Report: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre

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Authorisation

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

Scope and Purpose

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

The functions of the health service investigators were to:

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

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

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

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

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

1.1.4 Based on the information available to clinicians and staff between 6 August 2013 and closure of BAC in January 2014, advise if the individual healthcare transition plans for the then current inpatients and day patients of the BAC were appropriate. A detailed review of the healthcare transition plans for patients who have been associated with serious adverse events should be undertaken.

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

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

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

Process

1. Extensive documentation was made available to the investigators; refer Index of Documentation (Appendix A), including patient files, policies and miscellaneous.
2. Additional information confirming governance arrangements was provided to the investigators by Kristi Geddes, Investigator, following a meeting on 4 September 2014 with Executive Director Mental Health &Specialist Services at WMHHS and Director of Strategy Mental Health & Specialised Services WMHHS.
3. Written statement, senior BAC clinician, 13/10/14.
4. Interviews were conducted face-to-face over two days being 13th and 14th October 2014 (Appendix B: Schedule of Interviews).
5. Additional email communication senior BAC clinician 21/10/14 and 22/10/14.
6. Response letter from Metro North Hospital and Health Service 28.10.2014.
7. An extensive interrogation of the Documentation related to Transition Planning for the six clients with the highest complexity of needs and risk including those who have been associated with serious adverse events provides a reference for this report (Appendices C and D).

Limitations

- Noting that transition is a process in which the communication and negotiations between the referring and receiving services are critical, this investigation was limited to review of the available documentation and interviews with key clinicians formerly from BAC. Staff of receiving services were not interviewed and limited documentation was available from these services. Education Department staff associated with the BAC were also not interviewed.
- [redacted] was identified as having a key role in the transition planning process and was offered but declined an interview with the investigators. In assessing the impact of this as a limitation to the process of the investigation, the investigators considered the very large volume of material that was available and the level of confirmation across the material and re-confirmation during multiple interviews. It is the judgment of the investigators that they were able to build up a relatively complete picture at a relatively high level of certainty in regard to the perspective of the BAC staff on the transition process. The investigators do not regard the lack of an interview with this person as a key limitation in the process.

Context

- On 6th August 2013 Minister for Health, Mr Lawrence Springborg announced the closure of the Barrett Adolescent Centre (BAC), Wacol, West Moreton Hospital and Health Service (WMHHS)[1]. A planning process to develop new service options for the population of the State was announced under the governance of Children's Health Queensland (CHQ)[2]. A governance process to manage the transition of current individual patients of BAC was developed.
- The concentrated and focused process for managing the transition of individual patients from the care of BAC to alternative options commenced in September 2013[3] with the expectation that the service would close in January 2014.
- The investigators note that three previous patients of the BAC have died in 2014 and that their deaths are currently being investigated by the Queensland Coroner.
- The published literature regarding transitional care for adolescents provides guidance and principles in relation to the planning and outcomes for this group:
    - Optimal transition may be defined as adequate transition planning, good information transfer between teams and continuity of care following transition.
    - Predictors of positive transition include individual factors such as severe mental illness and treatment and care issues such as medication and inpatient care.
    - Neurodevelopmental disorders, personality disorders, complex needs and emotional/neurotic disorders can be associated with less favorable outcomes.
    - Other factors associated with poor outcomes include if the process is seen simply as an administrative event.
    - It is better to undertake transitional care in the context of relative stability for the young person rather than crisis.
    - Transition preparation requires an adequate period of planning and preparing the young person and carer(s) for transition. The planning needs to take into account broad health and developmental transitions recognising the young person's developing maturity and changing health-seeking behaviors.
    - Models for collaboration that support transition include: shared care/joint working across services and liaison models.
    - Barriers to transitional care include: lack of alignment between referral thresholds and criteria between Child and Youth Mental Health Services (CYMHS) and Adult Mental Health Services[4].

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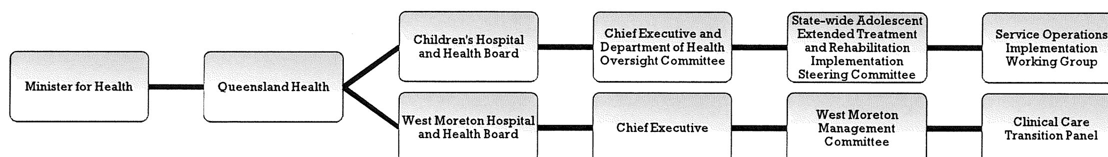
[1] Refer: letter dated 24th August 2014 from Health Service Chief Executive West Moreton Hospital and Health Service to Qld Health Chief Psychiatrist.
[2] This process was identified as out of scope by the investigators because it concerned strategic forward planning at the population level rather than care planning for the individual patients of BAC.
[3] Refer interview with Senior BAC clinician (6).

Governance

The figure below outlines the governance structure in place from August 2013 to January 2014 covering the transition phase for BAC patients[5].



The governance structure overseen by Children's Health Queensland was focussed on and responsible for the future of mental health services for adolescents in Queensland post the closure of BAC and the governance structure overseen by WMHHS was focussed on and primarily responsible for the transition and discharge of patients from BAC up until its closure[6];

(a) the West Moreton Management Committee had membership from various stakeholders and met once a week to address any concerns raised during the transition process and assist in developing solutions;

(b) the following was in place to ensure communication between the two governance structures, primarily between the WMHHS Management Committee and CHQ Steering Committee:

(i) mutual committee membership by a number of practitioners from each HHS, including three senior health service executives:

(ii) informal input sought and received on the drafting and development of key material;

(iii) informal and open communication and sharing of documentation;

(iv) regular formal reporting by both committees to the Department of Health and Minister for Health; and

(v) formal monthly reporting from Clinical Care Transition Panel to Steering Committee.

- The clinically driven process was supported by a formal governance structure comprising:
    - Clinical Care Transitional Panel:
        - Chaired by a senior clinician BAC.

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4 Singh SP, et al 2005, 2009, 2010

5 Refer additional information provided by Kristi Geddes, Investigator

6 Refer additional information provided by Kristi Geddes, Investigator

        - Key members: internal to BAC: multidisciplinary senior clinicians responsible for patient care and Acting Principal of the school.
        - Reported to the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee and the West Moreton Management Committee.
        - Met twice-weekly and on an ad hoc basis to focus on day to day patient care and planning for transition. An issues log was maintained and provided to the investigators by a senior clinician BAC.
        - Agendas and minutes were provided to investigators (Appendix A). No formal Terms of Reference available.
    - The West Moreton Management Committee[7]:
        - Chaired by senior manager.
        - Key members: range of senior clinician and management representatives from the health service, representative from CHQ and MHAOD Branch.
        - Reported to the Chief Executive WMHHS and Chief Executive and Department of Health Oversight Committee.
        - Met weekly from September 2013 until January 2014.
    - Chief Executive and Department of Health Oversight Committee:
        - Key members: Deputy Director General Department Health, Health Service Chief Executives from key hospital and health services; Executive Director MHAOD Branch and other key representatives from CHQ.
- The clinically driven process was supported by additional and specific resourcing:
    - Project Officer[8] appointed to support the Clinical Care Transitional Panel and the Barrett Adolescent Update Meeting.
        - Role to schedule agenda to ensure all patients reviewed in a timely way and record keeping.
    - Brokerage funds were provided where required to support the transition period and frequently offered up to June 2014[9].
- The closure of BAC was supported by a formal communication plan in effect from September 2013 to February 2014. This was managed by the Project Officer (above).

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

[8] The reviewers were advised during the interview with senior clinician BAC that a Project Officer was appointed to support the process of transition planning and the governance.

[9] Refer Appendix C –

The scope included families and carers, community, staff of BAC, hospital/health services, industrial organisations etc.

- The Queensland Health Procedure Document 201000447, *Inter-district Transfer of Mental Health Consumers within South Queensland Service Districts*, effective 8/11/10 and active at the time of the closure of BAC, provides guidance in relation to transitional care, notably including: the roles and responsibilities of transferring and receiving services; and consideration of potential shared care arrangements.

Findings

- The process of transitional planning occurred in an atmosphere of crisis consequent to the announcement of the closure and the in the context of an unrelated matter, with escalation of distress in a number of the adolescents and staff of BAC. There appears to have been a contagion effect of distress and anxiety amongst the adolescents and an increase in incidents on the unit. However whilst the general atmosphere of crisis contributed to the complexity of the situation, it does not appear to have detrimentally affected the process of transitional care planning for the patients.
- The closure date set an artificial/administrative deadline for transition, although all formal communication such as letters to parents and fact sheets/updates suggested that BAC would remain open until all transitions were completed. Whilst on the one hand there was a relatively long period of approximately 5 months to develop and enact the transition plans, on the other hand there was a sense of time-pressure for the BAC clinical staff because of the complexity of the planning process.
- Transitional care planning was led by a small multidisciplinary team of clinicians headed by the Acting Clinical Director BAC. Their task was enormous as they were required to review and supervise current care plans, manage incidents and crises, seek out information about service options that many times was not readily available, negotiate referrals, coordinate with the education staff and manage communication with patients and their families/carers. The team was dedicated to these tasks, with the day to day supervision of the young people undertaken by the Care Coordinators.
- The process of managing the transition of individual patients was centered on individualised and comprehensive needs assessment (including mental health, health, educational/vocational, and housing/accommodation needs) and care planning, extensive investigation to identify available and suitable services to provide coordinated care in community settings, iterative planning and collaboration with consumers and families and carers.[10]
- In relation to the patient cohort, it is noted:

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[10] Refer Appendices C and D for transition planning evidence and detailed review.

  - The young people were a very complex group with various combinations of developmental trauma, major psychiatric disorder and multiple comorbidities, high and fluctuating risk to self, major and pervasive functional disability, unstable accommodation options, learning disabilities, barriers to education and training, drug and alcohol misuse. In short, this was a cohort in the main characterised by high, complex and enduring clinical and support needs.
  - Organising transitional care for such a complex group would have been a very significant challenge even under ideal conditions. Each very complex young person required highly individualised care assessment and planning. These are not the kind of individuals who readily 'fit' with service systems because of the scope and intensity of their needs. The model of care in existence at BAC had promoted prolonged inpatient care and the forthcoming closure required the rapid development of care pathways to community care.

- The BAC team undertook an exhaustive and meticulous process of clinical review and care planning with each individual young person's best interests at the core of the process. Despite the pressure of a looming deadline, there was evidence that the first and critical emphasis of care was to establish and provide good clinical care including addressing physical health needs such as blood lithium levels and diet/weight management. [11]

- The process of communication and negotiation between the clinical team and the young person and their family/carers was careful, respectful, timely and maintained. As would be expected during a time of heightened emotions and anxiety about the future, there appears to have been some misunderstandings at times along the way but these appear to have been in each case dealt with promptly and appropriately. The misunderstandings arose, for example, in circumstances of unopened emails by parents/carers[12] or unexpected emerging clinical need requiring immediate action by the BAC clinical team[13], with communication following as time permitted. There is evidence of parent information sessions, letters to parents, individual email responses to parents and phone calls to support timely communication. Fact Sheets, FAQ sheets and the Executive Review Committee recommendations were also provided to parents/carers and made publicly available on the WMHHS website.

- The transition plans, without exception, were thorough and comprehensive. In some instances it was not possible to identify a variety of options for each care domain for each client, but in each case at least one reasonable option was able to be identified matched to a particular care domain[14]. At times there was considerable delay in settling on the final option – but this reflected the considerable work involved in

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[11] Refer Appendix D –

[12] Refer Appendix D –

[13] Refer Appendix D –

[14] See for example, Appendix D –

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

- In a number of instances the young people had psychiatric disorders that on their own did not cross the threshold to service in the community mental health system.[16] It is noteworthy that there were examples of successful negotiations that led to services accepting the referrals by exception[17]. The investigators did not find any example where it was not possible to organise a reasonable system of care for an individual.

- The inevitable challenges arose during this process, such as the changes in established long-term relationships between the clinicians of BAC and the young people; the differences between the culture and approach to care provided in services for adolescents and the culture and approach to care in adult services; the impact of the young person's developmental stage and maturity on their health-seeking attitudes and behaviors; and, adolescent's resistance to transfer from a service where they felt safe and 'connected' in a relatively closed environment to a community system of care and, in the case of transfer to an adult system, the different expectations of their maturity and health-seeking behaviour and the different expectations of involvement of their family.

- Whilst there was some drop-out from some aspects of the care organised, the investigators did not identify any examples where a young person was completely lost to care, nor where a core component of care was completely missing.

- There were numerous examples of the BAC staff working in a collaborative way with receiving agencies, as evidenced by the number of times young people were escorted to the other agencies[19], the detailed discussions and documentation in relation to risk management[20], maintaining contact post-transfer of care[21] and joint working by staff across the agencies[22]. These activities would be considered best-practice in transitional care and in the main appear to have been implemented.

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15 Refer Appendix D –
16 See for example, Appendix D –
17 See for example, Appendix D –
18 Refer Appendix –
19 See for example, Appendix D –
20 See for example, Appendix D –
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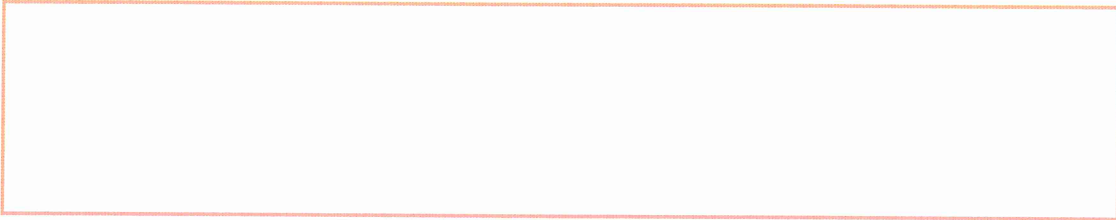

- There were examples where brokerage funding was very necessary and secured from Health to facilitate a high quality transition[24].
- The investigators confirm that:
    - the health care transition plans developed for individual patients by the transition team were adequate to meet the needs of the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

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

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

Recommendation

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