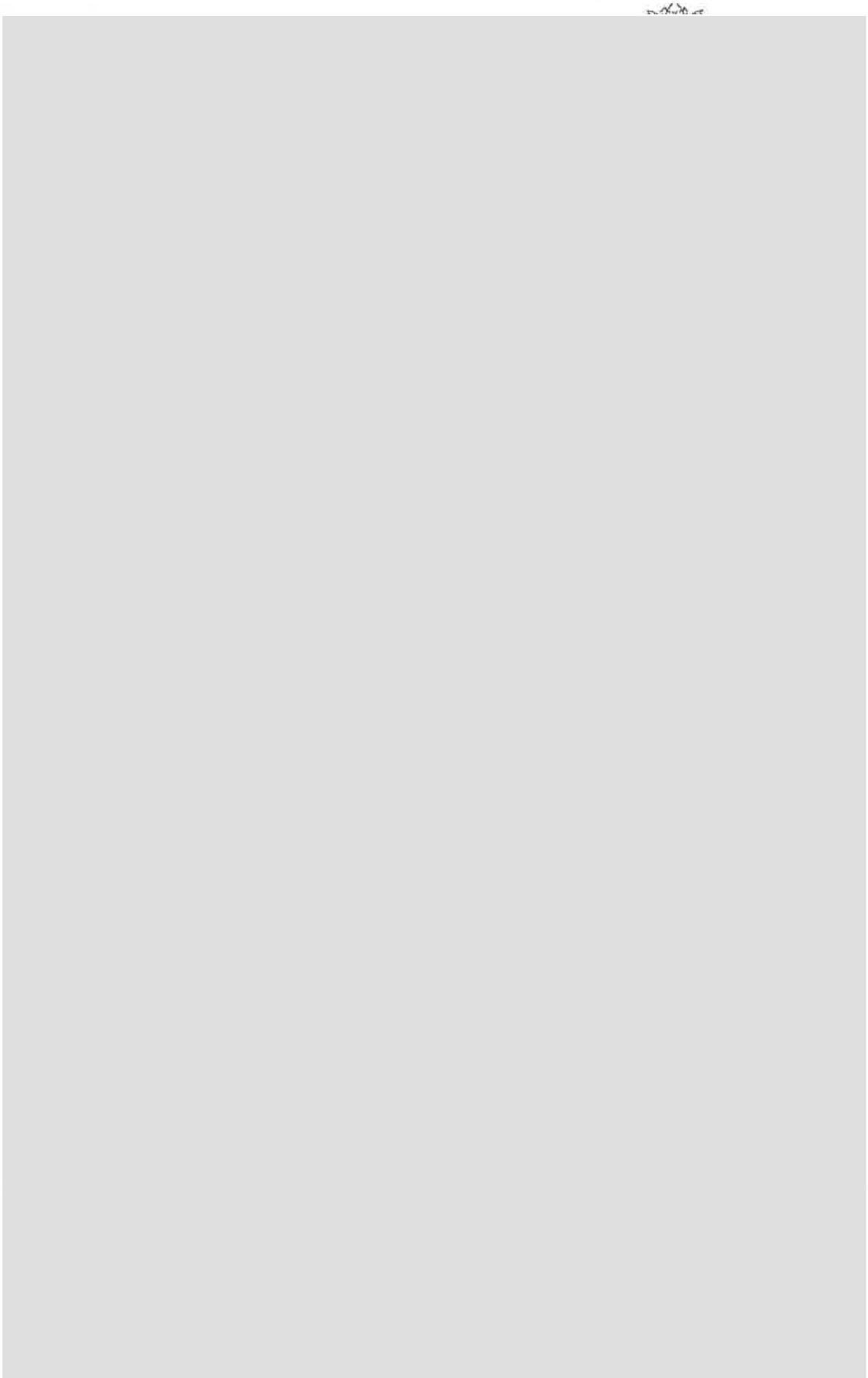
Thanks

Casey Irwin
Aftercare | Headspace Ipswich | Receptionist

26 East Street
Ipswich Qld 4305

[redacted]

w www.aftercare.com.au
w www.headspace.org.au
www.facebook.com/aftercareaustralia



Casey Irwin

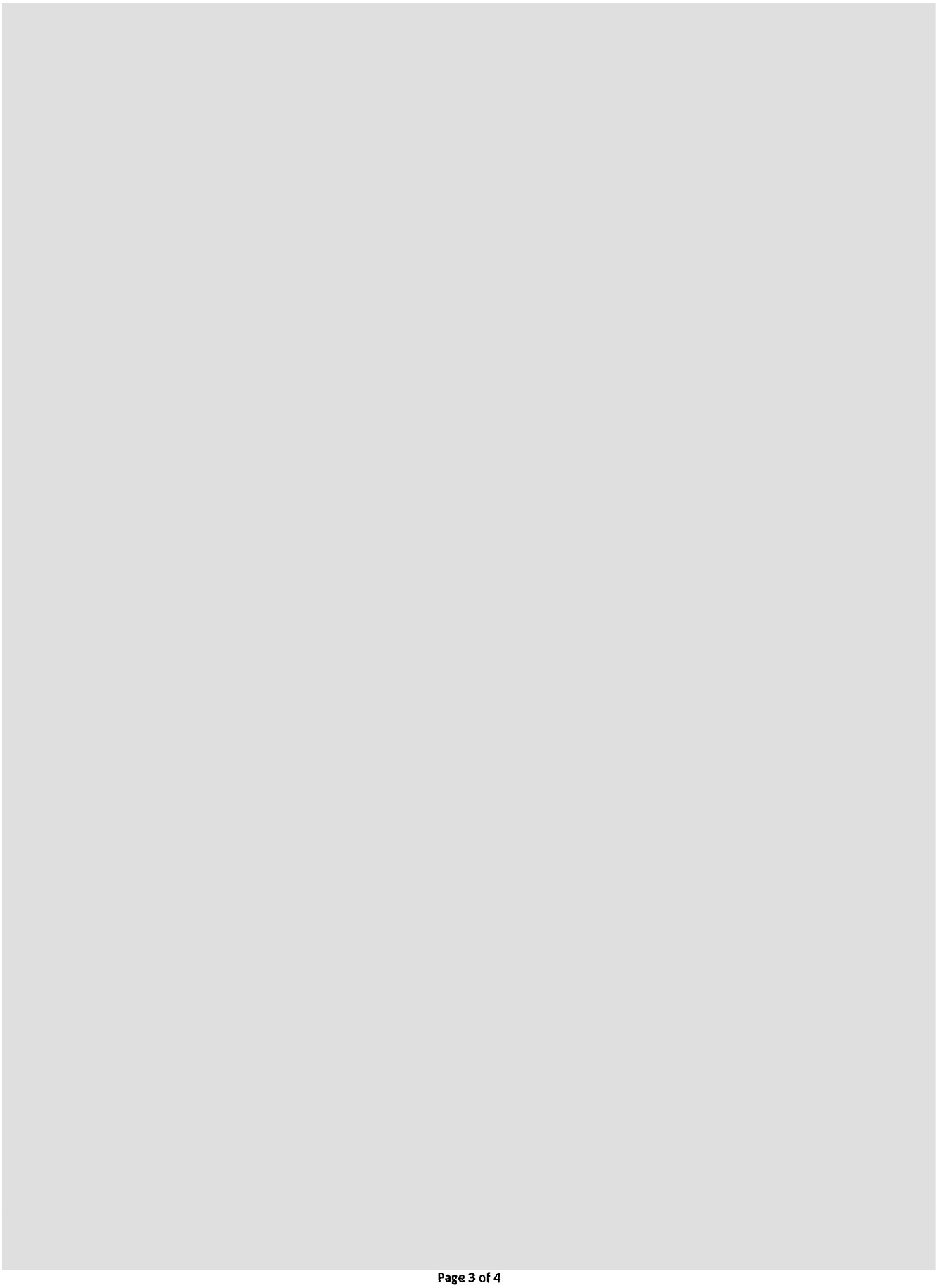
From: [redacted]
Sent: Thursday, 23 January 2014 9:43 AM
To: Headspace Ipswich
Subject: [redacted]
Attachments:

Hi Ipswich Headspace

[redacted]

Kind regards

[redacted]
Occupational Therapist
Barrett Adolescent Centre
The Park Centre for Mental Health
[redacted]
Tues, Thurs, Fri (alt)



Sarah Gilman

From: Kym Dann
Sent: Friday, 11 July 2014 12:59 PM
To: Sarah Gilman; Tess Stewart

Importance: High

Hi Girls

26 East Street
Ipswich Qld 4305

w www.aftercare.com.au
w www.headspace.org.au
www.facebook.com/aftercareaustralia

As a Gamilaroy Woman on country of the Yagara People *("Ugarapul, Yuggera and Jagera")*,
I wish to pay my respects and acknowledge them as the Traditional Custodians of this land.

Location:	26 East Street Ipswich
Mailing Address:	PO Box 187
Website:	www.headspace.org.au/ipswich

CLINICAL PRACTICE MANUAL

1.1.1. Approval

The contents of this Manual have been reviewed and approved by:

CEO ORGANISATION – Aftercare

On behalf of the Ipswich Consortium

Dr Geoff Mitchell **Date:**

Table of Contents

1. PRELIMINARY

1.1. Amendment Record for this Clinical Practice Manual

This Amendment Record page is to be used to record the incorporation of all changes/amendments made to this Manual. All changes/amendments to this manual are to be authorised by the Service Manager for **headspace** Ipswich as 'dated amendments' (for version control purposes). Changes are not to be implemented within the centre until amendments have been formally authorised and issued. All amendments are to be made available to all relevant staff once the amendment has been approved. Amendments may be implemented by either:

- reissue of replacement pages, or
- Complete reissue of the document or sections thereof.

Following incorporation of an amendment, the "Version Date" on the appropriate page is to be updated to reflect the current status of that page.

Details of changes made to this Manual are provided in the final pages of this document.

Date of Latest Version/Issue	Section Amended	Approved By CEO Aftercare (Lead Agency) (Signature or Date of Meeting Minutes)	Amended By
6/10/2010	Initial issue of framework		**headspace** Southern Downs (RHealth)
1/11/2011 11.6.2013	All Sections Reviewed for Establishment of Service.		Angela Barnes for Headspace Ipswich Clinical Governance Advisory Subcommittee
1/02/2013 11/06/2013	All Sections Reviewed for As per headspace national request.		**headspace** Ipswich Clinical Team Leader Kym Dann

1.2. Distribution of Hard Copies of this Manual

Copy Number	Master or Reference	Held by
1	Master Copy	Tess Stewart – Service Manager, **headspace** Ipswich
2	Reference Copy	Kym Dann –Clinical Team Leader, **Headspace** Ipswich

2. BACKGROUND[1]

The current mental health system is not resourced to deal with young people who have mild to moderate mental health issues. This often means that young people do not obtain timely treatment or they have difficulty finding a service that can respond to their needs. Timely intervention can prevent escalation of mild to moderate problems escalating to major mental health problems, which is the justification for the national headspace program.

Delays in obtaining a service are also caused because young people do not necessarily know the best place to seek assistance. Young people are most likely to talk to friends or family members as the first step in their help seeking journey. These key people are often also unsure how to find best possible support options for their friends or children.

As Australia's National Youth Mental Health Foundation, **headspace** is tackling the issues which stand in the way of young people's access to accessible and appropriate health services.

Key Statistics

Mental health problems and/or problematic alcohol and substance use is the most important health issue affecting young Australians.

- Approximately 14% of 12-17 year olds and 27% of 18-25 year olds experience these problems each year.
- 75% of longstanding mental health problems emerge before the age of 25.

[1] http://www.headspace.org.au/about-headspace/what-we-do/why-headspace (retrieved 1 Feb 2013)

- Up to 50% of substance use problems are preceded by mental health issues in young people.
- High suicide rates in early to mid-adulthood are related to untreated mental health problems in the late teenage and early adult years.
- Overall, mental health and substance use disorders account for 60-70% of the burden of disease among 15-24 year olds.
- Currently only one in four young people experiencing mental health problems actually receives professional help.
- Even among young people with the most severe mental health problems only 50% receive professional help.

headspace Ipswich will provide primary health care services that support the mental health, substance use, social and vocational needs of young people aged 12 to 25 years living in Ipswich and the -West Moreton region, with a focus on early intervention and prevention, and in a youth-friendly environment.

2.1. Purpose of this Clinical Practice Manual

This Clinical Practice Manual contains policy statements on some aspects of the Clinical Services provided at the centre, and should not be used as a stand-alone document. Rather, it should be used in partnership with Guidelines and Policies for specific Clinical Processes and the Clinical Governance Framework.

Sections of the Clinical Practice Manual will be periodically reviewed and updated by the **headspace** Ipswich Clinical Reference Group in line with the Clinical Governance Framework. It is acknowledged that this Clinical Practice Manual will be subject to Continuous Quality Improvement processes and will require ongoing review and refinement as the service develops and evolves.

2.2. Governance

headspace Ipswich is governed by a Consortium of 7 organisations, who form the Advisory Group for the service:

- Aftercare (lead agency)
- West Moreton Oxley Medicare Local
- West Moreton Hospital and Health Service(WMHHS)
- Max Employment
- Artius Employment
- Brisbane Youth Service

The Chair of this group is selected by the Lead Agency's Advisory Board, and this is then presented to the **headspace** Ipswich Advisory group for the final decision. The Chair of this committee is reviewed on a 12 month basis.

Three subcommittees also exist:

- **Friends of headspace** – comprised of individuals and/or organisations who support the service, but do not have a formal Service Level Agreement with **headspace** Ipswich . The Chair of this committee, and their rotation frequency is to be decided by the Advisory Group, and the secretariat is **headspace** Ipswich Community Engagement Coordinator.
- **Clinical Reference Group** – comprised of clinicians representing both themselves and their respective organisations in the local community. The Chair of this committee, and their rotation, is to be decided by the Advisory Group, and the secretariat is the **headspace** Ipswich Service Manager
- **Youth Advisory Group –** comprised of young people aged 12-25 from the local community. Members can be both young people who have accessed **headspace** and those who are just passionate about youth issues. The Chair of this committee is decided upon in the early stages of its development, as well as the Secretariat. Members from the Youth Advisory Group are encouraged to attend **Headspace** Ipswich Advisory group meetings.
-

2.3. Operational Management and Accountability

As lead agency, Aftercare oversees the operational management of **headspace** Ipswich.

The CEO of Aftercare through the **headspace** Ipswich Service Manager will assume this responsibility.

2.3.1. headspace Ipswich Roles and Responsibilities

The day-to-day management of **headspace** Ipswich, including the coordination and delivery of services at both the centre and at any outreach sites, will be the responsibility of the **headspace** Ipswich Service Manager.

In addition to this position, the **headspace** Ipswich team will include;

- a Clinical Team Leader,
- 2 Full Time x Intake and Assessment Workers, 1 Part Time Intake and Assessment Worker
- 2 x Admin/Reception,
- x1 Community Engagement Coordinator,
- a range of contractual GPs, Psychologists and Allied Health Practitioners' and
- A range of in-kind service staff from consortium members.

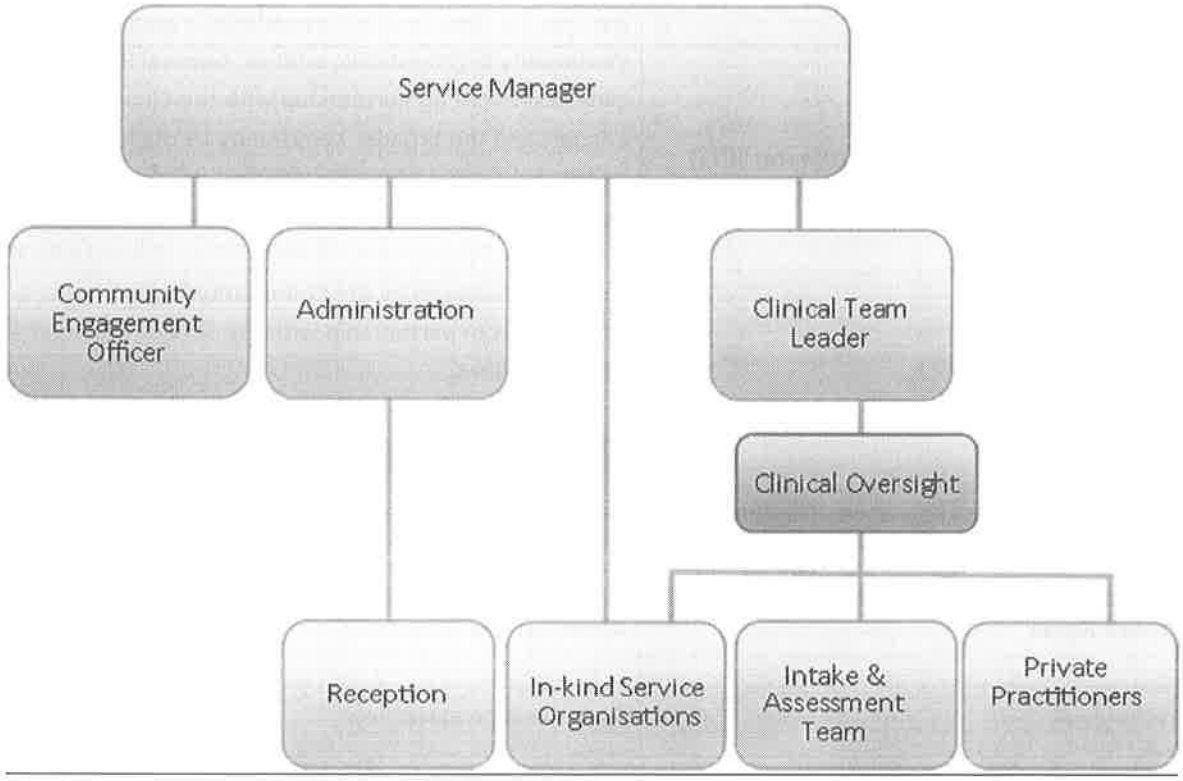
Employed Position	Role/Responsibility
Service Manager (FTE)	The Service Manager oversees the overall operations at the **headspace** Ipswich Centre. Reporting directly to the State Manager of the Lead Agency, they are responsible for the strategic direction of the service, and manages the Clinical Team Leader.
Clinical Team Leader (FTE)	The Clinical Team Leader is responsible for the provision of clinical leadership and management of all clinical team members. The focus of this role is on the day to day delivery of excellence in quality care provision, and ensuring that the clinical governance framework and associated policies are implemented and followed. The Clinical Team leader is also the backup for the Service Manager in their absence.
Intake and Assessment Officers (2 FTE) **(1 PTE)**	These positions are responsible for conducting initial screening assessments for young people accessing the service, and determining the appropriate pathway and referral. Working within a multidisciplinary team lead by the Clinical Team Leader, the Intake and Assessment Officers are a pivotal role within **Headspace** Ipswich

Senior Medical Receptionist & Junior Administration Officer (2 FTE)	The Senior Medical Receptionist role acts as a central point of communication for the centre. This position is responsible for providing a superior level of secretarial and reception services to young people and staff at **headspace** Ipswich. This position also has the capacity to support the Business Manager, and will be the backup to this position in their absence. Dependent on training and qualifications, this position may also assist General Practitioners during procedures in the absence of a Practice Nurse. The Junior Administration officer will be supported by the Senior Medical Receptionist and as a junior role will be responsible for basic reception and secretarial duties for both young people and staff at **headspace** Ipswich.
Community Development Coordinator (FTE)	The Community Engagement Coordinator is responsible for the promotion of **headspace** Ipswich. Ipswich to the community. This position is pivotal in engaging with community organisations, schools, General Practitioners, clinical services (in partnership with the Clinical Team Leader) and the broader community through events, health promotion presentations and development of the Youth Advisory Group and Friends of **headspace** sub-committee. All promotional material associated with the service is managed by the Community Engagement Coordinator in partnership with the Service Manager and hNO guidelines.
Contractual Staff	
GP's	As per service agreement
Practice Nurse	As per service agreement
Psychologists	As per service agreement
Mental Health Nurse	As per service agreement
In-Kind Contribution Staffing	

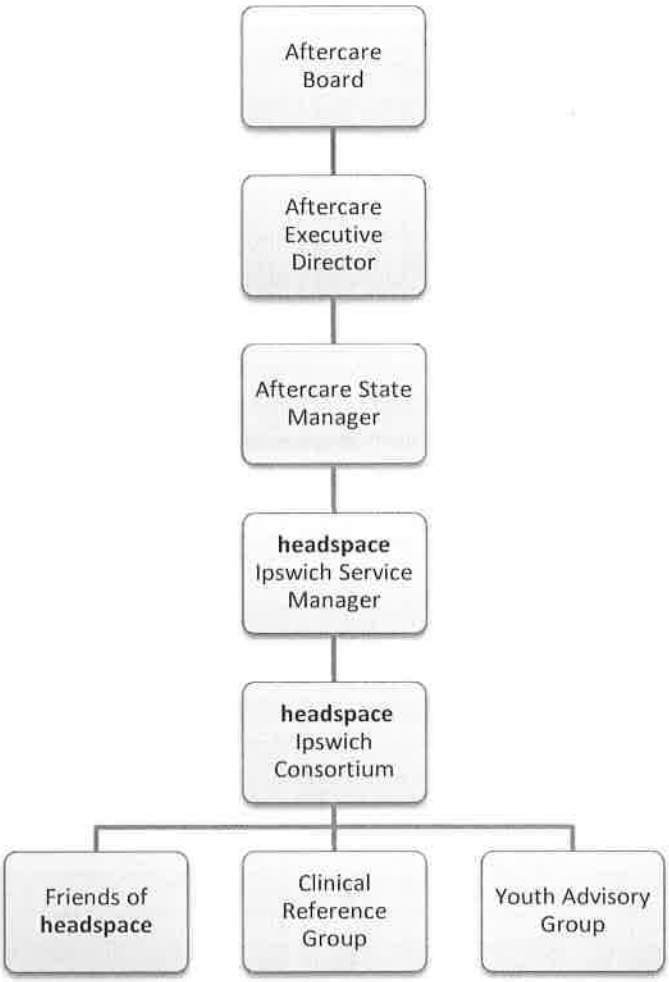
Young people Workers (.4 FTE)	Centrelink, Shop 101 (Sexual Health)
Employment Workers (.4 FTE)	confirmed x 1 Artius Employment X1 Max Employment
Mental Health Support Workers (.4 FTE)	Kambu Mental Health Support Worker
ATOD Worker (.4 FTE)	Boystown

Aftercare, as the lead agency for the **headspace** Ipswich contract, is responsible and accountable for fulfilling contractual service delivery and management obligations.

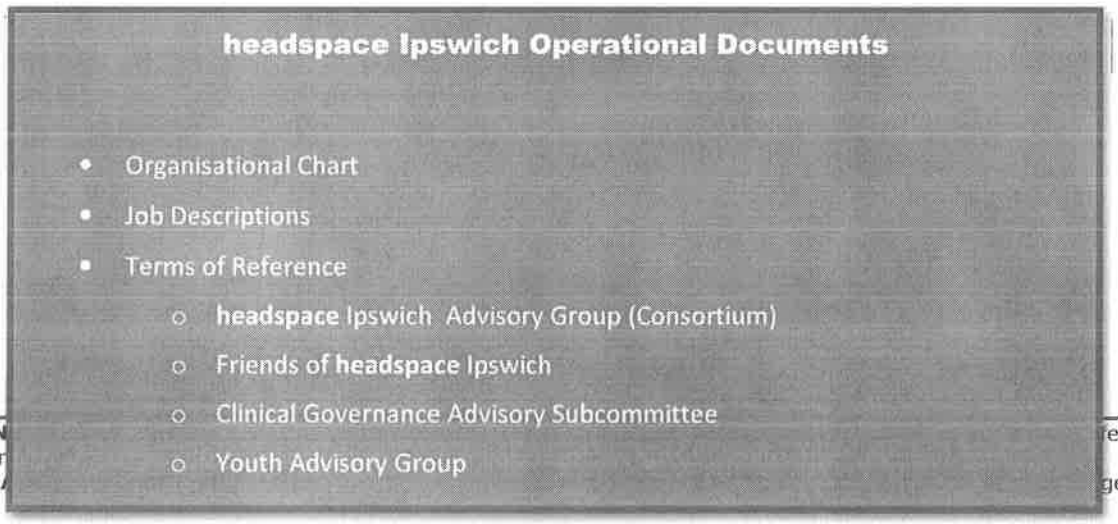
2.3.2. headspace Ipswich Organisational Chart



2.3.3. Governance Framework



2.3.4. headspace Ipswich Documentation Structure



3. DELIVERY OF CARE

3.1. PRINCIPLES OF CARE

3.1.1. Aim

The aim is to ensure that all young people of **headspace** Ipswich receive consistent, high quality care and support, suited to their individual needs and circumstances. The focus being on empowering young people to take responsibility of their own needs, whether that be to optimise their health, or to gain skills and/or improve their strengths to enable them to live a healthy fulfilling life in their community.

- **headspace** Ipswich strives to provide a simple, coordinated service for young people to navigate, through strategies such as an accessible intake process, co-location of agencies and a collaborative, multi-disciplinary team approach to provision of services.
- **headspace** Ipswich seeks to provide accessible, youth friendly and welcoming services for young people by removing identified barriers and ensuring that services at the centre are regularly reviewed and improved.
- **headspace** Ipswich provides evidence based clinical interventions to young people, that respond to the individual context of their lives in accordance with a strengths based approach.
- **headspace** Ipswich works in collaboration with other service, to achieve better functional outcomes for young people and remove some of the negative experiences associated with navigating existing services not tailored to young people.
- **headspace** Ipswich will utilise various evaluation programs and youth, carer and service provider reference groups to ensure that services delivered are of a high standard and quality, and are meeting the needs of young people.

3.2. TARGET GROUP

headspace Ipswich primarily targets young people aged 12 to 25 years with a wide range of issues, but focuses primarily on young people who present with mild to moderate mental health issues, relationship issues at home or at school, including bullying as well as issues finding work, navigating the Centrelink and housing system, or simply for general health issues. All young people accessing the service will be supported through increased literacy and understanding of mental health and wellbeing, and service availability. As per the National **headspace** framework, there will be a strong focus on encouraging help seeking behaviour in all young people aged 12 to 25 years, and to addressing the barriers that usually prevent the target group from accessing health services.

Families, carers and peers are secondary target groups that will be engaged through the **headspace** Ipswich service.

headspace Ipswich primarily services the Ipswich region but will accept all young people who present to the service.

3.3. LOCATION OF SERVICES

headspace Ipswich will primarily operate from 26 East St Ipswich , Ipswich.

3.4. SERVICES OFFERED

headspace Ipswich offers a range of services both directly by **headspace** Ipswich Staff and by on-site partner agencies;

3.4.1. Services provided by headspace Ipswich

Services that will be provided to young people by **headspace** Ipswich include:

- Intake and Assessment
- Referral
- Medical Services
- Psychological Services
- Drug and Alcohol Services
- Psychiatry services

3.4.2. Service provided by partner agencies

Other services that will be available to young people through **headspace** Ipswich are;

- Vocational Assistance
- Lifestyle support
- Housing and emergency assistance
- Sexual Health
- Centrelink support

3.4.3. Exclusions and Exceptions

Headspace Ipswich is an early intervention and prevention service and does not offer case management or crisis intervention. Referral will be offered for those young people assessed as needing such services. Ipswich

3.5. INVOLVEMENT OF FAMILIES AND SIGNIFICANT OTHERS[2]

3.5.1. Definition of Terms

a. Parent/Guardian/s

This refers to any person/s that is LEGALLY responsible for a young person.

b. Significant other/s

This refers to any other person/s that a young person may identify as important in their life or treatment. This could be a youth worker, neighbour, teacher, friend or sibling who is NOT otherwise legally responsible for the young person.

3.5.2. Principles

headspace Ipswich is committed to ensuring that young people and carers have direct input into ongoing service delivery and development.

Young people, their families, carers and significant others are encouraged to actively participate in service quality improvement activities as well as membership in both the Friends of **headspace** (parents/primary carers/businesses) sub-committee and the Youth Advisory Group.

Young people, their families, carers and significant others are remunerated for their participation in formal activities.

3.5.3. Target Group

headspace Ipswich youth participation activities are targeted at all young people aged between 12-25 years of age, regardless of whether they have accessed services at **headspace** in the past or not.

3.5.4. Youth Advisory Group

The **headspace** Ipswich Youth Advisory Group was developed in the early stages of establishment to:

- Guide the direction, development and initiatives within **headspace** Ipswich.
- Monitor and review the effectiveness of **headspace** Ipswich in relation to youth health service delivery.
- Encourage the voice of young people to be heard and acted upon.

[2] **headspace** National Starter Pack documentation on Youth Participation

- Identify youth health issues and promote positive youth health and well-being amongst other young people.

- Provide opportunities for skill development and fostering the leadership, communication and advocacy skills of local young people.

Young people, their families, carers and significant others are encouraged to seek assistance from the **headspace** Ipswich staff if they have any issues or concerns about their involvement in the advisory group that may impact on their own well-being.

3.5.5. Confidentiality

All young people and carers involved in representation activities are made aware that confidentiality is respected and are required to sign off on the **headspace** Ipswich Advisory Member Confidentiality Statement

3.5.6. Other feedback mechanisms

To ensure feedback processes are accessible for a representative number of young people and carers ongoing feedback processes that **headspace** Ipswich are committed to are;

- Written or verbal feedback provided to the **headspace** Ipswich Community Engagement Coordinator

- Written or verbal feedback to any of the **headspace** Ipswich team,

- Suggestion Box in the **headspace** Ipswich foyer (can be anonymous),

- Formal complaint (refer to Complaints Policy).

3.5.7. Informing Young People and Parents/Guardians of Participation processes

All young people, families, carers and significant others involved in a young person's case are informed of these processes in their Initial Intake session, and all young people involved in the Youth Advisory Group, or family members, carers or significant others involved in the Friends of **headspace** subcommittee are informed of these processes at their first meeting.

Rights and Responsibilities are also included in the Intake process for all young people and a **Parents and Guardians Information Pack** is provided for families.

4. SERVICE MODEL

4.1. OVERVIEW OF CASE COORDINATION MODEL

4.1.1. Definition

headspace Ipswich operates from a Case Coordination rather than a Case Management Framework.

Case coordination refers to the process of ongoing monitoring, reviewing and follow up as needed to ensure that each young person is receiving the care they need to optimise their outcomes.

4.1.2. Allocation of a Case Coordinator

The process at **headspace** Ipswich is that each young person who is accepted into the service will be allocated a Case Coordinator (Allied Health Professional, eg: *Psych, Social Worker)* following their intake appointment. This will be a twostep process;

1. Initially the young person's Case Coordinator will be the intake officer who completes the young person initial intake assessment
2. Once the young person has been allocated a private practitioner under ATAPS or Better Access and attends the first appointment it will be the responsibility of the private practitioner to case coordinate the young person.

4.1.3. Role of the Case Coordinator

The overall aim of the Case Coordinator role is to ensure communication between all stakeholders (including the young person) is optimised, and that the young person's care is reviewed on a regular basis according to their presentation and individual needs.

To this end, the specific duties of the role include, but are not limited to:

- performing initial and ongoing risk assessments,
- ensuring consent is explained and where gained, is recorded in a timely manner,
- where the young person is under 18 and does not want parental involvement the case coordinator, in consultation with other treating clinicians, must assess for ability to provide consent to treatment using the Gillick principle. For further information see Section 7 of the Clinical Practice Manual
- Ensuring the young person is aware of their rights and responsibilities whilst accessing services at **headspace** Ipswich.
- developing a Management Plan (in consultation with all other nominated clinical and non-clinical providers) for the young person and ensuring this is documented clearly into the young person's electronic record.
- Attendance or written information provided at team meetings and complex case review meetings (if relevant) to report progress and any changes in presentation or service needs.

- direct liaison with all treating clinicians and other service providers attached to headspace to ensure communication between all providers is optimised

- ensuring all information is captured into the young person's electronic medical record by all staff working with the young person,

- being the contact person for all stakeholders in relation to the young person,

- being available for feedback and comment by the young person in relation to their care needs and experiences of **headspace** Ipswich.

- ensuring the young person receives all relevant information/reminders from **headspace** Ipswich in a timely manner.

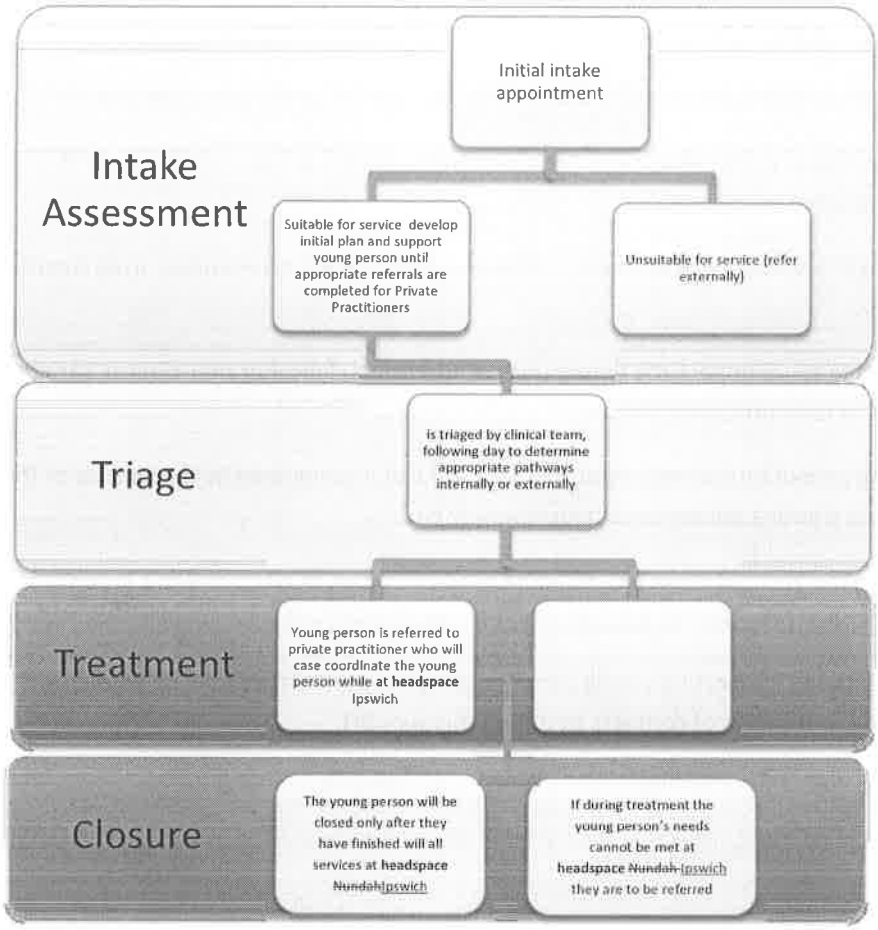
- attempting to reconnect the young person into other clinical or non-clinical services if they disengage prior to recommended closure,

- ensuring an exit interview (preferably face to face) is conducted at the closure of the headspace services including a young person satisfaction survey and,

- ensuring the young person has an appropriate exit plan in place and this is communicated on to other primary service providers as appropriate (i.e. ongoing GP, school counsellor etc.)..

This role is essential to supporting young people during the period they may be receiving services. There is no length of time or number of contacts to define this support.

4.1.4. Case Review Flowchart



headspace Ipswich CLINICAL PATHWAY/s

4.2. INITIAL CONTACT

4.2.1. Principle

Consistent with the **headspace** Ipswich commitment to being young person focused and recognising the importance of first contact in engaging young people and their families, every effort will be made to ensure that all first contacts with **headspace** Ipswich are positive and as responsive as possible to each young person's and families' immediate interests, concerns and wishes.

4.2.2. Staff

In most cases, the first point of contact will be the **headspace** Ipswich Reception Staff. However, initial contact may be made with any of the staff at the **headspace** Ipswich hub, in person, by phone or internet contact.

4.2.3. Types of Contact and response

The type of contacts may include

- general enquiries,
- requests for information, advice and/or referral, or
- referral into **headspace** Ipswich *(refer to Section 6.2 Referral)*

4.2.4. Record Keeping

Any **headspace** staff member who makes initial contact with a young person who is seeking assistance or referral is required to open a new electronic medical record for the young person, and record the nature of the contact, information given, intake appointment time and a follow-up plan (if required).

If the enquiry is for "information only" basic details of the contact are to be added under the "Information Only" client in Profile EMR which will be used as a central and secure means to keep this information.

REFERRAL

4.2.5. Principle

headspace Ipswich will consider referrals of young people aged 12 to 25 years from any source, living in the Ipswich area who have physical health needs, mental health and/or substance abuse issues, or who are requiring assistance with vocational support, or simply to access counselling.

4.2.6. Referrals into GP/Physical Health Service

Refer **headspace** Ipswich Flow Chart Physical Health Intake

Young people can make initial contact via phone, Facebook, email or by walking into **headspace** Ipswich and book a GP appointment or a referrer can do this on their behalf.

4.2.7. Referrals for Mental Health and/or Drug and Alcohol Services

Refer **headspace** Ipswich Flow Chart for Mental Health and/or Drug and Alcohol Services

Anyone can complete a referral for a young person using the headspace Ipswich Referral Form which can then be posted, faxed, emailed or hand delivered to **headspace** Ipswich.

A young person, family member or significant other are not required to make a written referral to the service. If a family member or significant other is make a referral it is preferable this is done in consultation with the young person. **headspace** Ipswich will encourage any third party referrers to provide as much information as possible to facilitate the most effective and efficient collaborative assistance that can be provided to the young person. In some cases initial contact with headspace Ipswich will not be arranged until a written referral is received form a third party referring agency.

It is the referrer's responsibility to discuss the referral with the young person and to ensure that they have consented to the referral including being contacted by **headspace** Ipswich.

All written referrals will be vetted by the headspace Ipswich Clinical Team Leader and if the referral is unsuitable, does not contain sufficient information or does not have the young person's consent to be contacted by **headspace**, a staff member of **headspace** Ipswich will contact the referrer.

Where the referral is for a young person aged 16 years or under, it is recommended that this referral be made with the consent of the young person's parent or guardian. However, the absence of parental or guardian consent will not exclude a young person from accessing **headspace** Ipswich (Refer to the Mature Minor Policy).Policy Consent

The **headspace** staff member accepting and/or reviewing the referral is responsible for advising the referrer (including self-referrers) that should they have any immediate concerns for the young person's personal safety or safety to others, they need to consider accessing or referring to more acute care such as the Emergency Department or West Moreton Hospital Health Service, Mental Health Services (Refer Policy Assessment and Management of Clinical Critical Incidents)Ipswich

All referrers must also be advised that **headspace** Ipswich is a voluntary service and that a young person may choose not to accept the offer of services.

4.2.8. Booked Intake Appointments

headspace Ipswich offers intake appointments every week day. Once a referral is accepted by **headspace** Ipswich, where possible, a referrer and/or a young person will be offered an intake appointment. If the referrer and/or young person advises that the available time or that the waiting period until the appointment is not suitable, the **headspace** staff member will endeavour to organise a suitable time, offer to add the young person to a waiting list for cancellations or advise alternative services. At the time of booking an intake appointment acute and emergency services will be explained to the young person or the person booking the appointment on the young person's behalf.

4.3. INTAKE AND ASSESSMENT

4.3.1. Principle

Every young person accepted into **headspace** Ipswich who is indicated for Mental Health and/or Drug and Alcohol Services will be offered an Intake Assessment that is conducted in a friendly, honest, young person focussed and positive manner.

4.3.2. Definition

Intake Assessment is defined as the process of engaging young people and conducting psychosocial assessment and screening of young people aged 12 to 25 years presenting to, or referred to, **headspace** Ipswich.

4.3.3. Staffing, Timing and Location

- All Intake Assessments will be conducted by one of the **headspace** Ipswich Intake and Assessment staff. At times, the Clinical Team Leader may perform Intake Assessments.
- All Intake Assessment appointments will be conducted at the **headspace** Ipswich centre, ,26, Bell Street, Ipswich.
- At least two staff members need to be on site when an Intake Assessment occurs. (*Refer Occupational Health and Safety)*
- **headspace** Ipswich does not currently endorse Intake Assessments via phone.
- An Intake Assessment Interview should usually be completed within one hour; however a second appointment can be scheduled if more time is required.

4.3.4. Involvement of Family and Significant Others

headspace Ipswich actively promotes the involvement of young people's families and significant others in all aspects of their engagement with **headspace** Ipswich (Refer Section Involvement of Significant Others) especially the Intake Assessment Interview.

Where the young person requests to speak to the **headspace** staff member without family or legal guardian present, a separate discussion will be offered to the family/guardian, if consented to by the young person.

If the young person is under 16 and explicitly requests no contact with their family/guardian **headspace** Ipswich will need to assess the young person for Gillick Competence in order to proceed.

Parents or guardians may also be deliberately excluded if the **headspace** staff deem it counterproductive or potentially risk creating for the young person if the parent/guardian to be involved (i.e. child protection concerns).

Young people are encouraged to include other significant person/s (non-legal status) as they desire in their interaction with **headspace** Ipswich.

4.3.5. Aims of Intake Assessment Interview

The key aims of the Intake Assessment Interview are to:

a. provide an opportunity to meet with the young person and for them to provide their information to **headspace** Ipswich;

b. advise the young person about the process of the Intake Assessment Interview;

c. discuss limits to confidentiality;

d. confirm referral information is accurate and obtain further information regarding presenting issue/s;

e. assess risk/safety to self/others;

f. complete Ipswich the headspace Psychosocial Assessment for Young People;

g. ascertain whether a young person has an existing Mental Health Treatment Plan;

h. assess whether a young person should;

   a. receive **headspace** Ipswich services,

   b. be referred elsewhere or

   c. does not require service.

i. develop a client centred intervention plan

j. advise the young person of the services available at **headspace** Ipswich.

4.3.6. Process for Intake Assessment Interview

The key components of the Intake Assessment Interview commences on arrival at headspace Ipswich;

a. Young person on arrival at reception

On arrival at headspace Ipswich, the headspace staff member will greet the young person and ask them to complete;

- the **headspace** National Minimum Data Set via iPad or a paper version
  - See MDS Information
- a Registration Form
  - **Medicare Number**

Within the Registration Form the young person is asked to provide their Medicare number and/or Health Care Card (as available).

If they do not have a Medicare Card they will be asked if **headspace** Ipswich can contact their parent/guardian or Medicare to gain this information

If they are over 15 and do not provide consent to obtain this information from their parent/guardian **headspace** Ipswich can legally assist them to obtain their own Medicare card.

If they are under 15 and do not provide consent to gain this information from their Parent/Guardian **headspace** Ipswich will proceed to work with both the young person to determine the best way to proceed with gaining a Medicare Number (Refer Section Consent - Under 18).

A young person can still receive service/s from **headspace** Ipswich without a Medicare Card.

- Medical Questionnaire

This questionnaire requests basic information for **headspace** Ipswich in case of emergencies and is completed on arrival

- Young Person Welcome Pack
  - Client Agreement Form
    - The young person will be given a copy of this form to read. The young person will then sign the Consent, Confidentiality and Client Agreement Form indicating they understand the contents of the client agreement. The young person will then be given the client agreement to take with them.
  - Confidentiality Statement
    - The young person will be given a copy of this form to read. The young person will then sign the Consent, Confidentiality and Client Agreement Form indicating they understand the contents of the confidentiality statement. The young person will then be given the confidentiality statement to take with them.
  - Consent, Confidentiality and Client Agreement Form
    - The young person will be given a copy of this form to read, sign and return to the intake officer at the commencement of the appointment, At which point the intake officer will briefly discuss the forms and confirm the young person and family members or guardians understand the forms.
  - Complaints and Compliments Brochure
  - headspace Ipswich Brochure
  - Information for Parents and Carers
  - Getting help from a GP

- What is mental health
- Want to help a friend
- If your friend is not ok
- Tips for a healthy headspace
- How headspace can help

b. Intake Interview

The **headspace** Ipswich staff member will then proceed to go through the following during the intake interview

- Confirm the young person's understanding of the paperwork completed in the waiting room
- Provide a brief overview of what services **headspace** Ipswich can offer the young person
- Provide a brief overview of the purpose of the intake appointment and assessment which is;
    - To assess the young person suitability for **headspace** Ipswich
    - For the young person to decide if they want to attend **headspace** Ipswich
    - Completing the headspace psychosocial assessment
        - Which is an evidence based assessment tool (adapted from the HEADDS Psychosocial Assessment) and includes a range of domains across the following domains;

- home and environment,
- education and employment,
- activities
- drugs and alcohol,
- relationships and sexuality,
- conduct difficulties and risk taking,
- anxiety
- eating,
- depression and suicide,
    - psychosis and mania.
    - Further assessments maybe required for

- risk taking behaviour,
- suicidality; and
- the ASSIST drug and alcohol screen

- The K10 and SOFA assessment will also be completed via MDS

- The final part of the intake appointment is to develop an initial management plan with the young person. If the intake officer is unsure of the next steps they can discuss the appointment at the intake meeting and then contact the young person to discuss the plan,

c. Ipswich Mental Health Treatment Plan/Existing GP Involvement

While the young person is in their intake interview headspace Ipswich reception staff will contact Medicare on 132 150 to check if the young person has a GP Mental Health Care Plan in place If the young person has a GP Mental Health Care a copy of the plan needs to be gain from the GP who completed the plan

If the young person has not had a mental health treatment plan completed and the assessment indicates a need for mental health intervention the **headspace** staff member will facilitate a referral to either the young person's existing GP or a **headspace** GP (with the young person's consent).

If the young person has any other presenting physical needs the **headspace** staff member will also facilitate a referral to either the young person's existing GP or a **headspace** GP (with the young person's consent).

A young person can also be referred for mental health intervention by a psychiatrist, psychologist, social worker or OT-. A psychiatrist is only required to provide a referral letter for a young person to be seen for mental health interventions

d. Other significant stakeholders – Consent to Share Information

If the young person is receiving health care and/or support from other services providers the headspace staff member will check if the young person has given consent to contact the relevant service provider/s if they have not, the staff member will seek consent using the Consent to Share Information Form.

4.3.7. Outcome of Intake Assessment Interview – Next Steps

a. Requirement for headspace Ipswich Services

If, as a result of the Intake Appointment and Assessment, it is identified that the young person requires further support from **headspace** Ipswich, The intake officer will support the young person access the service and transition the young person to a private practitioner who will become the young person's case coordinator. While at **headspace** Ipswich if the young person wants to continue using their own GP **headspace** Ipswich will release copies, with permission of the young person, of the young person's initial assessment to their regular GP to help the GP in completing a GP MHTP or other referrals (e.g., psychiatrist)

b. No Requirement for headspace Ipswich Services

If, as a result of the Intake Assessment Interview, the young person does not require any further assistance from **headspace** Ipswich, the young person is to be:

- given information to assist them to independently access generalist services of interest to them;
- with consent, referred to the generalist services they want to immediately access; and

c. encouraged to return to headspace **Ipswich should their needs change in the future. General Practitioner Access**

headspace Ipswich promotes the importance of consulting with a GP to rule out any physical problems and the benefits of the GP developing a Mental Health Treatment Plan. Furthermore headspace Ipswich promotes proactive and preventative interventions for mental, physical, and sexual health. Headspace Ipswich staff will promote seeking preventive health check-ups.

Young person HAS a GP Mental Health Treatment Plan

1. If a young person already has a GP developed Mental Health Treatment Plan which;
   a. indicates the type of support they need from **headspace** AND
   b. the young person wants to act in accordance with this plan,

Then the young person will be advised that this will be organised with a **headspace** private practitioner i.e. appointments made with a "Better Access" or ATAPS provider.

2. If the young person already has a GP developed Mental Health Treatment Plan but it is not reflective of the care the young person desires;

Then an appointment will be made to see a **headspace** Ipswich GP (or their own GP if they prefer) to update their MHTP plan.

Young person does NOT have a Mental Health Treatment Plan

1. If the young person does NOT have a GP developed Mental Health Treatment Plan and has any mental health and/or drug and alcohol needs then the **headspace** intake and assessment officer will discuss with the young person making an appointment for one of these to be completed with a **headspace** GP (or their own GP if they prefer Next Step GP form to be provided).

It will be explained that this will then enable a referral to **headspace** private practitioners who work as Better Access or ATAPS providers If a young person does NOT have a GP developed Mental Health Treatment Plan and the young person does not present with any unmet health needs and/or does not wish to see a GP, but has needs for support with social, vocational, housing or other community services, the **headspace** staff member will develop a support plan with the young person.

d. Young Person who requires Psychiatry Interventions

If the young person requires psychiatric intervention they will require a written referral for the headspace psychiatrist. The young person will need to see the headspace GP (or their own GP if they prefer Next Step Psychiatrist form to be provided) to complete a referral to the headspace psychiatrist.

4.3.8. Record Keeping

The **headspace medical receptionists** are responsible for all information from the Young person Registration Form to be entered into Profile. Headspace medical receptionist are also responsible for all hard copy paperwork being attached to Profile. The headspace Intake and assessment officer is responsible for completion and attachment of the young person's assessment. All headspace Ipswich staff and private practitioners are responsible for timely completion of notes and other documents on Profile.

4.3.9. Feedback to Referrers

Following the conclusion of the Intake Appointment, the **headspace** intake and assessment officer is to (with the consent of the young person) complete a Feedback to Referrer Form and send this back to the referral. This will only be completed for a written referral.

4.4. REVIEW OF CARE

4.4.1. Principle

headspace Ipswich is committed to regular reviews of young people to ensure they are receiving the best possible care.

Furthermore, the National Standards for Mental Health Services (2010) set out the following to ensure that minimum standards for case review are met:

- *ensure that young person assessment and treatment is continually reviewed throughout their contact with the Service.*

The Better Access and ATAPS schemes both have in-build review mechanisms in that any person accessing psychological intervention under these schemes are required to see the referring doctor to access blocks of sessions. For the majority of young people who attend headspace Ipswich this is how they will be reviewed.

4.4.2. Intake and Complex Case Meetings

headspace Ipswich has daily Intake Meetings for all available staff, and where required Complex Case Review Meetings at which complex cases will be reviewed in consultation with Queensland Health staff from Child and Youth Mental Health Services, Adult Mental Health and ATODs.

4.4.3. Intake Meeting

The key aims of the Intake Team Meetings are;

- To have a multidisciplinary approach to the initial assessment and planning of all young person at **headspace** Ipswich
- To seek further opinion on how to manage complex cases who present to **headspace** Ipswich

- To manage the caseloads of private practitioners
- To flag young people who may be suitable for complex case review
- To ensure all independent young people under 16 assessed as Gillick Competent are discussed with a team approach
- To ensure all staff are aware of any clinical practice changes which may impact headspace Ipswich staff

4.4.3.1. Roles and Responsibilities for Staff Members

Intake Assessment Officers

- Will provided a brief overview of the assessments completed, this will include a brief outline of the assessment and an outline of the proposed plan for the young person, generally the young person will be aware of the plan as it would have been discussed during the intake appointment. If from the intake meeting the plan for the young person changes the intake officer will contact the young person to advise them of the changes.

Clinical Team Leader

- Will coordinate the meeting and note in Profile an outline of main points of an assessment and the plan for the young person,
- Will manage, via profile, the case load and if required the waiting list for private practitioners
- Will have the final decision on private practitioner allocation, decisions to make child safety reports and steps required to assess Gillick Competence

Private Practitioners

- If at all possible, private practitioners are to attend the intake meetings

4.4.4. Complex Case Review

Complex cases are/will be considered on a case by case basis the final decision as to the young people considered complex sits with the Clinical Team Leader. The following criteria will be considered when deciding if a case is complex;

- Young people with suspected early psychosis symptoms
- Young people diagnosed with a psychotic disorder
- Young people who have a number services involved in their care

- Young people who are consumers of Queensland Health acute care services
- Requests from private practitioners who would like a second opinion from Queensland Health services

The key aims of the Complex Case Review Meetings are;

- To seek the support of appropriate Queensland Health service in managing complex cases at **headspace** Ipswich to help in the seamless support for young people engaging with headspace Ipswich
- To seek a second opinion from appropriate Queensland Health service on the management of young people attending headspace Ipswich
- To discuss cases which maybe more suited to a Queensland Health mental health service
- To seek collateral information on young people who have accessed Queensland Health mental health services.

4.4.4.1. Role and Responsibilities of Team Members

Clinical Team Leader

- Will lead case reviews daily to review young people's internal and if required external pathways, suitability to service and acuity level
- Will chair the meeting and allocate time for the meeting
- Will case note on Profile the outcome of the complex case review

Private Practitioner/Case Coordinator

- Will when available attend complex case review to discuss the progress of a young person listed for complex case review
- If unable to attend will provide written correspondence (using the case review template) on the progress of a young person listed for complex case review. This information is to be provided to the intake assessment officer who completed the young person's initial assessment
- Will follow-up on any outcomes from the complex case review

Intake Officer

- Will provide information regarding the initial intake assessment of a young person

- Will provide any written information for the young person's private practitioner
- Will provide staff from the following area's
    - CYMHS
    - ATODS
    - Adult Mental Health
    - Psychiatrist
    - PHAMS

4.4.5. Points for Consideration during Reviews

Refer Case Review Guidelines for Case Coordinators

4.5. REFERRAL WITHIN headspace

4.5.1. Principle

Ipswich Each young person receiving **headspace** Ipswich support will be referred to the most appropriate GP, clinician, worker or agency/s considering the;

- young person's needs,
- young person's personal preferences and
- Availability of service/s (funding and capacity).

4.5.2. Allocation to headspace Ipswich

Allocation to **headspace** Ipswich staff is initially the responsibility of the **headspace** intake officer performing the Intake assessment. This can be in consultation with the Clinical Team Leader.

The first priority should be the allocation of a private practitioner who will become the young person's Case Coordinator (*see Sections Case Coordination)*

The number of cases allocated to **headspace** private practitioner depends on their hours worked, their area of expertise and the funding stream a young person is accessing. The monitoring of individual workloads will be the responsibility of the Clinical Team Leader and **headspace** staff.

4.5.3. Eligibility for Service

A range of funding models are used to operate **headspace** Ipswich including funded **headspace** staff, private practitioners funded via Medicare, Access to Allied Psychological Services (ATAPS) and Better Access as well as in-kind services.

These models have differing eligibility requirements and will guide which services a young person accesses while at **headspace** Ipswich.

The funding guidelines relevant to the **headspace** service providers engaged to practice at **headspace** Ipswich will be observed when scheduling appointments.

4.5.4. Ipswich Who can refer

Any **headspace** Ipswich staff member or service provider, with consent of the young person, can refer a young person to another **headspace** Ipswich service.

4.5.5. Appointments – how to refer

All appointments are made through **headspace** Ipswich reception including internal referrals.

Ipswich

4.5.6. Case Coordinator

All young people of **headspace** Ipswich have an allocated Case Coordinator (*refer Section Case Coordination Model) initially their intake and assessment officer and their private practitioner .*

Young people are to be explicitly referred to their Case Coordinator in the instances of:

- requiring review or coordination of their care including after critical incidences or
- when a **headspace** staff member is not sure of what is the most appropriate course of action/referral for a young person

4.5.7. Appointment with a GP

Appointments with a headspace GP are made by Clinical Team Leader and/or private practitioner for young person attending **headspace** Ipswich by booking an appointment via a headspace medical receptionist

4.5.8. Referral for psychological intervention

If a **headspace** Ipswich staff member identifies any mental health issues which would benefit from psychological intervention a referral to a Better Access or ATAPS provider should be facilitated.

If the young person does not have a current and relevant Mental Health Treatment Plan then a referral to a GP (as above) should first be facilitated.

4.5.9. Referral to a Psychiatrist

If a young person requires psychiatric intervention they will require a GP referral. Headspace Ipswich staff should help facilitate this referral via a headspace GP. If the young person is seeing an external GP for a referral they should be provided the Next Step – Psychiatrist form

4.5.10. Referral to on-site consortium partners

A range of consortium partner's offer services on site at 1264 Sandgate Rd and will accept referrals from **headspace** Ipswich staff.

Most of these referrals will be made during the young person's intake appointment. However any headspace Ipswich staff member can make a referral to a consortium partner service.

4.5.11. Recording and Documentation

Any **headspace** Ipswich staff person who refers a young person to another **headspace** Ipswich worker or service must ensure this is documented in Profile in a timely manner. *(Refer Section Documentation and Recording)*

CLINICAL OUTCOME MEASURES

4.5.12. Principle

As good clinical practice, a young person's contact with **headspace** Ipswich will be measured in terms of health and wellbeing outcomes.

4.5.13. Outcome Measures Used

- The Kessler 10 (K10) and the Social and Occupational Functioning Assessment (SOFA) is part of the MDS

4.5.14. Additional Outcome Measures

headspace staff are permitted to utilise additional outcomes measures as relevant to the young person needs, and as per the individual practitioner's knowledge, skills and experience.

4.5.15. Ongoing Quality Improvement

The **headspace** Ipswich Clinical Ipswich Reference Group will provide support for ongoing quality improvement.

4.6. REFERRAL TO OTHER SERVICE PROVIDERS[3]

4.6.1. Principle

Continuity of care is the seamless transition of the young person from worker or service to another, with specific goals outlined and timeframes kept to where possible. Continuity of care ensures that the young person and their carer know why they are receiving treatment, who they are receiving the treatment from, and specific goals of the treatment, their rights and responsibilities regarding treatment and when they can expect to no longer require the support of **headspace** Ipswich.

When **headspace** Ipswich **cannot** provide the services required by the young person, he/she will be referred to the most appropriate service provider in the appropriate area. This will be discussed with the young person and their carer (if appropriate).

4.6.2. Consent

Consent for referral and sharing of clinically relevant information will be obtained by the **headspace** Ipswich staff member and must be documented in the young person's file.

Where consent is withheld, referral **cannot** occur. The next best options will be discussed with the young person and their family/significant others.

The only occasion where a referral can take place without the consent of the young person is when the young person is a danger to his/herself or others due to an acute presentation of mental illness and is refusing to seek help (refer to Critical Incident Policy and Guidelines on Assessment and Management of Clinical Critical Incidents)

4.6.3. Process for Referral

Any **headspace** staff member working with young people at the service can make a referral to an external service ; In supporting the referral, the **headspace** Ipswich staff member will contact the service provider, provide all relevant information and establish an appointment time in consultation with the young person Ipswich.

4.6.4. Documentation and Follow up

The **headspace** Ipswich staff person making the referral must ensure all information is documented in - Profile (*refer* Section Documentation and Recording) and any another headspace staff working with the young person are advised of the referral via Profile secure messaging

[3] Reference – GPAP Continuity of Care Planning Framework for Queensland, Queensland Health and the Division of General Practice

4.7. WAITING LISTS FOR HEADSPACE REGION SERVICES

4.7.1. Principle

headspace Ipswich understands the need for timely and responsive services to best meet the needs of young people and will strive to respond to all new referrals as soon as possible.

The benchmark **headspace** Ipswich aims to meet is that all new referrals are offered an Intake Assessment within one week. The clinical reference group will be advised when the waiting time for an initial intake exceeds two weeks. If a young person is seeking a GP appointment headspace Ipswich will endeavour to offer an appointment within 3 days.

It is expected that as the service becomes established and capacity full a wait-list may need to be held. This will be further developed as the **headspace** Ipswich Clinical Team and the service are established.

4.7.2. Location of Waiting List

If a wait-list does become established it will be regularly updated and kept on Profile.

4.7.3. Responsibility for Maintaining the Waiting List

The **headspace** Ipswich Clinical Team Leader will be responsible for ensuring the wait list is maintained and current.

4.8. EXIT FROM HEADSPACE

4.8.1. Principle

headspace Ipswich will endeavour to plan exit from the service with the young person, their families and significant others (if appropriate), so that they are well prepared and are aware of how to reengage with headspace or other appropriate services.

4.8.2. Planned and Supported Exit

Throughout contact with each young person and his/her family, **headspace** Ipswich will provide information about their range of service options, help them to plan their priority goals and actions, and assist them to commence using these services.

headspace Ipswich will work with them to plan their future support needs and directions. Support plans will involve non-**headspace** services, so that, whenever possible, a young person's exit from **headspace** support will be planned, positive and engages the young person with supports in the community.

Young people will be advised that if in the future they require further support and are still age eligible for headspace service the can again access headspace Ipswich services. Ipswich

4.8.3. Discharge Process

Ipswich

4.8.4. Withdrawal of headspace Ipswich Support

There are some occasions **headspace** Ipswich will withdraw its support.

These are;

- When a young person has been unable to be contacted after two phone calls and a letter being sent their case will be closed
- When the level of need for a young person is deemed acute and/or pervasive and therefore not within the **headspace** target of early intervention and high prevalence disorders,
- When threat of or actual violence to **headspace** staff has occurred and cannot be satisfactorily risk managed by **headspace** Ipswich.
- When a young person is no longer eligible for ongoing service (i.e. additional therapy sessions etc.) although if care is still deemed as necessary **headspace** Ipswich will endeavour to support the young person to seek appropriate support. Or where possible arrange this extra support(?)
- When a young person does not meet the age requirements for the service, young person will continue being seen after the age of 25 only to finish their current episode of treatment with **headspace** Ipswich

COMMUNICATION BETWEEN HEADSPACE AND YOUNG PEOPLE

4.8.5. Principle

headspace Ipswich staff need to balance the importance of a client centred approach to care with the financial model of the service. **headspace** Ipswich will endeavour to support young people to engage the service and be an active partner in their care this includes reminding young people of appointments and communicating in a youth friendly manner.

headspace Ipswich operates a financial model which means if young people do not attend appointments clinicians do not get paid. Therefore the service needs to balance both support for young people, staff and the service model.

This is all explained to young people clearly in their Intake Assessment via the Client Agreement Form.

4.8.6. Appointment Reminders

headspace Ipswich uses a combination of phone calls and SMS services to remind young people of upcoming appointments.

4.8.7. Ipswich Young person Did Not Attend

If a young person regularly misses appointments with **headspace** Ipswich staff it is standard practice to ask them to meet with one of our Intake Team to ensure the young person is still willing to engage with the service

4.8.8. Change of Contact Details

headspace Ipswich asks young people to notify **headspace** of any change of address or phone number.

4.8.9. Extenuating Circumstances

headspace Ipswich appreciates that some young people will find it very difficult to commit to the above conditions and headspace Ipswich will support these young people as much as operationally manageable.

4.9. ACCESS AND EQUITY ISSUES

4.9.1. Special Needs

Headspace Ipswich is committed to working with young people with special needs and will endeavour to develop strategies to ensure access and equity is acceptable for all young people.

This includes but is not limited to;

- Aboriginal and Torres Strait Islander Young People
- Culturally and Linguistically Diverse Young People
- Young People with a disability
- Young People who are homeless or at risk of homelessness

4.9.2. Transport

In the initial instance transport will not be directly provided by **headspace** Ipswich for young people or their families/carers.

However, **headspace** Ipswich is able to provide support for transport via the use of Queensland Rail travel warrants which will allow a young person to travel to and from headspace Ipswich via the Translink rail network at no cost to the young person.

5. DOCUMENTATION AND RECORDING

5.1.1. Principle

headspace Ipswich will ensure that all information about young people is keep in the best possible manner with the strictest adherence to accuracy, relevancy and confidentiality.

5.1.2. Software

a. Profile

This is the electronic medical record used by **headspace** Ipswich.

It is a secure system that ensures confidentiality and privacy of young person records.

Only authorised persons have access to this program and there are varying levels of access dependent on a person's authority level.

5.1.3. Ipswich **headspace Minimum Data Set**

- The Minimum Data Set (MDS) will be collected via the headspace National mandated web based data collection sight. This is a two-step process;
    - Firstly a young person will complete an online or paper survey, this is completed each time the young person attends headspace Ipswich (http://mds.headspace.org.au/login/young_person)
    - Secondly the service provider(s) the young person is seeing will complete an associated occasion of service survey (http://mds.headspace.org.au/login/centre)

5.1.4. Clinical Notes

headspace Ipswich workers have a legal responsibility to maintain accurate and comprehensive records of services that are provided to young people.

Continuity of care is maximised by **headspace** Ipswich workers through making sure case notes are accurate, comprehensive and relevant.

Notes are to be concurrent with the session, that is, recorded during or at the conclusion of a session or as soon as practicable.

Clinical files provide the history of:

- the information the young person has given the **headspace** worker,
- issues the **headspace** worker has discussed,
- the information or choices provided to the client, and
- Specific goals and action plans.

The clinical record shall be sufficiently detailed to enable:

- Identification of the reason for attendance at **headspace** Ipswich.
- the young person to receive effective continuing care
- emergency responses as necessary, and
- all **headspace** workers and practitioners to access necessary information.

Essential legal requirements:

- the date and time of the conversation/s with young person or headspace workers related to the young people situation (e.g. Monday 1 January 2008 9am – 10.15am);
- if different from the time of a conversation, the date and time that the entry is made in the file (e.g. Monday 1 January 2007 11.20am);
- the date and time of incidents or events referred to in the note;
- whether the conversation is by telephone or face to face;
- the venue of face to face conversations;
- any consent or withdrawal of consent, written or verbal, given by the young person for headspace Ipswich workers to communicate with other relevant parties, about the young people situation. It should be recorded in the clinical file if the young people do not wish to consent to the sharing of their personal information.

Headspace Ipswich staff are able to write clinical notes in their own style

5.1.5. headspace Workers Review of Notes

Prior to each session, the **headspace** workers are to review the clinical file notes held in Profile.

This will include the review of any messages sent via Profile's internal messaging system.

Any significant information following individual sessions that service providers should be aware of must be communicated via the Profile internal messaging system.

5.1.6. Hard Copy Records

headspace Ipswich has paperless client files. Profile has the capacity to store scanned documents, which are then attached to the young person's electronic record. Hard copies are to be securely destroyed after the documents are attached to Profile.

This is the preferred method of storing documents, however if hardcopies need to be kept these are to be kept securely in lockable filing cabinets

5.1.7. Alerts

As a risk management strategy and to ensure continuity of care for young people it is important for clinical files to include alerts about any important information relating to;

- consent,
- risk,
- violence or
- medication issues such as allergies.

The principles of relevancy and accuracy are vital to be adhered to when making such an alert within the system to maintain the integrity of young people.

5.1.8. Ownership of Data

Headspace National Office as the funding body will have ownership of the online minimum data set information. **headspace** Ipswich has ownership of information held on Profile.

5.1.9. Young person Rights Regarding Clinical Files

a. Principles

headspace Ipswich operates from a framework of openness regarding young people's access to their information.

headspace Ipswich believes it is more often than not, empowering for young people to have relatively easy access to their clinical files and will endeavor to facilitate this.

headspace Ipswich also appreciates the need to be mindful of the possible impact of sensitive information and in ensuring adequate resources are available to support a young person to access their information as requested.

headspace Ipswich also recognizes the need to manage sensitively, other persons/stakeholders request/s to keep information confidential

b. Practice

Initial Agreement

At the beginning of any young person's access to **headspace** they are provided with the information regarding the expected use of their personal information and asked to provide (or decline) consent for this (Refer Section Consent).

Access to Clinical Files throughout headspace Support

headspace Ipswich staff may show a young person their records and files in the course of their support/intervention (i.e. they may enter data together into the data-base/s etc.)

Requests for full access to file

Young people are required to put into writing any requests for a copy of their entire case file and to give this to the **headspace** Ipswich Service Manager or Clinical Team Leader. Any **headspace** personnel can support a young person in this request.

The **headspace** Ipswich Service Manager or Clinical Team Leader will then ensure that a **headspace** staff member goes through the young person's file and in consultation with all practitioner's /clinician's involved with the young person highlight any potentially controversial areas and develop an agreed management plan for the sharing of this information. At the discretion of the **headspace** Ipswich Service Manager or Clinical Team Leader some information may not be released to a young person. Examples of this include child safety reports, information provided confidentially by other people or services or information from other services which **headspace** Ipswich does not have the right to release.

When this has been agreed to by all parties (any conflict of opinion to be managed by the **headspace** Ipswich Clinical Team Leader and the Service Manager as necessary) the **headspace** Ipswich worker to make an appointment with the young person to go through their file with them. Outcomes of this appointment will be documented in Profile.

This is to be completed within as timely a manner as possible.

Disagreement over Content

Each young person has the right to voice any disagreements they may have with a clinical note. This disagreement should be documented within the file at the time of the discussion about the disagreement.

If the disagreement cannot be resolved with the person the young person raises this with, they are to be encouraged to raise this as a formal grievance and use the associated process.

Non-standard Information Usage

From time to time **headspace** Ipswich may be interested in using client information for other purposes such as research, audit or evaluation. Where this falls outside of the areas agreed to within the original consent process young people will be consulted on the use of their information even when this is de-identified (see Section 10.3 Evaluation Research)

5.1.10. Written Reports

From time to time **headspace** staff will be asked to prepare a report about a young person based on their access of **headspace** Ipswich. Such reports maybe required for court appearances, the Dept. of Child Safety or schools etc.

All such requests should be discussed with the young person before any report is prepared and unless such a report is legally required i.e. being subpoenaed by a court or for the Department of Child Safety (*Section Mandatory Reporting)* the young person should be able to choose whether any report is prepared. **headspace** Ipswich staff are to abide by all legal requirements or acts which may obligate them or the service to disclose information. Either verbal or written consent should be sought from a young person before releasing information. If a written request for information is sought after a young person had ended an episode at **headspace** Ipswich all reasonable efforts should be taken to contact the young person and discuss what information will be released. If the young person cannot be contacted information will still be disclosed if written consent has been provided. Ipswich When a report is prepared it should be prepared with strict adherence to the principles of accuracy and relevancy. It should be an objective document that states fact and an opinion should be duly highlighted.

6. CONSENT To Service

6.1. Principle

headspace Ipswich is committed to ensuring that rights, responsibilities and actions associated with service provision will be fully explained to all young people and where relevant parents/guardians and significant others.

When engaging with **headspace** Ipswich young people will be asked to indicate their informed consent – that is, consent that is given freely, without coercion, threats or improper inducements.

Young people have a right to have all questions answered in relation to consent, including how their personal information will be used.

6.2. AGE OF CONSENT

The target age group of **headspace** Ipswich is 12 to 25 years. This presents complexity in regard to consent for those young people who are under the age of 18 years and, in particular, those under the age of 14 years.

In Queensland, There are no specific laws about minors and consent to medical treatment. Thus the Common Law applies for those under 18 years. The common law states that young people under 18

might be capable of giving informed consent, although the health professional must consider the nature of the treatment and the ability of the young person to understand the treatment. [4]

6.2.1. Gillick Competency

Valid consent can be measured by using the Gillick Competency[5]. The 'Gillick Test' refers to the common law as it applies to a young person's ability to consent to medical treatment. No age is specified.

Consent is based on the capacity of the young person to understand the nature and extent of treatment and side effects of treatment. It requires that the young person be encouraged to involve parents in knowledge of treatment but places the 'best interests' of the young person above any parental right to be informed. (For more detailed information refer to the Mature Minor Policy & Mature Minor Tool).

6.3. CONSENT TO HEADSPACE - COLLECTION AND USE OF INFORMATION[6]

Information will be provided to ensure that young people (and their parents/guardians) entering **headspace** Ipswich have an absolute understanding of their personal information being shared with other **headspace** service providers.

During intake and assessment, a young person will be asked to provide consent to receive **headspace** Ipswich services. This is explained in the Young person Confidentiality Statement - Collection and Use of Your Information.

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Whether a young person has presented alone or accompanied by a parent or guardian, the **headspace** staff member will read through the consent form with the young person, explain the confidentiality process and ask for feedback on their understanding. The **headspace** staff member will answer any questions the young person and/or the parent/guardian may have in relation to the consent form, and explain anything that is not clear to the young person.

If a **headspace** worker has any concerns about the young person's capacity to consent, the worker should consult with the Clinical Team Leader and/or Service Manager.

[4] Adolescent Health: Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds (pg. 68)

[5] Gillick v. West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402, HL; and Southern Downs Mental Health Service Clinical Practice Manual

[6] REFERENCES: ACT Health Consent To Treatment Policy, Queensland Health Policy on Informed Consent, National Standards for Mental Health Services 5.4

The GP will be responsible for attaining consent for any medical treatment considered necessary for the young person's clinical management.

It is the responsibility of the **headspace** staff member to document the consent process and outcome in the young person's clinical file.

6.4. CONSENT TO SHARE INFORMATION

Where it is indicated that a young person is having contact /has had contact with another service provider, and the **headspace** Ipswich worker determines that this information is relevant to the young person's current needs, the young person will be asked to complete a Consent to Share Information Form.

This form then allows **headspace** Ipswich to have contact with the external service provider and to discuss personal and confidential information that may be relevant to the support and care that **headspace** Ipswich is providing.

6.5. Documentation and Recording

To meet legal, policy and ethical requirements, staff are to comprehensively and accurately document the basis of their decision (Gillick competence assessment) and all action taken in Profile.

7. PRIVACY AND CONFIDENTIALITY

7.1. Principle and definitions

Confidentiality and privacy are related but different concepts – information privacy is a much broader concept than confidentiality.

All professional who work within **headspace** Ipswich will have access to all relevant information while at the same time following up the legal requirements of ensuring confidentiality.

headspace Ipswich needs to maintain confidentiality in relation to private and sensitive information in order to create an environment that is respectful of the rights of young people and **headspace** workers.

Under common law, young people have the right to have their confidentiality respected and can pursue legal action including damages for specific breaches of confidentiality.

7.2. Privacy Limitation

headspace Ipswich workers are required to disclose information about young people relating to:

- suspected child abuse,
- risk of self-harm,
- possession of firearms,
- serious criminal activity, and
- missing persons.

All **headspace** Ipswich young people and **headspace** Ipswich workers have the right to strict privacy of personal information, including the determination of if and when any personal information about themselves will be disclosed.

headspace Ipswich workers are required to sign a Clinician Confidentiality Statement on commencement of working with **headspace** Ipswich project and adhere to these practice policies. It is the responsibility of all **headspace** Ipswich workers to work within confidentiality requirements underpinned by their professional code of practice.

At the first appointment, young people are clearly made aware of both their rights to and the limits of confidentiality of **headspace** Ipswich.

headspace services will only collect personal and sensitive information relevant to the provision of the service.

Personal and sensitive information about young people is only available to those **headspace** Ipswich workers who need that information to provide a service for that client.

All **headspace** Ipswich workers will ensure electronic data is within secure network storage, and undertake to only access that data which is necessary to perform their role.

headspace Ipswich workers have the right to debrief in a professional manner within the **headspace** services, provided the organisation as a whole provides confidentiality. That is, young people are assured confidentiality by **headspace** Ipswich to external parties but that some information may be shared between practitioners/staff within **headspace** Ipswich if necessary for client or staff wellbeing.

When young person information is required for statistical purposes, information will be de-identified.

When a young person is no longer receiving a service from **headspace** Ipswich personal and sensitive information will be stored securely as per legal requirements of medical record storage.

If **headspace** workers breach confidentiality their ability to work within **headspace** Ipswich will be reviewed in line with Aftercare Human Resource Policy or Service Contractor Agreement (whichever is applicable).

8. INVOLVEMENT OF parents/gUARDIANS AND SIGNIFICANT OTHER/S IN SERVICE[7]

8.1. Principle

headspace Ipswich strongly believes in as best practice and will work to support wherever possible the involvement of parents/guardians and significant others in a young person's access of the service.

This is balanced with the young person's right to self-determine involvement of parents/guardians and significant others and how this can impact on their ability to access the services they require.

8.2. Impact of Parental Involvement/Non Involvement

The funding structure of **headspace** centres limits how parents/guardians and significant others can be involved in a young person's time at **headspace** Ipswich. However **headspace** Ipswich believes that parent/guardian involvement is preferable and evidenced based, particularly when working with young people under the age of 18..

Therefore, wherever possible, **headspace** Ipswich should endeavour to consult, involve and support families and significant others. With the young person's consent, family members and significant others will be involved in planning, provision and review of the young person's support.

8.3. Young person's right to self-determine

headspace Ipswich is a young person focussed service whose priority is to ensure young people have access to the services that they need. Whilst every effort will be made, initially and on-going, to encourage the young person to inform and/or involve their parent/guardian failure to do so will NOT limit their access to services (Refer Section Consent)

Generally;

- Information will only be released or discussed with others if the young person has given consent to do so. The young person will be offered the opportunity to disclosed information themselves with the support of their **headspace** worker; or

[7] References: National Standards for Mental Health Services – Standard 3 – Consumer and Carer Participation

- where the young person does not want their parent/guardian involved in any way or at a particular stage, consent requirements will be discussed with the young person. The most appropriate way forward will be decided as follows:

I. Where it is determined that a young person's decisions or actions not to~~in~~ involve parents/guardians could seriously jeopardize the young person's wellbeing, this will be discussed the young person with a view to develop a plan of action less likely to negatively impact the young person.

II. Generally, **headspace** Ipswich must act according to each young person's wishes, except in the exceptional cases where it is determined that the young person is not in a position to give informed consent or where their decisions or actions could place their own safety and well-being at IMMEDIATE risk, and/or the safety and well-being of others.

8.4. Sharing Information/Confidentiality

When a young person consents to have their parent/guardian informed and involved in their care at **headspace** Ipswich this does not imply immediate and total consent to sharing all information at all times. The level and type of consent for information sharing must be confirmed with the young person, and also for the parent/guardian who may share information that is sensitive.

8.5. headspace Ipswich choosing to not include parent/guardians

headspace Ipswich staff and workers may choose to limit family and guardian involvement or information may be restricted in cases where **headspace** Ipswich determines that the involvement of family members or carers may not be in the best interests of a young person, for example when child protection issues apply.

Similarly, circumstances may apply when, irrespective of the wishes of the young person, it is our professional judgement that we cannot share information with parents or guardians, or when we may be required by law not to do so. In such cases, the reasons for this will be explained.

8.6. Other Support People/Services

headspace Ipswich strongly believes in involving other services and persons that are nominated by a young person as significant in their lives. If appropriate, consent would be gained to share information with them (Consent to Share Information) and involve them in case planning and reviews. (Case Review)

8.7. Documentation and Recording

headspace Ipswich staff and workers must ensure that all information regarding parent/carer involvement/consent is documented in a timely manner and clearly and that the source of information is clearly delineated in a young person's file on MASTERCARE-MHAGIC.

9. RESOLVING SERVICE DIFFICULTIES

9.1. Principle

headspace Ipswich understands that the lives and circumstances of young people, and particularly those of young people with mental health and/or substance use issues, impact on their ability to meet agreements, commitments, appointments and obligations. Therefore, **headspace** Ipswich aims to ensure that there are clear processes in place to rectify any difficulties in delivering support to young people before such problems escalate.

9.2. General Strategies

Support and rectification strategies will include:

- ensuring that **headspace** and the young person are clear about their expectations of each other and of their commitments and obligations;
- discussing the young person's rights and responsibilities as well as their and **headspace** Ipswich's expectations, commitments and obligations; (refer Complaints and Compliments Brochure and Complaints and Compliments Policy)
- suggesting strategies to support young people to meet their commitments, appointments and agreements egg assistance to help them to meet any behaviour expectations or to remind them of appointments, to travel to appointments and/or to support them to get to appointments;
- Advise how young people can notify **headspace** Ipswich if they believe they will be unlikely to be able to meet an expectation or agreement;
- using clear strategies to discuss and resolve delivery difficulties, which do not seek to lay blame for difficulties but to rather design strategies to avoid the recurrence of difficulties;
- reviewing a young person's case, to determine more effective ways of meeting each young person's needs and situation;
- involving other specialist agencies or support in a young person's plan to better reflect their immediate needs and situation (egg enhanced family, mental health, drug and alcohol, cultural and/or developmental support); and
- referring the young person and/or their family to specialist agencies for additional support.

9.3. Formal Grievances and Complaints

When a service difficulty becomes un-resolvable it becomes a Formal Complaint and refer to the **headspace** Ipswich Policy Complaints and Compliments.

10. EVALUATION, QUALITY IMPROVEMENT AND INNOVATION

10.1. Minimum Data Set

- see headspace Minimum Data Set Section

At the national level, the hNO will access data for evaluation and reporting purposes. All data will be de-identified by the time it reaches the hNO. At a local level headspace Ipswich management will be able to access local data and compliance reports via Tableau (https://reporting.headspace.org.au/)Data Entry at headspace Ipswich

It is the responsibility of all **headspace** Ipswich staff to complete good quality reporting (Refer Section Documentation and Recording)

10.2. headspace Evaluation

The minimum data set contains the key data elements that will be used to evaluate **headspace**. It will provide useful information on many areas including the following:

- the demand for **headspace** services,
- the volume of young people receiving care from a **headspace** site,
- how the clinical model at each site has been implemented,
- the key concerns that young people are presenting with,
- the functional outcomes of young people exiting the **headspace** site.

10.3. Ipswich Evaluation Research

MDS data maybe used from time to time as part of evaluation research conducted by both **headspace** national and **headspace** Ipswich

11. WORKFORCE AND HR MANAGEMENT

11.1. HEADSPACE STAFF

11.1.1. Recruitment and Selection

Aftercare is committed to ensuring the highest quality ~~of~~ staff are employed for **headspace** Ipswich. Aftercare has stringent HR processes that are adhered to for all **headspace** Ipswich Staff which ensures appropriate persons are selected for roles and adequately credentialed. (Refer to the Aftercare Policy for more detail).

11.1.2. Induction

headspace Ipswich is committed to a structured and thorough induction that will follow the **headspace** Ipswich Induction Checklist.

Induction of the **headspace** staff and workers will be the responsibility of the **headspace** Ipswich Service Manager.

All new staff will be required to sign the **headspace** Ipswich Workers Orientation Program Agreement and either the Clinician or All Staff Confidentiality Statement (depending on their specific role).

11.1.3. Management and Supervision of headspace Staff

a. Principle

headspace Ipswich is strongly committed to ensuring all staff are well supported and supervised within their roles.

This is to ensure the highest quality of service is delivered and that staff are supported to develop in their roles and to maintain their wellbeing and satisfaction with their position.

All staff are supported to engage in ongoing professional development in their area of practice.

All staff are supervised regularly to debrief and manage the impact of the nature of the work of **headspace** Ipswich on their person. This is especially relevant for any staff are fulfilling clinical roles however is also important for non-clinical staff in relation to involvement in any critical incidents etc.

b. Roles and Responsibilities

The operational management and supervision is as outlined in the **headspace** Ipswich Governance and Management Framework and the Organisational Chart.

The operational level manager is the **headspace** Ipswich Service Manager.

Clinical Supervision and Support for **headspace** Ipswich clinical staff (Intake and Assessment Workers) is the responsibility of the Clinical Team Leader.

Individual formal supervision will occur at a minimum of every month.

Ongoing support is provided regarding client management and approaches both informally and via daily Intake Meetings.

The Clinical Team Leader will be supervised regarding the management component of their role by the Service Manager. They will also be provided with access to a monthly external professional clinical supervisor.

c. Performance Monitoring

As per Aftercare Policy all staff complete an annual performance appraisal with their line manager. Ongoing informal monitoring also occurs via formal supervision and observation processes.

11.2. CONTRACTED STAFF AND SERVICE PROVIDERS

11.2.1. Application and Selection

All potential **headspace** Ipswich Contractors will be required to complete an application form and contract

From receipt of this application a selection panel from **headspace** Ipswich (as developed by the Service Manager) will review it for eligibility and where a matched vacancy exists the potential contractor will be contacted to discuss the process, which may include an interview and/or the induction process.

11.2.2. Service Level Agreements

All contracted service providers will be required to sign a service level agreement or formal contract with Aftercare as the lead agency for **headspace** Ipswich.

11.2.3. Induction/Orientation of Contracted Service Providers

All contracted service providers will be asked to complete the **headspace** Ipswich Induction Program.

Contracted service providers will be asked to sign an acknowledgement of their participation in the induction program, including their reading and understanding of the Clinical Practice Manual on a Workers Orientation Program Agreement.

Induction is the responsibility of the **headspace** Ipswich Service Manager.

11.2.4. headspace Contractor and Service Provider Responsibilities

Ipswich All workers at **headspace** Ipswich will demonstrate competent clinical practice standards that ensure they:

- practice in a safe and competent manner, within their scope of practice.
- practice in accordance with the agreed standards of their profession.
- comply with all applicable legislation, regulations, industry standards, policies, guidelines, professional codes of conduct and codes of ethics.
- respect the dignity, privacy, culture, values, beliefs and choices of every individual.

- work in partnership with young people and family or significant others to improve the health, wellbeing and informed decision making of each young person.

- communicate effectively and appropriately with young people, family or significant others, staff from other relevant agencies and staff members of the headspace Ipswich team at all times.

11.2.5. Supervision and Professional Development

headspace Ipswich is unable to provide the on-going supervision and professional development to contractors and service providers.

It is expected however that all contractors and services providers are committed to ensuring they have a schedule of supervision and professional development in place for their practice especially in relation to working with young people.

headspace Ipswich is committed however to providing support where it is possible for contractors and service providers to access supervision and professional development (i.e. access to training or support to develop a peer supervision forum for allied health staff at **headspace** Ipswich etc.).

Intake and Assessment Officers will be provided with a small amount of supervision through Clinical Team Meetings, and following any Clinical Incidents by the Clinical Team Leader, however will be responsible for receiving the majority of their Clinical Supervision requirements externally or via in-kind arrangements.

Critical Incidents

headspace Ipswich is committed to ensuring all staff and workers have access to support, debriefing etc. in response to any critical incidents that occur and this is the responsibility of the Clinical Team Leader in partnership with the Service Manager.

11.2.6. Management of Non-Compliant Contractors/Service Providers

In the instance of any contractor or service provider acting in a manner that is not in line with the above expectations/responsibilities the headspace Ipswich Service Manager will follow Aftercare Policy to address this with the service provider in question.

Any person suspecting any such issues should raise their concerns with the Service Manager or follow the **headspace** Ipswich Complaints Process.

12. WORKPLACE HEALTH AND SAFETY

12.1. headspace Worker Safety

Aftercare is committed to ensuring the headspace services safe and secure and policies reflect a commitment to workplace health and safety laws.

The Aftercare Work Place Health and Safety Officer is responsible for ensuring the safety of **headspace** Ipswich and in general, all Aftercare Workplace Health and Safety Policies apply to **headspace** Ipswich.

Specifically in relation to **headspace** Ipswich located at 26 East Street, Ipswich QLD 4305, the practices outlined below are in place to ensure the safety at all times of **headspace** Ipswich staff, contractors, services providers and young people and their families/carers that are accessing the service.

The **headspace** Ipswich Service Manager is responsible for ensuring adequate workplace health and safety is maintained at **headspace** Ipswich.

12.2. Staff on Site

- **headspace** Ipswich Reception must always know which staff, contractors and service providers are on-site and staff must notify Reception as they arrive and leave the building,
- Whenever there are young people on site at **headspace** Ipswich there must be a minimum of two **headspace** staff person/s also onsite,
- Where there is only one staff member on site all doors must be locked and no young person or family member is to be allowed entry to the building.

12.3. Safety and Duress

Refer to **headspace** Ipswich Safety and Duress Policy and Procedure.

12.4. Visitors on Site

All visitors (including young people) will be required to sign in and out at reception. A separate register will be maintained for young people to sign in and out of and in in order to maintain their confidentiality this will be kept under the counter at reception.

12.5. Home Visits

Currently home visits are provided by **headspace** Ipswich if deemed suitable or required a policy will be developed accordingly.

12.6. Transport of Young people

Currently transport of young people by **headspace** Ipswich is not provided, if in the future this is required a policy will be developed accordingly.

12.7. Infection Control and Disposal of Waste

headspace Ipswich will ensure that the standard precautions form the basis for the prevention and control of infection appropriate to medical services including:

- hand hygiene
- immunization
- asepsis
- personal protective equipment
- maintenance of a clean, safe environment
- cough etiquette
- sharps management

12.8. First Aid

headspace Ipswich will ensure adequate first aid supplies (in addition to medical supplies in the treatment rooms) and first aid trained staff are available at all times on site.

Where this is not possible appropriate emergency personnel will be contacted.

13. CHILD PROTECTION CONCERNS and mandatory reporting

13.1. Principle

headspace Ipswich works to promote the health and well-being for all young people and takes any evidence of harm; abuse and/or neglect associated with any young person they come into contact with very seriously and works to minimise this.

All staff and workers of **headspace** Ipswich as either mandatory reports or as a duty of care will report suspected cases of abuse or neglect to the relevant Department of Child Safety. Legal Requirements

The legal requirement to report suspected cases of child abuse and neglect is known as mandatory reporting. All jurisdictions possess mandatory reporting requirements of some description. However, the people mandated to report and the abuse types for which it is mandatory to report vary across Australian states and territories.

Within Queensland, under the Child Protection Act 1999 certain professions; as per the table below are mandated to report suspected risk;

"as soon as they form an opinion that there are current concerns for the child's safety, welfare or wellbeing".

	Who is mandated to notify?	What is to be notified?	Maltreatment types for which it is mandatory to report	Relevant sections of the Act/Regulations
Qld	An authorised officer, employee of the Department of Communities (Child Safety Services), a person employed in a departmental care service or licensed care service	Awareness or reasonable suspicion of harm caused to a child placed in the care of an entity conducting a departmental care service or a licensee	Physical abuse Sexual abuse or exploitation Emotional/psychological abuse Neglect	Section 148 of the *Child Protection Act 1999* (Qld)
	A doctor or registered nurse (*Public Health Act 2005*, s158)	Awareness or reasonable suspicion during the practice of his or her profession of harm or risk of harm		Sections 191-192 and 158 of the *Public Health Act 2005* (Qld)
	The Commissioner for Children and Young People	A child who is in need of protection under s10 of the *Child Protection Act* (i.e. has suffered or is at unacceptable risk of suffering harm and does not have a parent able and willing to protect them)		Section 20 of the *Commission for Children Young People and Child Guardian Act 2000* (Qld)

13.2. Procedure

When there are concerns for the wellbeing of a child or young person in relation to serious abuse and neglect risk or potential of risk as defined by the Child Protection Act 1999 (as above) **headspace** Ipswich staff will consult with the **headspace** Ipswich Clinical Team Leader or other clinical team members (as needed) and report such concerns by contacting the Department of Communities, Child Safety Brisbane

Regional Intake Service on 1300 682 254 or after hours on 1800 177 135 or 07 3235 9999 (for more information click here) to complete a verbal report.

Where harm is assessed as imminent and no other clinical staff are available for consult **headspace** Ipswich clinical staff may choose to report without prior consultation using their own professional judgement to assess the immediacy of need.

13.3. Documentation and Reporting

All reports must be documented within Profile as soon as possible. A Clinical Critical Incident will also be completed and placed on the young person's file.

Where a notification has been made without other clinical staff consultation the **headspace** staff member/s must ensure the **headspace** Ipswich Clinical Team Leader is directly informed as soon as possible.

13.4. More information

For more information and assistance on making such decisions refer to;

- What is child abuse?
- Department of Child Safety – Protecting Children
- Policies

INCIDENT MANAGEMENT AND REPORTING

13.4.1. Clinical & Non-Clinical

Refer to;

- Critical Incident Policy
- Guidelines for the Assessment and Management of Clinical Critical Incidents
- Assessment and Management of Acute Clinical Phone Calls Policy

14. RELATED REFERENCE DOCUMENTS

Related documents may include, but are not limited to:

- National Standards for Mental Health Services
- National Practice Standards for the Mental Health Workforce
- Competency Standards for Allied Health Mental Health Workers (Psychologists, Social Workers, Occupational Therapists)
- Practice Standards and Code of Ethics for Social Workers (AASW)
- Practice Standards and Code of Ethics for Psychologists (APS)
- Psychotherapists and Counsellors Association Australia (or State) Practice Standards and Code of Ethics
- RACGP Standards for General Practice
- Relevant Commonwealth and State Acts of Parliament and Regulations
- Privacy Act 1988 (Commonwealth)
- Freedom of Information Act 1992 (Commonwealth)
- Freedom of Information Regulation 2006 (Queensland)
- Mental Health Act 2000 (Queensland)
- Mental Health Regulations 2002 (Queensland)
- Child Protection Act 1999 (Queensland)
- Child Protection Regulation 2000 (Queensland)
- Working with Children Act 2004 (Commonwealth)

- Commission for Children and Young People and Child Guardian Act 2000 (Queensland)
- Commission for Children and Young People and Child Guardian Regulation 2001 (Queensland)

Domestic and Family Violence Protection Act 1989 (Queensland)

- Domestic and Family Violence Protection Regulation 2003 (Queensland)
- Workplace Health and Safety Act 1995 (Queensland)
- Workplace Health and Safety Regulation 1997 (Queensland)
- REGION Mental Health Clinical Practice Manual
- **headspace** National Starter Pack June 2008
- **Legislation** – Australian Health Practitioner Regulation Agency www.ahpra.gov.au/Legislation-and- Publications/Legislation.aspx

The **headspace** Ipswich Clinical Practice Manual was originally adapted from a Draft document developed by **headspace** Southern Downs, and has since been adapted from **headspace** Ipswich.

CLINICAL PRACTICE MANUAL AMENDMENT HISTORY

Issue Date	Section and process	Page

15. FORMS, TEMPLATES AND FLOWCHARTS

15.1. Forms and Templates

- Advisory Member Confidentiality Statement
- All Staff Confidentiality Statement
- Client Agreement
- Client Confidentiality Statement
- Client Registration Form
- Clinical Critical Incident Reporting Form
- Clinic Practice Manual Issues Log V1
- Clinician Confidentiality Statement
- Complaints and Compliments Brochure
- Consent to Share Information
- Feedback to Referrer
- **headspace** Ipswich Complaints' Register
- Incident and Hazard Report Form
- Intake Assessment
- Medical Questionnaire V1
- Psychologist Application
- Referral Form
- Report of Reasonable Suspicion of Child Abuse
- Standard Referral to External Service
- Workers Orientation Program Agreement

15.2. Flowcharts

- Case Coordination Flowchart
- Clinical Critical Incidents Flowchart
- Mental Health and Drug and Alcohol Intake Flowchart
- Physical Health Intake Flowchart

15.3. Polices and Guidelines

- Complaints and Compliments Policy and Procedure
- Incident Management and Reporting Policy and Procedure
- Guidelines for Assessing and Managing Young People at Risk
- Mental Health Act Guidelines
- Mature Minor Policy and Mature Minor Tool (adapted from **headspace** Brisbane South)

Note: *Due to formatting requirements within the body of this Manual, the version of forms included in the Manual may be formatted differently to the forms in clinical use. The content included is accurate.*

END OF DOCUMENT