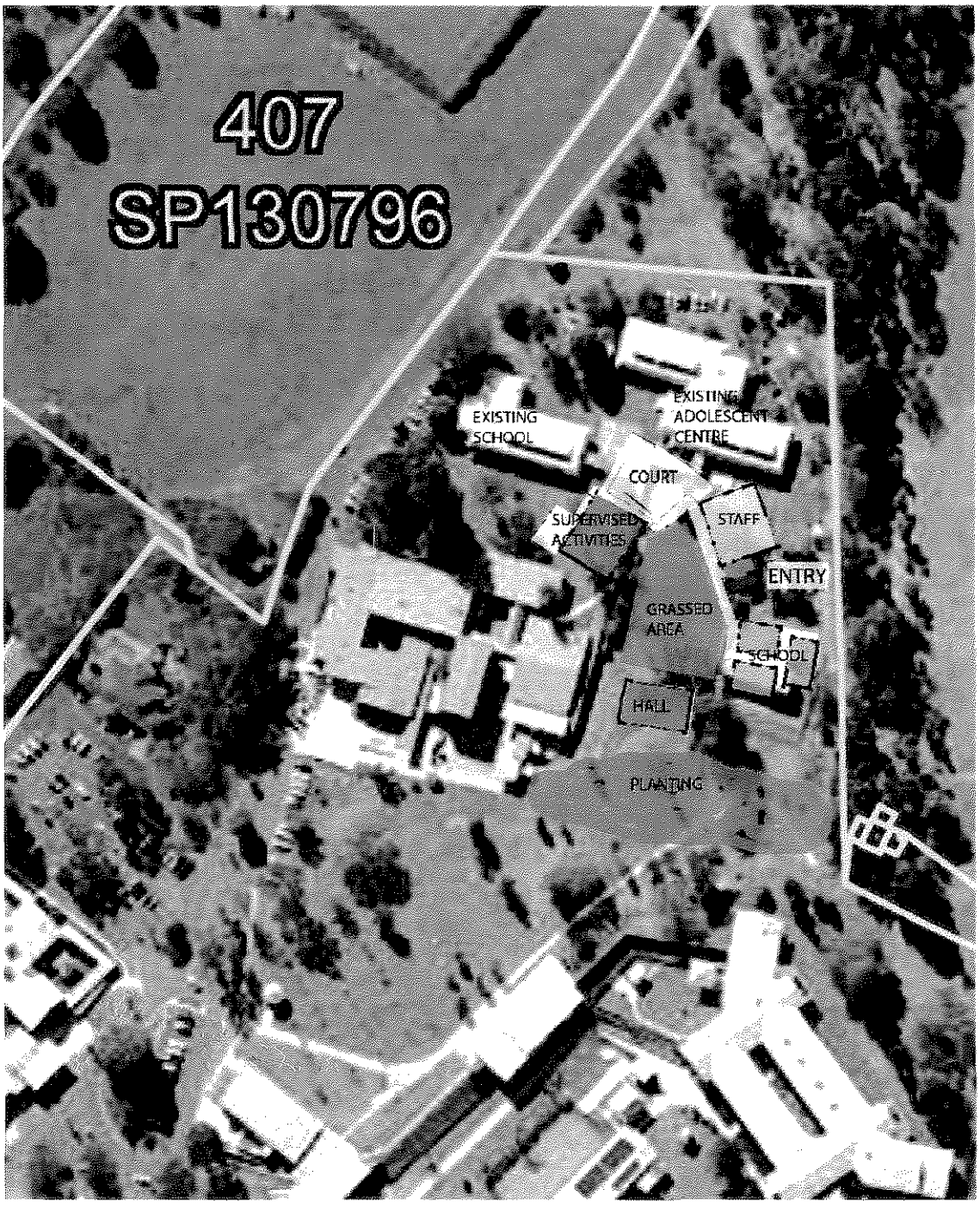
Fig 3. Site P2 Stage 1 (Existing Site Redeveloped in 3 Stages) (Aerial View)



SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 1

Project No: 5'426
Project Title: 16 Bed Adol. ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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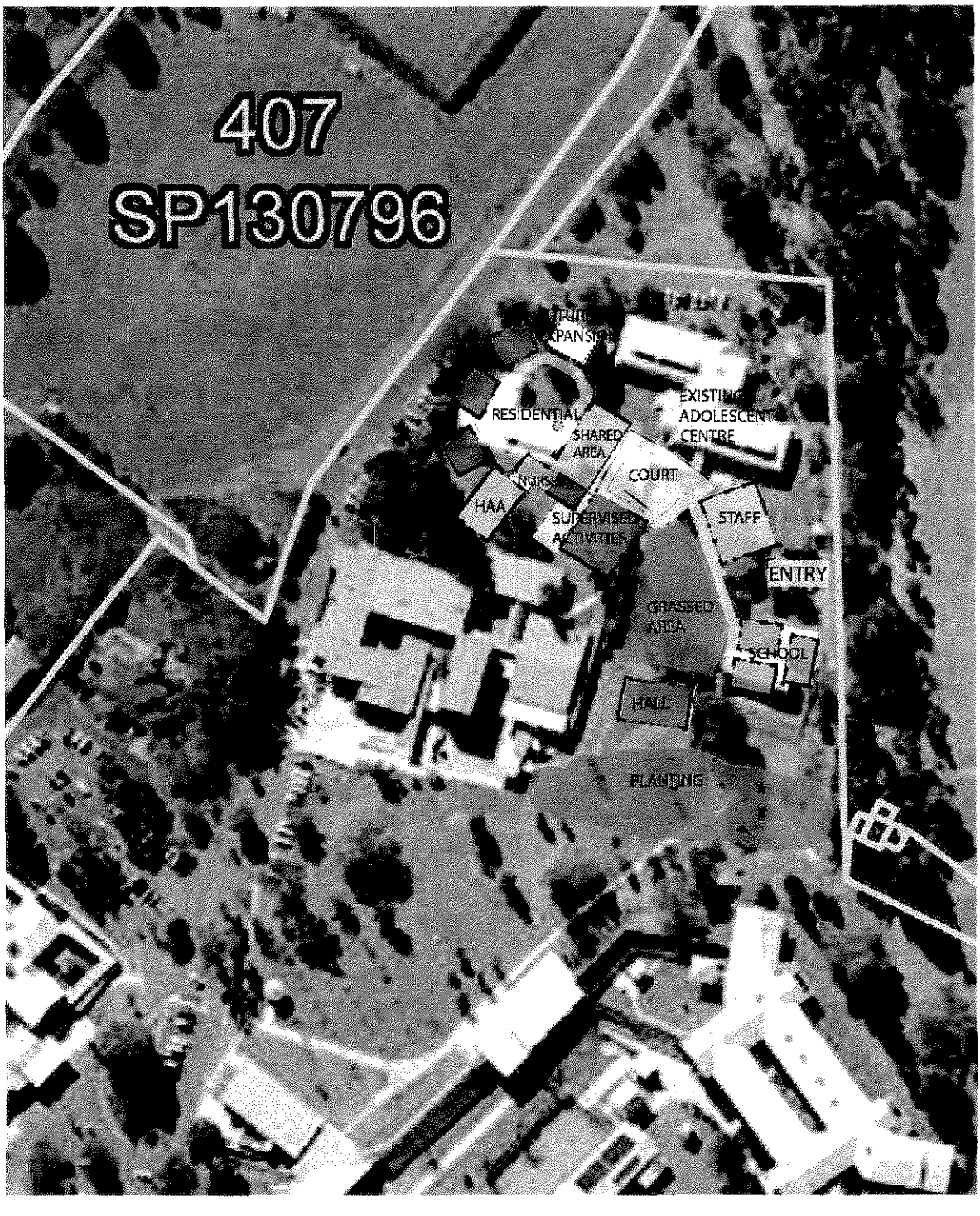
Fig 4. Stage 2 Site P2 (Existing Site Redeveloped in 3 Stages) (Aerial View)



SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 2

Project No: 51426
Project Title: 16 Bed Addl, ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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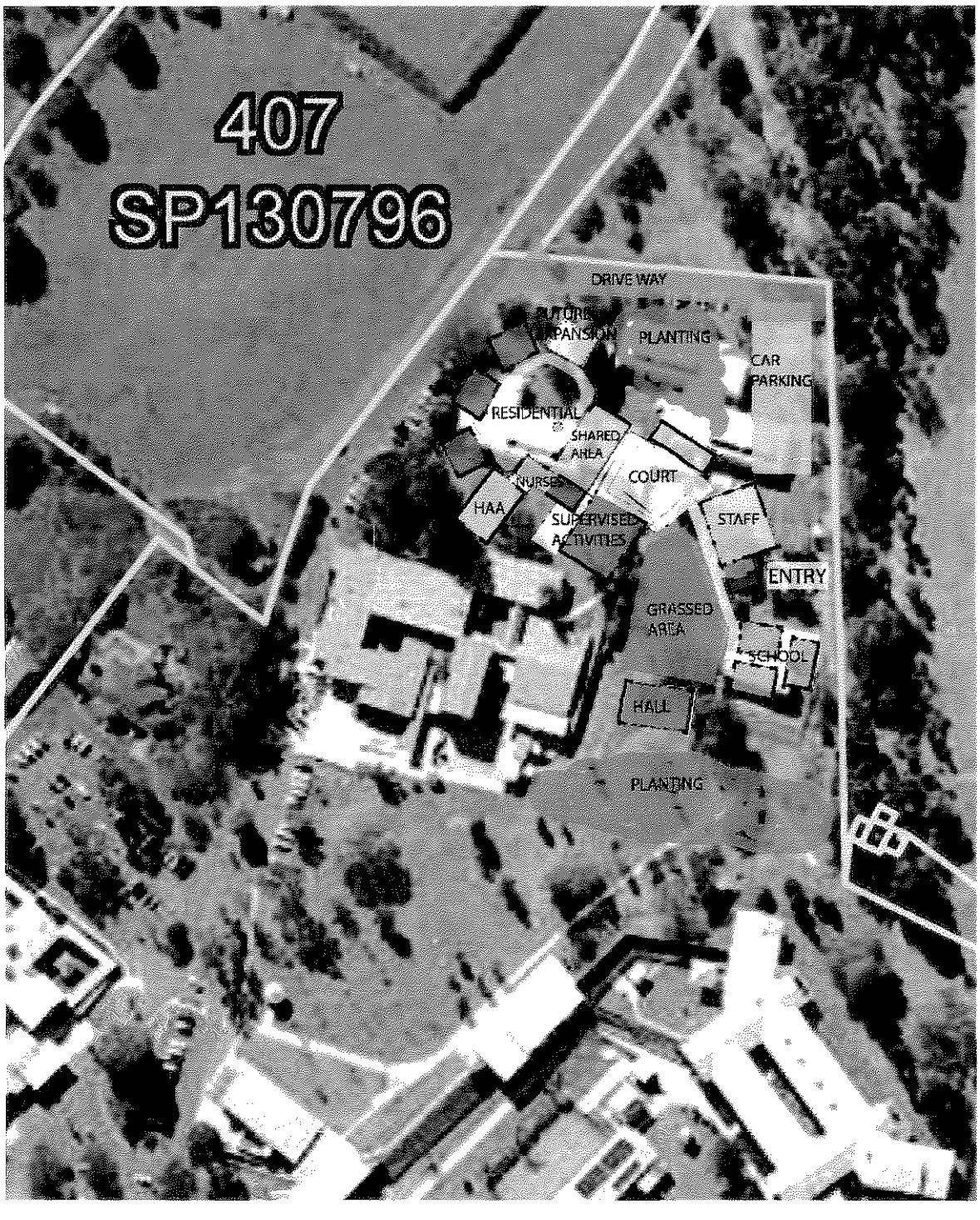
Fig 5. Stage 3 Site P2 (Existing Site Redeveloped in 3 Stages) (Aerial View)



SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 3

Project No: 51426
Project Title: 15 Bed Addl, ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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5. Site Options Conclusion

Redland
According to the analysis provided in this report Redland appears to be the most suitable location for the redevelopment of the 15 Bed adolescent extended treatment unit.

This site measures favourably against the 'Essential' and 'Desirable' characteristics nominated in the revised 'Site Selection Criteria'. The local area affords considerable opportunity to access the natural environment, rehabilitation activities and community and primary care services. The area is adequately serviced by public transport, without being too busy or likely to become a thoroughfare.

The development of a 'green field' option will also avoid some of the logistical challenges and time and cost implications of redeveloped existing buildings.

Importantly, it is not compromised by the risks associated with co-location with forensic inpatient services.

The BAC Clinical Director has identified that the greatest challenge associated with this site is its distance from the existing service at Wacol. In addition, nurses operate under different awards at the two sites. Some senior and experienced staff from both Queensland Health and the Department of Education Training and the Arts definitely would not make a transition to Redland. Managing the retention of experienced staff is critical to avoid crossing a threshold of loss of experience at which all existing staff would seek employment elsewhere. Such a loss of specialised staff would render the unit inoperable. Clearly a human resource management plan would be required to mitigate these significant challenges.

One of the potential benefits of this site is its proximity to Redland Mental Health Service. There are plans to both redevelop and add new acute inpatient beds at Redland in the second half of the Queensland Plan for Mental Health 2007-2017. Initial discussions indicated that the additional beds could well be targeted as youth beds (age 18-25). There has also been suggestion that a child and youth service hub be developed with community and the extended service located at Redland. There could also be opportunity to model improved coordination and integration between adolescent and adult services. It has been noted that co-locating the unit with other mental health services is in the strategic interest of the service.

Among the potential advantages of co-location of this kind include meeting the challenge of staff recruitment and retention.

The Redland site is the preferred option.

The Park
Although the existing and planned forensic services at The Park significantly impact on the feasibility of this option, there are understandable incentives to retain the current adolescent centre location. The service has enjoyed the development of an experienced cohort of staff and the formulation of effective local partnerships. Both are critical to the service model. The key strength of redeveloping in the same location is the inherent support this offers in sustaining the existing culture, expertise and partnerships.

Alternate options that consider relocation and redevelopment must acknowledge the challenges of service development at another site.

Of the three sites identified at The Park, the option to redevelop on the site of the existing unit (P2) is the only option that could be pursued from an architectural/ site planning perspective. The Adolescent Centre Site Appraisal identifies how the redevelopment might be staged to minimise its impact on the provision of services. It is important to acknowledge that this staging process would have time and cost implications for the project. It also indicates that the overall site footprint would need to be reduced in order to be developed on this site.

The site measures well against other 'essential' and 'desirable' characteristics. Close proximity to the natural environment, public transport and the presence of a natural buffer are among the attributes of the location. However, its relative isolation from other child and youth or other (non forensic) mental health services may pose a challenge for service development in the longer term.

As stated the close proximity of the site to the growing high security and extended treatment forensic programs compromise this option. Redeveloping the unit in close proximity to mentally ill offenders is likely to pose clinical and practical challenges and may become a matter of public interest.

Appendix 1 – Site options Appraisal

Fig 1. Sites P1 A and P1B- The Park Centre for Mental Health (Aerial View)

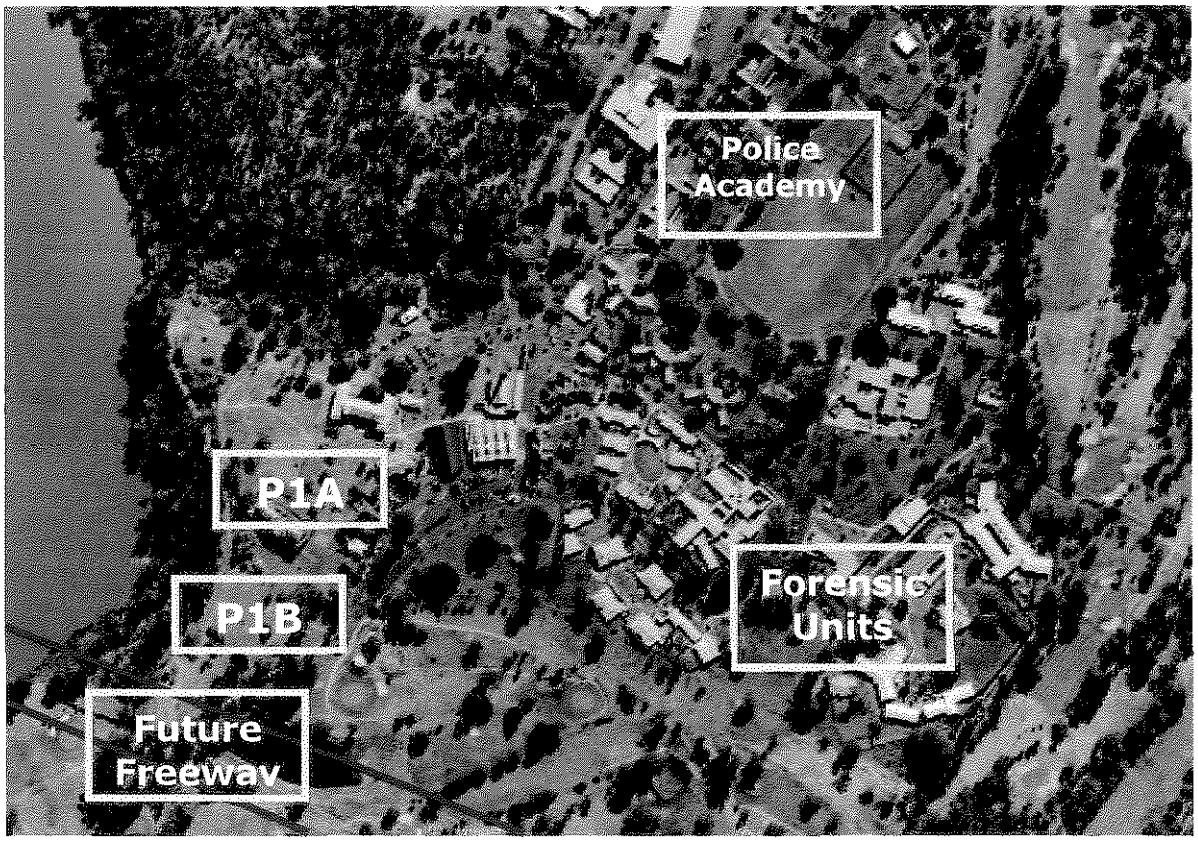


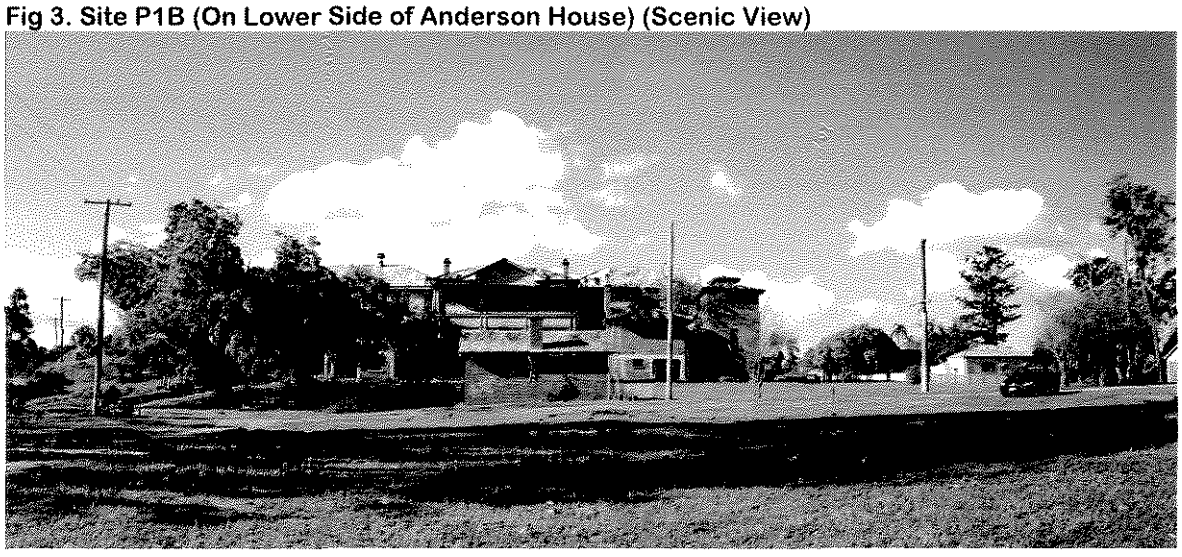
Fig 2. Site P1A (On Upper Side of Anderson House) (Scenic View)

Specific Site Considerations for P1A

- Old asylum buildings create an institutional ambience
- Proposed 110 km/hr freeway nearby with bridge over river.
- Close to forensic units affects "Undesirable Persons" & "Public perception & politics" aspects
- There is only about 5,000m2 of reasonably level site available, and this is only 33% of the 15,000m2 minimum
- Residents need to walk through forensic areas and across a golf course to reach the train station.

Conclusion
The size, topography and environment of the site make it unsuitable for the proposed Adolescent Unit.

Fig 3. Site P1B (On Lower Side of Anderson House) (Scenic View)



Specific Site Considerations for P1B

- Old asylum buildings create an institutional ambience.
- Proposed 110 km/hr 6 lane freeway adjacent with freeway bridge over river. Refer to Figure 1.
- Undesirable persons - Close to forensic units
- Level site area of only about 0.4 Ha (2 Ha preferred area / 1.5 Ha minimum)
- Residents need to walk through forensic areas and across a golf course to reach the train station.
- The proximity to forensic unit may influence Public Perception, Politics.
- High pressure water main across middle of site is likely to prevent development economically

Conclusion
The size, topography and environment of the site, plus the existing high pressure water main and possible future freeway make it unsuitable for the proposed Adolescent Unit.

Specific Site Considerations for Rogers St, Spring Hill

- Main roads and high rise buildings adjacent. Generally a busy inner-city location not compatible with the model of care.
- Too far from RBH
- Multiple physical hazards in the immediate vicinity.
- Numerous potential opportunities for contact with undesirable persons and activities in the Spring Hill and Fortitude Valley areas.
- No buffer space.
- Multiple escape routes and hiding places.
- Site is only 6684 square metres which is less than 50% of the 15,000 minimum.
- The existing buildings on site are unlikely to be suitable for the proposed new adolescent centre.
- Demolition of the buildings would be difficult to justify, given the quality and character of the buildings, and there may be heritage issues.
- There may also be heritage trees.

Conclusion
The size and environment of this site make it unsuitable for the Adolescent Unit as currently envisaged.

Specific Site Considerations for CAFTU

- Very steeply sloping site with existing buildings on three levels would not allow the kind of development required by the model of care.
- Site is adjacent to major hospital with high rise buildings.
- Site is near to main roads, a railway line, and high buildings, including multi-storey car parks.
- Limited buffer space, and multiple escape routes and hiding places
- Site area of under 5,000m2 is only about 30% of the minimum required.

Conclusion

The size, topography and environment of this site make it unsuitable for the Adolescent Unit as currently envisaged.

Appendix 2 – Site Tour Notes

THERAPEUTIC FACTORS				
External Views: Importance: 2 Desirable				
Desirable views: sky, trees, distant objects, grass, landscape, sports ovals. Sense of distance, calmness more important than people, but distant views of people engaged in gentle activities is desirable. Water is a bonus				
Undesirable views: anything that is too busy or intrusive; buildings				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Green field sight currently surrounded by bushland Located next to Redland hospital Commercial warehouse precinct adjacent separated from site by a road Future use of other vacant land unknown Some nearby reserve areas	Both sites afford greenery/sense of distance Views of the river possible in one site Sense of calmness might be inhibited by police training exercises including use of firearms and sniffer dogs Derelict ward may also compromise views from some angles	Relatively secluded location Some established trees and greenery Located on busy hospital campus No views of green spaces or water	Relatively quiet, leafy site Some established trees at the periphery Limited sense of distance eg views of horizon No immediate water features	Offers some nearby bush land and park areas. These are somewhat compromised by industrial area close by.

ACCESS TO NATURAL ENVIRONMENT				
Importance: 2 Desirable				
Desirable: Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Nature reserve readily accessible from site Bay is close by for arrange of other supervised activities Parks also in close proximity	Both sites afford some greenery/sense of distance Views of the river possible in one site Access without supervision may be compromised by safety issues eg accessing water alone and use of the campus in conjunction with other users of the grounds	Some established trees and greenery Victoria Park may be accessed under staff supervision	Some established trees at the periphery. Capacity to access Victoria Park precinct under staff supervision	Some potential amid existing green space.

ACCESS TO OUTDOOR ACTIVITIES				
Importance: 2 Desirable				
Desirable: Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Affords nearby nature reserves, readily accessible from site Bay is close by for other supervised activities Greenfield site may enable development of space for courtyards, games etc depending on exact land size	Some established trees and greenery Access to Victoria Park precinct under staff supervision Few other opportunities.	Some established trees and greenery Access to Victoria Park precinct under staff supervision Few other opportunities	Access Victoria Park precinct under staff supervision. Existing courtyard may be used for onsite for games etc	Site offers some potential for these spaces

EXTERNAL BUFFER SPACE & BOUNDARIES ESPECIALLY FOR NOISE MANAGEMENT				
Importance: Essential				
At least 50m away from houses is a minimum to reduce bad interactions with neighbours (both ways). There needs to be clearly defined boundaries but boundaries should be as invisible and unoppressive as possible. Good buffer spaces can reduce the need for fences				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Considerable buffer space with existing nature reserves Neighbouring hospital campus and adjacent commercial area may compromise aspects of this buffer Suitability of future use of land for this purpose is also unknown- unlikely to be factored into planning	Hospital campus and golf courses provide buffer. Compromised on some areas by steep slope of river bank, derelict ward and neighbouring services eg DSQ and Juvenile Justice Centre	Limited external buffer space apart from hospital	Some capacity to provide external buffer	Limited external buffer space apart from schools

TOPOGRAPHY				
Importance: Nice to Have				
An elevated site with long views and vistas into the distance is preferable, but the site of the facility must be reasonably level.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site is undeveloped but natural topography is unlikely to afford long views to the distance	Site affords long views to the distance from some areas	Site does not offer long views into the distance.	Site does not offer long views into the distance	Site not elevated limited views

CLIMATE / ASPECT				
Importance: Nice to Have				
Good cooling breezes are desirable for personal comfort and to reduce the need for air-conditioning. Site must allow buildings to predominantly face north and south to maximise opportunities for natural cooling and light				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Extent of breezes uncertain but proximity to the bay likely to be favourable in this regard	Significant breezes likely at sites overlooking the river Open spaces may contribute to breezes in other sites	Extent of cooling breezes difficult to determine Unlikely given buildings closely neighbouring the site	Unsure as to the extent of cooling breezes Established trees likely to offer shade	Level of cooling breezes difficult to gauge

SURROUNDING BUILT ENVIRONMENT				
Importance: Essential				
Avoid:- High rise and high density buildings. Overlooked sites. Main roads, railways, and other noisy busy areas. Intimidating, institutional or non-domestic general environment.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site relatively free of high rise buildings Road in front of site does not currently have through access and therefore not a major thoroughfare Aspects of the neighbouring hospital site likely to be non-domestic Unsure about future uses of other neighbouring parcels of land	Natural environment is a real asset, but located in institutional (potentially intimidating) precinct- juvenile justice, high security unit, extended treatment forensic unit, medium secure unit, police academy etc	Nearby high rise buildings and close proximity of residential areas likely to be challenging aspect of this site Hospital campus location largely overcomes issues of busy roads, but campus itself might present intimidating non domestic feel.	Neighbouring school buildings may constitute a challenge Large Salvation Army facility overlooks site, but its windows are not oriented to where the service may be developed While the site is in an inner city location it appears reasonably protected from busy roads and thoroughfares	Some benefits in vacant land. Some semi industrial use nearby

PRIVACY				
Importance: Essential				
Privacy for the adolescent consumers is important, but the facility should not be too isolated. It is desirable for consumers to have opportunities to see people outside, but adolescents should not be "on display". Contact with the public and families needs to be controlled. It is important that public thoroughfares do not happen through the facility site.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Undeveloped site and neighbouring reserves afford good potential to develop site in a manner that maintains privacy Impact of future use of vacant land unknown	Open spaces offer potential to maintain privacy but other users of the site and surrounds may create some challenges Not likely to be a thoroughfare although may be isolated	Neighbouring buildings on hospital campus and neighbouring residential buildings may create a challenge for maintaining privacy on the site Unlikely to be a public thoroughfare	Neighbouring schools and homeless shelter may create some challenges for maintaining privacy in this area. Location is not isolated	Private site

SAFETY – EMERGENCY BACKUP				
Importance: Essential				
Access to help for 'code blacks' is critical. These incidents require back up from psych nurses specifically trained in aggressive behaviour management. A response is needed within 5 minutes; therefore the adolescent facility needs to be located where appropriate help is available.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Proximity to the adult acute unit and hospital campus is favourable in this regard	Service currently receives code black support from ETR and Medium Secure staff High security service does not provide code black response Code black response might be compromised at Orford drive site As ETR is replaced by community care units and in time medium secure is downsized the maintenance code black response may not be assured	Code black response may be offered from hospital security Size of the campus makes fast code black response from adult mental health staff unlikely	After hours code black access to this site is an outstanding issue	Major weakness. Not near enough to mental health unit

PHYSICAL HAZARDS				
Importance: Nice to Have				
Avoid: bridges, high buildings, cliffs, multi-storey car parks, bridges, main roads, train lines				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Some main roads located in vicinity	Train line and abandoned buildings located in vicinity	Multistorey car park located on hospital campus Other physical hazards in the vicinity	Some high buildings and other physical hazards located in the vicinity	Some distance from these things

UNDESIRABLE PERSONS				
Importance: Essential				
Avoid opportunities for contact with 'undesirable persons'.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site is not located near 'undesirable groups'	Growth in forensic programs particularly Extended Treatment Forensic programs makes this area problematic	May be some concern in the event consumer absconded to Fortitude Valley	May be somewhat of a challenge in Spring Hill and close proximity to homeless shelters	Site is not located near 'undesirable groups'

ABSCONDING				
Importance: Desirable				
A buffer of space around the facility is important – a buffer of 5 minutes walk (300m) to public transport to deter rapid absconding. Avoid potential hiding places. Multi-purpose games court (tennis, basket ball, volleyball).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site likely to offer reasonable buffer for accessing public transport. Neighbouring nature reserve may be a challenge in the event of an absconding attempt	Site has about a 300m buffer between it and public transport.	Hospital campus may act as a buffer to accessing public transport but may not deter rapid absconding.	Closest bus stop about 450 metres May not deter absconding due to building density	

SITE PLANNING FACTORS				
On Site Activities Multi-purpose games court (tennis, basket ball, volleyball).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Potential for on campus sporting options	Site has about a 300m buffer between it and public transport.	Limited on campus sports and activity options	Some opportunity to have some onsite sporting and other activities	

Vehicle Access & Parking				
Importance: Nice to Have Need space for car and mini-bus access to front of building and truck / ambulance / police access to rear. Must adhere to QHealth and building code requirements.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Not likely to be problematic on site	Not likely to be a problem on site	Might be a challenge on site	Not likely to be problematic on site	

Access to Facilities				
Importance: Desirable Access to Gymnasium				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Land size may permit larger design	Land size may permit larger design Access to large open grassed area	Land may not permit entire gymnasium, but exercise room may be	Land may not permit entire gymnasium, but exercise room may be possible.	Land size may permit larger design
Importance: Essential Access to Large Open Grassed Area				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Footprint may be larger on this site	Footprint may be larger on this site	Large open grassed area unlikely on site	Large open grassed area unlikely on site	Footprint may be larger on this site
Importance: Nice to Have Access to a small swimming pool with spa and swim jets				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature
Importance: Desirable Access to a full size swimming pool				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site within 5 minutes drive of local aquatic centre	Site within 5 minutes drive of Goodna Pool	Site within 5 minutes drive of centenary pool	Site within 5 minutes drive of centenary pool	?
Importance: Desirable Access to a Sports Oval or park				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site within reasonable distance of sporting facilities	Site located close to cricket oval	Site within reasonable distance of Victoria Park precinct	Site within reasonable distance of Victoria Park precinct	Close proximity to sporting facilities
Importance: Desirable Access to adventure training and water sports				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Bay is accessible to site	Brisbane river accessible to site	Accessible to 'Riverlife' at Kangaroo point and Rock Climbing at Fortitude Valley	Accessible to 'Riverlife' at Kangaroo point and Rock Climbing at Fortitude Valley	Reasonable proximity to activities

Public Transport				
Importance: Essential Need access to good public transport. Trains are preferred as being more reliable in timetable and less intimidating. (See attached summary)				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Not likely to be problematic on site	Not likely to be problematic on site	Might be a challenge on site	Not likely to be problematic on site	

Shops				
Importance: Desirable Need access to a variety of shops via public transport. There is graded use of shops in rehabilitation starting with smaller, less dense and closer shops and progressing on to large shopping malls. Ideally there should be a corner store within walking distance, and a major shopping centre a train ride away.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Some shopping available at Cleveland	Variety of shops accessible from Ipswich line	Variety of shops available in Brisbane City/Fortitude Valley/ New Farm	Variety of shops available in Brisbane City	Some shopping available at Logan

Other Facilities				
Importance: Desirable It is desirable to have other types of social activities available in the community such as:- churches, youth groups, sporting groups, dancing classes etc. (these are examples only – it is not important to have a particular type of community activity, group, club available).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
May be able to access these activities and opportunities in the Cleveland area	May be able to access some activities in the Goodna/ Gailes area	Lack of isolation increases likelihood of accessing community activities in local area	Lack of isolation increases likelihood of accessing community activities in local area	Access to some activities likely

On-site independent accommodation units				
Importance: Essential Future proof for on-site independent accommodation units (for family visits and for consumers preparing to leave). Note: This is not in current scope of works but should be considered in future construction.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site size unlikely to prohibit provision of this space	Site size unlikely to prohibit provision of this space	Size of site may make future proofing a challenge	Size of site may make future proofing a challenge	Site size unlikely to prohibit provision of this space

Hospitals & Doctors				
Importance: Essential Hospital emergency department within a 20 minute drive of the facility. A good working relationship with a local hospital is important.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Located at Redland Hospital	Ipswich Hospital closest available emergency facility	Located at RBH	Within 20 minutes of RBH	Within 20 minutes of Logan
Importance: Essential Proximity to the Qld Children's hospital is desirable				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Considerable distance from Qld Childrens Hospital close proximity to other mental health services	Some distance from Qld children's hospital, some distance from other child and youth services. Close proximity to forensic mental health services and medium secure staff.	Reasonable proximity to Qld Childrens Hospital close proximity to other C&Y mental Health Services	Reasonable proximity to Qld Childrens Hospital close proximity to other C&Y mental Health Services	Considerable distance from Qld Childrens Hospital close proximity to other mental health services

Importance: Desirable Proximity to an 'after hours' GP clinic is desirable.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Significant number of General Practitioners in Cleveland area with opening hours to 7pm.	Access to General Health Service- The Park	Some options in reasonable proximity	Some options in reasonable proximity	Access to Logan Clinics

Public Transport Importance: Essential Hospital emergency department within a 20 minute drive of the facility. A good working relationship with a local hospital is important.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Located at Redland Hospital	Ipswich Hospital closest available emergency facility	Located at RBH	Within 20 minutes of RBH	Within 20 minutes of Logan

Access for Families & Visitors Importance: Nice to Have Local external accommodation for families such as motels and hotels with good public transport access to the facility.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
'Holiday style' accommodation available in close proximity	Limited accommodation options at Darra.	May be some local options with existing partnerships eg Ronald McDonald House.	Variety of temporary accommodation options in Spring Hill.	Some options available

Police Importance: Desirable Police do not need to be close, but a relationship with a small local police station is good, more for consumer education and contact than to handle emergency situations.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Close proximity to local police station	Reasonable proximity to Mt Ommaney police station	Reasonably close to Valley Police Station	Reasonably close to Valley Police Station	Reasonable proximity to police station

Staff Access Importance: Nice to Have Staff recruitment and retention are important factors. Consider metropolitan location.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
45 minute drive from CBD may be a challenge for some staff. May also be a challenge for existing staff. May be some benefit from co-location with other services.	Advantages associated with retaining existing location and staffing group- some concern in the future about the isolation of the service from other child and youth services.	Centrally located. May be some advantages in being located with other mental health services.	Centrally located. May be some advantages in being located with other C&Y services	Some distance from existing service. Serviced by Logan and Pacific Motorways

Site Acquisition & Development				
Importance: Essential What are the cost and time implications of site acquisition?				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
	Applicable to all sites Sites on The Park Campus QHealth Land. Orford Drive site may not be Q Health land.	Applicable to all sites- Q Health Land	Applicable to all sites- Q Health Land	Applicable to all sites

Site Development				
Importance: Essential Includes:- Obtaining development approvals. Providing site infrastructure (power, water, roads, sewers, drains, phones). Site preparation costs (earthmoving, site drainage). Foundation costs (does the site have problem ground?). Are there any existing facilities/services which need to be decanted (budget, timelines and other impacts)? Is the site large enough, now and in the future? Any heritage or indigenous issues? What are the time and cost implications of the above? Will any of these factors affect the use of the facility now and in the future?				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Applicable to all sites	Applicable to all sites	Applicable to all sites	Applicable to all sites	Applicable to all sites

EXHIBIT 43

Adolescent Extended Treatment Site Selection

Summary of Consultation on Site Selection

March 2009

Queensland Government
Queensland Health

EXHIBIT 43

MSS.900.0002.0191

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Executive Summary

This report summarises consultation to replace the Barrett Adolescent Centre at The Park Centre for Mental Health at Wacol with a new purpose built facility at Redland Hospital at Cleveland.

A Site Selection Subgroup report previously identified two architecturally viable options for service redevelopment. The previous report concluded the existing site at The Park is ultimately compromised by its proximity to the expanding forensic mental health service. It recommended Redland as the preferred option to develop a replacement unit subject to further consultation with the sector and relevant stakeholders. This consultation was endorsed by the CEOs of Metro South and Darling Downs West Moreton Health Service Districts.

Consultation focussed on the following themes:

- Consumer and Carer Perspectives
- Clinical Workforce
- Transport
- Risks associated with the surrounding environment
- Advantages and disadvantages of the local area
- Provision of school services by Education Queensland
- Impact of Clinical Services Capability Framework (CSCF)
- Collocation Options
- Time and cost implications of staged development and potential for future expansion

The consultation confirmed considerable support for the preferred option among members of the State-wide Child and Youth Subgroup, Child and Youth Design Reference Group and carers. They saw a future opportunity to develop a Child and Youth Mental Health Hub at Redland which could not happen at Wacol. Presentations were provided to the Health Reform Consultative Committee and Local Consultative Forum at The Park. These industrial bodies sought assurance that if the service was relocated, existing staff would be supported. They await a final decision. Consultation with Education Queensland confirmed that the relocation of the service would not be a barrier to the continued provision of education services.

Existing consumers expressed their opposition to the relocation of the service while responses from carers were mixed. Consumers and carers who oppose service relocation are convinced of the attributes of the existing site. However, they are unlikely to be personally affected by relocation or the impact of service development planned for The Park precinct. Most existing staff involved in consultation have expressed their opposition to relocation and do not accept the rationale. Some staff are adamant they would not continue working in the service if it were relocated, a number are undecided, and another group, including some senior clinicians, have indicated their preparedness to establishing the service at Redland.

Despite this opposition, this report concludes the rationale for relocating the service is sound. It is more appropriate to locate a purpose built state-wide facility for vulnerable adolescents at a site with mainstream mental health and clinical services than one with a growing forensic mental health population. On this basis, it recommends the relocation of the adolescent extended treatment unit to Redland and endorsement to proceed.

Consultation

- Consumers and Staff- 20 February 2009
- Carers survey 20 February 2009- 10 March 2009
- Staff- 17 November 2008
- Health Reform Consultative Committee- scheduled for 9 December, circulation of report, meeting deferred to 10 February 2009
- Local Consultative Forum- The Park Centre for Mental Health- 17 December 2008
- Child and Youth Design Reference Group- 17 December 2008
- State-wide Child and Youth Subgroup- 27 November 2008
- Meeting with Student Services Department of Education Training and the Arts (DETA)-15 January 2009
- Meeting with Regional Director Moreton Region Education Queensland- 23 January 2009

An artist's impression of the replacement Adolescent Extended Treatment Unit based on initial design concept

Summary of Consultation Findings

Consumer Perspectives

All current consumers of the inpatient unit attended a meeting accompanied by a number of nursing and Education Queensland staff. Some staff and consumers expressed reservations about the consultation process, expressing feelings of powerlessness and the sense that little could be done to affect what is a 'forgone conclusion'.

Staff and Consumers asked for it to be recorded that the majority of participants opposed Redland as a preferred option. It was noted that due to the timeframe associated with the construction of the new service the preferred option to relocate the unit is unlikely to impact on current consumers.

Consumers and staff indicated they were not convinced by the rationale for the preferred option. They argued the lack of incidents connected with the existing High Security Inpatient Service and lack of empirical evidence associated with the risks of close proximity to forensic consumers refuted the rationale for relocation.

Consumers also expressed reservations about the impact relocation may have on families, carers, existing day patients and the links that had been forged with schools and community groups in the local area. They also felt the distance between the site at Redland and the CBD would be a disadvantage.

One clinician identified improved access to generic medical and emergency services as among the only attributes of the Redland option. On the other hand, consumers expressed a concern about no longer having access to the General Health Service (GHS) at The Park. Some suggested GHS staff are more sympathetic to consumers with a mental illness.

Both consumers and staff emphasised the contribution of the existing workforce and were sceptical about the capacity of the new service to replicate the current level of service provision if it failed to attract its existing staff.

Carer Perspectives

Five responses to a relative carer survey sent to the carers of current inpatients were received. Carer perspectives on the relocation of the service were mixed. Three of these responses opposed, while two supported the relocation of the service to Redland.

Of the three who opposed the relocation of the service, two questioned the need for a new purpose built facility. Those who opposed relocating the service highlighted the attributes of the existing site in terms of its accessibility to the population of South East Queensland, accessibility for existing staff and pleasant natural environment. Carer feedback reiterated comments from staff and consumers about the contribution of the existing team. The carers who supported the move live outside Brisbane. The carers who oppose the move live within 20 to 25 kilometres of the current site.

Current consumers oppose the relocation of the service while carers' opinions about relocation are mixed. Current consumers and carers are unlikely to be personally affected by the relocation of the service.

Clinical Workforce

The initial report of the site selection subgroup identified the implications for the workforce on the relocation of the service as constituting the most significant challenge associated with the relocation of the service.

> *The BAC Clinical Director has identified that the greatest challenge associated with this site (Redland) is its distance from the existing service at Wacol. In addition, nurses operate under different awards at the two sites. Some senior and experienced staff from both Queensland Health and the Department of Education Training and the Arts definitely would not make a transition to Redland. Managing the retention of experienced staff is critical to avoid crossing a threshold of loss of experience at which all existing staff would seek employment elsewhere. Such a loss of specialised staff would render the unit inoperable.*

The consultation process reinforced the significant implications for the workforce of relocating the service. Staff identified the important contribution made by the existing, well developed team in working with what can be an extremely challenging client group. The risk of failing to attract a sufficiently experienced cohort of staff to work in the service was emphasised. Staff also indicated their concern about the financial implications of working under a different award. Although, exhaustive analysis of the transport options for staff have not been undertaken, most staff indicated that working at Redland would significantly contribute to their travelling time to and from work.

Staff expressed concerns about the impact of the site selection process and the length of time associated with decision making on the service. Some people cited the uncertainty of the situation as an unhelpful stressor in what is already a challenging workplace. Some indicated they thought the proposed relocation of the unit would have an impact on staff retention in the lead up to the new service opening. A number of staff expressed scepticism about the prospect of working in other positions in the district should they choose to remain, as their experience and interests were focussed on working with adolescents in an extended treatment setting.

No longer having access to the pool of Graduate Diploma Programme (GDP) nursing staff training at The Park was identified as presenting a recruitment challenge. It was acknowledged however, that access to similar training opportunities for GDP nurses did not rely on being located at The Park.

Some senior staff members have indicated their commitment to continue working in a relocated service despite the challenges associated with this option. Most staff who attended the meeting appeared to agree that the prospect of a purpose built facility co-located with a general hospital would provide considerable opportunity to contribute to the model of service.

There are significant implications of relocation for the workforce. This change must be supported by a human resource plan that supports staff to make the transition and ensures a sufficient number of staff to operate the unit.

Transport

Investigation of transport options, including duration and cost of journeys and comparison of site accessibility from rural, regional and remote areas and consumers accessing day program.

Consideration of the transport options of the proposed site is a significant factor in testing its suitability. Access to public transport makes an important contribution to the model of care delivered by the existing service. It is important for consumers to have access to public transport to support their involvement in community rehabilitation and recovery activities. Public transport contributes to the accessibility of the service to day program participants, family, carers and staff. The service must also be accessible to consumers, families and carers who visit the service from regional, rural and remote parts of Queensland.

Public Transport Summary	
Redland	**Wacol**
10 minute bus journey (approximately 3.6km) to Cleveland Station-10 minute wait for train	Approx 10 minute walk to Gailes Station through The Park Campus and Golf Course
One hour train journey to Central Station	35 minute train journey to Central station
6 zones: $4.80 and $2.40 Concession one way	5 zones: $4.30 and $2.20 Concession one way

Consultation with stakeholders concerning public transport noted that Redland Hospital is further from the CBD than the existing site. It is slightly more expensive and requires a connection from local bus to train to make this journey. It was acknowledged that the impact on access to the local area by these public transport arrangements would be minimal. It was thought the local area would be a fruitful source of local rehabilitation activities.

Relocating the unit at Redland was thought likely to impact on the feasibility of existing day program users to access the service. However access for consumers in the area surrounding Redland would be improved. The impact of the proposed location was thought to be less problematic for family and carers visiting from rural and remote areas. The proposed site is as accessible to long distance travellers as the existing service location.

The consultation process has not made an exhaustive analysis of the impact of the change in public transport options for staff. However, it is assumed that for most existing staff accessing the service via public transport, relocation to Redland will considerably impact on the viability of public transport use.

The Redland site is serviced differently by public transport than the existing service. This is likely to present the greatest challenge to staff accessing public transport to get to work and existing users of the day program. It is unlikely to significantly impact on the use of public transport to access rehabilitation with the exception of where consumers require transport to the CBD. It is also unlikely to compromise access to the service by consumers, family and carers from rural, remote and regional areas.

Public transport services are not considered a significant obstacle to developing the service at Redland.

Risks associated with surrounding environment

Consideration of risk management strategies associated with surrounding bushland including bushfires, wildlife and proximity to infrastructure. Further analysis of the impact of the built environment at The Park and associated risk management strategies. This may include consideration of the implications of having vacant buildings on the site.

The initial report of the Site Selection Subgroup identified a number of risks associated with the surrounding environments of the sites at The Park and Redland Hospital. With respect to the site at The Park it identified the proximity of the existing site to the growing high security and extended treatment forensic programs as a significant issue. It also identified that vacant buildings, mobile phone tower, river and train line were among the hazards of the existing site that had been the subject of local risk management strategies.

> *Redeveloping the unit in close proximity to mentally ill offenders is likely to pose clinical and practical challenges and may become a matter of public interest.*

The report also acknowledged a number of the risks associated with the Redland option. The area of bushland that forms part of the reserve next to the proposed site has some benefits in contributing to the privacy of the service and offering some potential for therapeutic, recreational activities.

The possible dangers for consumers and staff caused by consumers absconding to this area were identified. In particular, the risks to consumers if they were to become lost in the bushland and remain undetected and the risk of staff injury as a result of pursuing them through a hostile physical environment were noted. The risks of fire in this area were also discussed.

Discussion with local police about the number of incidents in the local area was also suggested to assist the service in considering the security that may be required to protect consumers from any of the 'undesirables' who may congregate in this area.

Participants at the Child and Youth Design Reference Group suggested that the design of the unit may be able to prevent unauthorised access to the bushland. Fencing this area was suggested as one option to discourage absconding via this route. Existing staff also commented that consumers have generally attempted to access public transport when they have absconded, although not in all cases.

The light industrial, warehouse complex adjacent to the site was also identified as presenting some disadvantages. It may be an area to which consumers may abscond in an attempt to escape detection. It is assumed that the complex is likely to be a source of traffic in the surrounding area and it was noted that the absence of landscaping or established trees diminished the aesthetic appeal of this view from the proposed site.

No site is risk free. Some of the risk management strategies used at the existing site may be applicable to the Redland site. However, new approaches will need to be developed that account for the unique characteristics of the area. Significantly, developing the site at Redland positions the service in close proximity to a general hospital rather than a growing forensic inpatient service.

Advantages and Disadvantages of the local environment

Identification of the challenges and opportunities associated with the proximity of the existing service to the Police Academy site.

The initial site selection report dealt with the advantages and disadvantages of the areas surrounding the two sites. However the strengths and weaknesses of collocation with the proposed Police Academy site was identified as requiring further consideration.

Formal discussion with Queensland Police Service has not occurred, but the Child and Youth Design Reference Group concluded that it was likely the Police Academy site would be secured and not available to adolescent centre consumers to share the facilities. While the opportunity to provide education to the recruits was acknowledged, it was also noted that the proximity of the service to the academy is not a requirement of the inclusion of mental health components in police training. Noise and traffic associated with the use of the academy for motor vehicle, dog squad and firearms training were considered likely to detract from existing location.

Collocation of the adolescent extended treatment facility with the redeveloped Police Academy site would be likely to present new challenges to a service in the existing location. While it may present some opportunities these are not critical to supporting the model of service.

Continuing Provision of school Services by Education Queensland

Negotiation with the Department of Education, Training and the Arts is required in the process of deciding the preferred option.

During the course of consultation, representatives of the Mental Health Branch met with Representatives of the Student Services Division of Education Queensland and West Moreton Regional Office. The background to the project and the preferred option for the relocation of the service was discussed. It was acknowledged that the relocation of the service would have a significant impact on existing Education Queensland staff as it would Queensland Health staff. Education Queensland indicated relocation would require the school to move to a different region. The Regional Executive Director, Moreton District gave informal feedback to the effect that the region would regret the relocation of the service to another region. No further feedback had been received in time for inclusion in this report. Representatives of Student Services, Education Queensland indicated that the relocation of the service would not be a barrier to the provision of education services to consumers of the adolescent extended treatment service. A body of work has now commenced between Education Queensland and Queensland Health to establish a state-wide approach to the provision of Education Services to child and youth inpatient services.

Relocation of the Adolescent Extended Treatment Unit to Redland would not be a barrier to the provision of education services to the unit.

Impact of Clinical Services Capability Framework (CSCF)

Consideration of the impact of the service level assigned to the service in accordance with the Clinical Services Capability Framework.

The current draft of the mental health module of CSCF is not yet finalised nor formally endorsed. For the purposes of the consultation undertaken concerning the CSCF, it was assumed that the adolescent extended treatment unit would be assigned as a 'Level 6 service.'

> *A Level 6 child and youth non-acute inpatient mental health service is capable of providing medium- to long-term inpatient (and associated day patient) mental health care to patients (up to the age of 18 years) presenting with the highest level of risk and complexity, who may present with complex co morbidities and/or indicators of severe treatment resistance. This service will be provided on an extended basis.*
> *This highly specialised and/or state wide inpatient service will be provided by child and youth mental health professionals and the primary service site will be co-located with a specialised child/adolescent mental health unit. Alternatively, the primary service site may be delivered from a purpose-designed and built mental health facility.*
> *This service demonstrates specialist mental health expertise in the delivery of child and youth mental health services to a targeted population requiring non-acute extended inpatient mental health treatment and rehabilitation. (Working Draft- Child and Youth Mental Health Services, Mental Health Services, Clinical Services Capability Framework Queensland Health: 2009).*

Planned assignment of the service as level six further emphasises the importance of an experienced workforce and co-location with other specialist child and youth services.

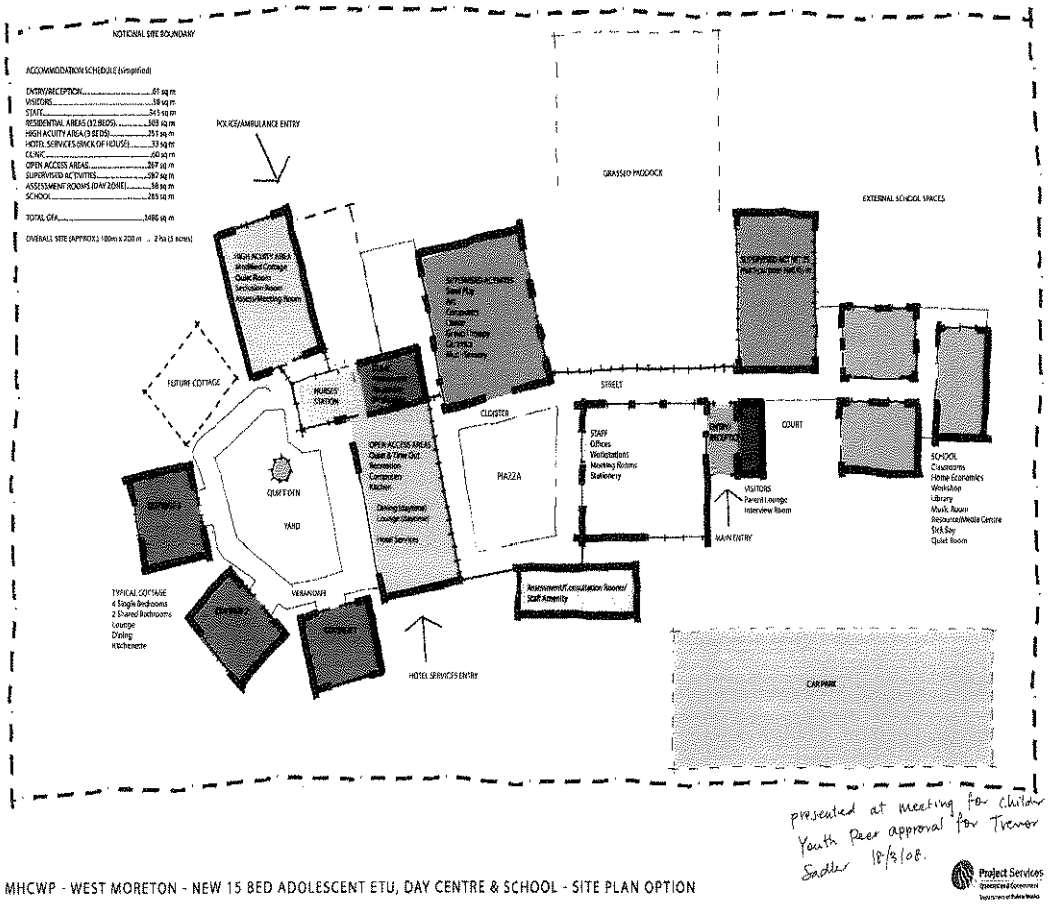
Co-location Options

Examination of the potential advantages of co-locating the service near the Brisbane Youth Detention Centre at Wacol, Child and Youth Forensic Outreach Service (CYFOS), Mental Health Alcohol Tobacco and Other Drugs Service (MHATODS).

> *....given the extremely small numbers of referrals, the differing service development directions, the longstanding plans already in place for the new and expanded MHATODS facilities within the Brisbane Youth Detention Centre and CYFOS' ongoing community outreach, the combined Child and Youth Forensic Services can see no tangible benefit in co-location with the Barrett Adolescent Centre, based on service data and service profiles. The siting of the BAC is not reliant on co-location with Forensic Services.* (Child and Youth Forensic Services: 2008)

Co-location opportunities at Redland include the existing Adult Inpatient Unit and The Child and Youth Community Team. There is also a possibility of creating greater inpatient capacity for young people on the site in an upgrade of the existing mental health facilities planned for the second half of The Plan.

One of the advantages of the Redland site is collocation with child and youth mental health services, while co-location with forensic services is not considered essential.



MHCWP - WEST MORETON - NEW 15 BED ADOLESCENT ETU, DAY CENTRE & SCHOOL - SITE PLAN OPTION

Time and Cost Implications of staged development and potential for future expansion

Further consideration of the cost and time implications should a staged redevelopment at the existing site be pursued and impact the potential for future expansion.

Further consideration was given to the strengths and weaknesses of the two sites from a construction program perspective. Among the benefits of constructing a replacement unit at the Redland site is the opportunity to reduce construction time. Delivering a new, purpose built facility is a priority, particularly given the condition of the existing building. Project Services have not made a comparison of construction costs between staged construction at the existing site and green field development at Redland.

Project Services further advised that the provisional allocation of area on the Redland site is the only option that could accommodate the proposed design concept and future expansion to include 20 beds.

The advantages associated with developing the replacement unit at Redland include a shorter construction period and potential for future expansion.

Conclusion

The initial report of the Site Selection Subgroup identified the contentious nature of the selection of a site for the redevelopment of the Barrett Adolescent Centre.

The process of consultation undertaken to inform this report has confirmed the divergence of opinion about a preferred service location.

On one hand there is support among members of the State-wide Child and Youth Subgroup, Child and Youth Design Reference Group and carers to redevelop the service at Redland. These stakeholders argue it is more appropriate to locate a purpose built state-wide facility for vulnerable adolescents at a site with mainstream mental health and clinical services than one with a growing forensic mental health population.

However, most existing staff, consumers and some carers do not share this view. Those who oppose relocation are sceptical about the risks associated with co-location with the forensic inpatient service. They are also concerned about the impact of relocation on the existing workforce, local partnerships, accessibility of the service and possible risks associated with the surrounding environment at Redland.

Despite this opposition, the rationale for relocating the service is valid.

While the relocation of the service constitutes a significant change involving considerable challenges, these do not appear to be insurmountable.

Therefore, this report recommends that the Adolescent Extended Treatment Unit is redeveloped at the preferred site at Redland.

Queensland Government
Queensland Health

MEMORANDUM

To: Dr David Theile, CEO, Metro South Health Service District

Ms Pam Lane, Clinical CEO, Darling Downs-West Moreton Health Service District

Copies to: Dr David Crompton, A/Chair Metro South Health Service District

Ms Monica O'Neil, A/ Director Mental Health Services, West Moreton- South Burnett Health Service

From: Dr Aaron Groves, Senior Director, Mental Health Branch **Contact No:** **Fax No:**

Subject: Adolescent Extended Treatment- Site Selection

File Ref: Ref Number

ACTIONS:

- It is recommended that the District CEOs consider the findings of the consultation included in the attached report.
- It is further recommended that the District CEOs provide endorsement of and approval to proceed with the redevelopment of the Barrett Adolescent Centre at the site identified adjacent to Redland Hospital.

BACKGROUND:

- Replacement of the BAC is one of 17 capital works projects associated with the *Queensland Plan for Mental Health 2007-17*, and has been funded as part of the 2007-08 State Budget.
- An initial working group was formed comprising staff members involved in the existing BAC and Project Services architects to consider the redevelopment of the unit and provide advice on the service model and design specification.
- Making a determination about a preferred location for the unit is contentious and likely to be subject to public scrutiny.
- A previous attempt to close the unit in the late 1990s was strongly resisted by staff, consumers and carers.
- Redevelopment of the unit at an alternate site should not be resisted as strongly as closure, but may still attract adverse comment.
- Redevelopment on the existing site is problematic for a number of reasons outlined in the site options paper, primarily its collocation with forensic services for mentally ill offenders.

- The "Site Evaluation Subgroup" was convened on the advice of the previous Area General Managers to evaluate site options identified by Area Health Services.
- The consensus of the Site Evaluation Subgroup was that a vacant site adjacent to Redland Hospital constitutes the most appropriate option for the redevelopment of the unit.
- The Director of Capital Works has provided in principal support for this proposal.
- With the approval of the District CEOs of the Metro South and Darling Downs West Moreton Health Service Districts, further consultation with the sector and key stakeholders was undertaken to support a final decision.
- The consultation confirmed considerable support for redeveloping the service at the site at Redland among members of the state wide child and youth subgroup; child and youth design reference group and some carers.
- Industrial bodies included in the consultation have sought assurance that if the service was relocated staff would be supported.
- Existing consumers and some carers expressed their opposition to the relocation of the service. However, current consumers are unlikely to be personally affected by the redevelopment due to the timeframe of the project. Nevertheless they with staff have developed a petition against its relocation.
- Existing staff involved in the consultation indicated their opposition to the relocation of the service. However, some staff, including some senior clinicians, have indicated their preparedness to re-establishing the service at Redland.
- Despite this opposition, the rationale for relocating the service is sound.
- Following endorsement of the preferred option for the redevelopment of the service, a local user group will be formed to manage the project.

Dr Aaron Groves
Senior Director, Mental Health Branch
1/04/09

EXHIBIT 43

MSS.900.0002.0205

Fwd: Re: Adolescent Extended Treatment- Site Selection

From: David Crompton

To: Ed_mhsmetrosouth

Date: Mon, 11 May 2009 18:22:38 +1000

Attachments: 030409 BAC Site Selection Memo.pdf (113.28 kB); BAC Consultation Report March 2009.pdf (2.36 MB)

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for filin

A/Professor David Crompton OAM
MBBS Grad Dip Soc Sci [Psych]
FRANZCP FAChAM
Executive Director Mental Health Metro South Health Service District

g
>>> MD05-PrincessAlexandra-HSD 8/05/2009 5:03 pm >>>
Good afternoon,

Please be advised that Dr Theile, District CEO, Metro South has considered the content of the attached documents. The findings of the consultation have been noted and Dr Theile would like to provide his endorsement to proceed with the redevelopment of the Barrett Adolescent Centre at the site identified adjacent to the Redland Hospital.

Regards, Heather

District Executive Services, Metro South
Level 3, Building 15 | Princess Alexandra Hospital | Ipswich Road | Woolloongabba Q 4102

Manager Executive Services: *Heather Tyrrell*

Senior Executive Support Officer to District Chief Executive Officer: *Marissa Tilby*

Correspondence Officer: *Frank Murphy*

>>> Paul Clare 03/04/2009 10:22 >>>
Hello,
Please find Memorandum and Summary of Consultation on Site Selection for the Adolescent Extended Treatment Unit attached.
Regards,

Paul Clare

EXHIBIT 43

Principal Project Officer
Mental Health Plan Implementation Team
Mental Health Branch
Office of the Chief Health Officer
Queensland Health

E:
T:

GPO Box 48
Brisbane Q. 4001

(2)

Queensland Government
Queensland Health

MEMORANDUM

To: Dr David Theile, District CEO, Metro South

Ms Pam Lane, District CEO, Darling Downs-West Moreton Health Service District

Copies to: Ms Monica O'Neill, A/ Director of Mental Health Services, West Moreton-South Burnett Health Service

Dr David Crompton, Executive Director Mental Health, Metro South Health Service District

From: Ms Cheryl Furner, A/ Senior Director, Mental Health Branch **Contact No:** [redacted] **Fax No:**

Subject: Site Selection Adolescent Extended Treatment Unit

File Ref:

Thank you for your advice endorsing the recommendation of the Site Selection Subgroup to redevelop the Adolescent Extended Treatment Unit at a site adjacent to Redland Hospital.

The Mental Health Capital Works Working Group accepts this advice.

A user group needs to be established as a matter of priority to progress this project. The group should include mental health staff from Metro South and the existing service and report to the Executive Director Mental Health, Metro South Health Service District.

I support the ongoing work on this important project.

[redacted]

Ms Cheryl Furner
A/Senior Director, Mental Health Branch
19/05/2009

EXHIBIT 43 MSS.900.0002.0208

Fwd: MOSD for Adolescent Extended Treatment and Rehabilitation Centre

From: Ed_mhsmetrosouth

To: "Claughton, Miranda

Date: Tue, 16 Mar 2010 10:53:34 +1100

Attachments: OBSERVATIONS OF ADOLESCENTS WITH SEVERE AND COMPLEX MENTA ILLNESS.doc (75.26 kB); REFERRAL SOURCESTO THE AITRC.doc (27.14 kB); Covering Letter to D.Crompton.doc (225.28 kB); AETRC Draft MOSD 4.3.10.doc (258.56 kB)

>>> David Crompton 8/03/2010 6:47 pm >>>

Can we do a letter to committee members to thank them.
Davi

A/Professor David Crompton OAM
MBBS Grad Dip Soc Sci [Psych]
FRANZCP FAChAM
Executive Director Mental Health Metro South Health Service District
Telephone
d
>>> Judi Krause 5/03/2010 8:33 am >>>
Hi David
please find enclosed the modified draft MOSD for Adolescent Extended Treatment and Rehabilitation Centre. I have enclosed a covering letter to add context to the MOSD changes. I have also enclosed some information Trevor Sadler sent to the group whilst overseas.

I had taken hard copies of this information with me yesterday to the Facility Project Team Meeting at Redlands as I had anticipated that you and Shirley would be there and that we could discuss this further.

The facility project team were keen to hear about the changes to the MOSD in relation to the building design. I mentioned some of the proposed changes but stated that it would be hard to comment on design implications without knowing firstly what current design has been confirmed, now the site has been chosen (most of the CYMHS group were unsure of the status of the current design) and secondly if the MOSD changes would be endorsed and when/how this would occur. We were unclear what the process would be now the CYMHS group have forwarded the recommendations to you.

Katie Eckersley suggested that before decisions could be made about design changes further discussion would need to occur to address the abovementioned issues. This will be reflected in the minutes of the meeting and I am sure Katie will be in touch with you in relation to this.

I would envisage that the next step is for myself and Brett McDermott (as representatives of the broader group) to meet with you to discuss the draft MOSD and further discuss the design and operational implications.

Please do not hesitate to contact me (or any of our working group members) if you require further clarity in relation to any of the enclosed information.
Kind Regards
Judi

EXHIBIT 43

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

{ SEQ CHAPTER \h \r 1}OBSERVATIONS ABOUT ADOLESCENTS WITH SEVERE AND COMPLEX MENTAL ILLNESS: DIFFICULTIES AND PROCESSES OF CHANGE

Presumably all adolescents admitted to the AITRC will have had an extensive range of evidenced based treatments in the 12 - 36 months they have been in CYMH services prior to admission. Questions on the MOSD review panel's minds will naturally be:

- why haven't they responded to date to evidenced based treatments?
- what does an AITRC offer to bring about change? (Do they have access to other evidenced based therapies that other CYMHS don't?)
- what do they observe about the processes of change?

The previous paper outlined the lack of guidance from research about interventions for adolescents with mental illness at the most severe and complex end of the spectrum. This necessitates going back to first scientific principles - good observations about individual phenomena and behaviours, observing trends, developing hypotheses and testing hypotheses.

This first section outlines my observations from the last 23 years. (I don't have any strong preferences for treatment approaches - we draw from a number of evidenced based therapies. I don't think these observations are selective to fit into any theoretical frameworks. In fact some were confusing at first, not fitting in with dominant theories.) In some disorders, we are simply continuing to make observations, in others observing trends and in some making hypotheses. That's the state of our science to date.

The facts

- that adolescents have disorders which persist in spite of evidenced base treatments,
- we find change only after multiple interventions, often with several interventions in a week or even in a day and
- change only occurs over time

suggest that the relationships between interventions are likely to be complex to describe. Any notion of further, easily described interventions for a particular condition is naive.

Observations of lack of responses to previous evidenced based treatments and on processes of change

- As described in the previous paper, most adolescents with any disorder have profound difficulties in recognising, understanding, differentiating and expressing emotions. We observe that progress in therapy commences when this skill develops.
- The few who have an adequate capacity for emotional understanding gave invariably been in a chaotic environment which has never validated legitimate emotions.
- Many adolescents with severe anxiety have great difficulty in acknowledging their anxiety.
- All adolescents with school refusal, severe social anxiety and have a specific learning difficulty have major difficulties acknowledging their learning difficult, because it is another area in which they can be judged. They can be strongly avoidant of some or all school work for months. Prior to admission, this has been a significant factor perpetuating their school refusal.
- Cognitive based approaches to manage anxiety cannot proceed until they can acknowledge their anxiety.
- Non-verbal interventions (in our case art, sand play and adventure therapy) often

facilitate emotional expression.

$ We observe that a treatment only approach for a disorder does not necessarily reult in decreased impairment.

$ We observe that impaired functioning in development tasks limits treatment interventions.

$ We observe that as adolescents with anorexia face a challenge in a developmental task or in expressing some emotion their eating behaviours become more resistant to change at that point. Conversely, mastering a developmental challenge lessens the rigidity in their eating disordered behaviours. Consequently I conclude that developmental difficulties and difficulties expressing particular emotions are expressed in eating disordered behaviours and this perpetuate the disorder.

$ Conversely we observe that progressing in a development task (the rehabilitation component) in which they had difficulty can facilitate progress in treatment again. This differs from physical medicine (e.g. a fractured hip) where treatment (surgical stabilisation) is followed by rehabilitation.

$ We do not observe a one to one correlation between disorder or behaviour and therapy. We observe that a prescribed approach for a particular disorder or behaviour is not supported by the literature nor is it reflected in our experience. What is necessary for adolescents with persistent disorder is a thorough assessment of an individual to map out potential therapeutic interventions, but being flexible to modify as various issues for that adolescent arise. This is entirely consistent with the literature.

$ For example, three adolescents present with school refusal. One has poor expressive language, severe social anxiety, reasonable parents and good cognitive and problem solving skills. He is impaired in a number of areas including peer relationships, competencies for independence and restricted leisure skills. Therapy for him is largely an integration of treatment for the social anxiety, family therapy and rehabilitation of the various impairments. The second has an avoidant personality disorder, some learning difficulties in an area in which she would like to establish a career, strengths in another area and an enmeshed relationship with a mother who utilises a lot of abnormal illness behaviour. The girl stays home to care for her mother (with whom she feels angry and trapped) as much as she does for her extreme social anxiety. She requires a lot of remedial educational work in the area of her difficulty, family therapy and the opportunity to individually work through some of her conflicts about her mother, as well as exposure work and cognitive therapy for her social anxiety. The parent adolescent interaction is well described in the literature. The third, as well as severe social anxiety, has gender identity disturbance, Asperger's syndrome, severe learning difficulty, an absent mother and a very uninvolved father. There has been trauma in the past. Individual therapy is largely guided by issues the adolescent wishes to discuss. The gender identity disturbance is modified by interactions with peers and staff, addressing some developmental tasks, but not by individual therapy. As this resolves, her social anxiety lessens. She utilises individual work more for grief issues about her absent mother, the impact of trauma and how to implement strategies she hears about in the DBT group. The school refusal continues because she has been defensive about the learning disorder for so long, that she avoids work. It is of a nature that will impair most of the vocational pursuits she is interested in. She will require further exposure to work opportunities where this will not be as critical.

$ Anyone familiar with the literature on self harm will be aware that there is neither a consensus approach to treatment or even assessment or how to conceptualise the

range of presentations in adolescents with self harm.

For the purpose of explaining the next point

- Psychologists (in particular) are trained in a range of cognitive therapies - motivational interviewing, acceptance-commitment therapy, DBT, stress inoculation as well as more generic CBT approaches. They and other staff have attended specialised workshops on CBT-E etc.
- Many cognitive therapies are what I would term "linear" or therapist directed. That is, therapy progresses in some sort of line - they have a beginning and work through a series of steps to examine and modify cognitions. The more manualised versions are highly "linear" (therapist directed), whereas some are "modifiably linear" therapist directed but modified in collaboration with the adolescent.
- Psychologists, occupational therapists, nursing staff and medical staff have basic to advanced training in behaviour therapies. These are primarily utilised in behaviour modification and graded in vivo exposure. Good behaviour therapy requires an individualised approach, but along a proposed hierarchy - this I would term "individualised linear" therapy - that is the therapist makes an individual assessment, directs the course of the action, but continually individualises the approach according to the adolescent repsonse.
- Currently we do not have anyone formally trained in psychodynamic therapy. There are many insights from these schools of therapy which are invaluable in therapeutic work with adolescents at the severe end of the spectrum, and in particular, those who have been abused. These insights include the profound interactions between parent and adolescent and adolescent's conflicts about their parenting; issues of dependency, individuation etc.; concepts of defences against various emotions; and emotional interactions between therapists (including not only the prime individual therapist, but on a long term inpatient unit a number of staff significant ot the adolescent) and the adolescent. CBT based therapies often do not acknowledge these issues (I am not sure about CAT). I would term psychodyamic therapy "non-linear" or "adolescent directed".
- Family therapy has provided insights particularly in how systems interact. While we have a social worker trained in family therapy, and utilise it where possible, I do not attempt to clssify it in terms of its linearity.

Back to observations

- We observe that therapeutic progress is rarely linear i.e., that therapy for a particular disorder begins and progresses until recovery. It begins, progresses to a certain stage (with respect to individual therapy) and then there is a moratorium on that issue. Often this will not progress further until they have developed mastery in an area of impairment, or addressed and issue in family therapy and/or individual therapy will need to explore another area of concern for the adolescent.
- In this way treatment at the AITRC is far more likely to be non-linear akin to psychodynamic treatments, even with a primary individual therapy utilising a cognitve approach. I observe that therapists who are highly structured without being sensitive to the issues important to an adolescent and being flexible in their approach rarely facilitate change. On the other hand, adolescents who have difficulties with verbal (and in particular emotional) expression find non-directive psychotherapies difficult. They prefer some structure, but one that is very sensitive to them, and which facilitates expression.

- Similar co-morbidities often interact differently in different adolescents. Strong co-morbidities between anorexia nervosa and social anxiety disorder were previously noted. Add to this the perfectionism found in a number of adolescents with anorexia and what Chris Fairbairn called "core low self esteem". We observe that these interact in different ways in different adolescents to maintain each other. We observe that parallel therapy aimed at each (the eating disorder, the social anxiety disorder, the core low self esteem and the perfectionism) is overwhelming to an adolescent. We do not observe that therapy proceeds in a sequential order - first treat one disorder, then another etc. Therapy progresses by treating one to a certain stage, then it becomes apparent another must be addressed for further progress to be made. Therapy on the first disorder may resume, or it may go to a third. There is no order of sequence. The therapist and team must be flexible to provide adolescent centred therapy. The interactions of components in therapy are very poorly described in the literature. Descriptions of evidenced based treatments for co-morbid conditions are almost absent.
- Behavioural interventions are offered at various times and in various situations. One example is a community access group. This may be a simple outing to the movies, catching public transport. An adolescent with social anxiety may have difficulties asking for tickets, food etc, sitting with people, eating in front of other people. In effect this is a form of graded exposure for various aspects of their social anxiety. Some may do the entire activity simply to be part of the group, some may be able to perform only some of the activities, which is part of grading their exposure, while others may need some preparatory exercises. Simply being out with others and not doing any of these activities will the most basic elements of the exposure. Thus a group activity, with careful assessment and monitoring of the individuals within the group provides a recognised therapeutic intervention for anxiety. This occurs throughout treatment - it is not specific to any stage. As well as addressing anxiety, it may facilitate a number of developmental tasks (e.g. competencies for independence, acquiring different leisure skills). This may then facilitate individual work in another area. There are multiple interventions similar to this.
- A behavioural intervention at one time may have a different impact on an adolescent at a later stage, when they are cognitively and emotionally able to assimilate more. Thus groups may be repeated at later stages.
- A number of non-verbal interventions (e.g. music, art, sand play) are used in CYMHS. The evidence base for these is not strong, but clinicians find them useful. I have noted our observations about their utility in facilitating emotional expression. We have observed that adolescents do not utilise them as the sole means of expression (i.e., the whole of therapy is not art or sand play or whatever). Rather verbal therapy can be enhanced when they have the capacity to utilise art or sand play for a period either as part of therapy with the prime therapist, or with a specialist in the area. I regard their role as facilitative therapies. Research methodology into interventions which facilitate other therapies is underdeveloped.
- Adventure therapy (problem solving, high ropes, etc) is another form of non-verbal therapy. We note a variety of effects. For some it facilitates problem solving to be able to be utilised in cognitive therapy. For others who do not recognise anxiety, it is a tangible form which then helps them to recognise it in others. A third group learn specific strategies for anxiety reduction in these tangible activities which they can then apply to other, less tangible areas. Adolescents who have been abused from the avoidant disorder of childhood group find the sensory experiences facilitate working through abuse. Others dins a sense of mastery in some activities which decreases

anxiety in other areas. This is a generic activity which is non-specifically applied (as long as the adolescent has the basic competencies) whic has a number of different effects. This can be measured on A-B-A methodology for individuals, but may be lost on a group effect. Again this is facilitative rather than a primary intervention.

$ Adolescents who have been multiply abused have difficulties with DBT. They do not like relaxation, nor sensory awareness. They are prone to somaesthetic hallucinations. Their bodies have experienced horrific sensory overload. This is consistent with some of the research from van der Kelk and others. They regain somatic mastery through a number of physically based interventions - sports and exercise, drumming, high ropes, multi-sensory room etc.

$ Impairments are addressed through exposure (where anxiety is the major issues), a range of opportunities (for those from impoverished environments) and education (e.g. cooking groups, learner's licence preparation).

$ We observe some adolescents simply wish to continue formal schooling, and have the capacity to do so. For others, simply being in the routine of initially sitting in a classroom and doing some work provokes anxiety. The school needs to be involved in graded exposure of school work.

$ Relationships with staff obviously have an impact on an adolescent when they are in the unit for months. Adolescents recognise staff as individuals. If they have experienced "good enough" parenting, they will regard staff hopefully as decent adults who are there to help them work through their issues. Adolescents who have been abandoned, abused or neglected by their parents after several months of observing and interacting with staff begin to reflect on their own parents, and work through issues. This is an important in helping them work through their trauma issues.

BAC Interventions

I observe that the particular features of the BAC program which add on to what adolescents may have received in community or acute adolescent inpatient CYMHS are:

$ a range of both specific, individualised and generic interventions
$ interventions which occur throughout the day
$ interventions which facilitate primary interventions
$ interventions which help to generalise and reinforce primary interventions
$ interventions which address impairment
$ interventions which help to generalise the impacts of hospitalisation into integration into the community.

These interventions are more wide-ranging and more intensive than in a community CYMHS These interventions are more treatment orientated that in an acute adolescent inpatient CYMHS (particularly with respect to treatments that require longer terms of intervention. These interventions are more independent of family structure and effects than either a community or day patient CYMHS. This is important for those adolescents who cannot return to their families.

1. Assessments

A comprehensive assessment, while the initial phase continues throughout the admission. Assessments are from multiple sources:

$ obtaining as much collatarel information that is avialable including information from

CYMHS, school reports, Child Safety (where relevant).

- $ formal assessments e.g. psychological assessments of both general and disorder specific factors, language and problem solving assessments, occupational therapy assessments of both living skills and sensorimotor skills, educational assessments
- $ assessments of various aspects of function within the unit e.g. interactions with peers, self care skills, mood changes etc. These usually occur over several weeks to understand what is trait, and what was due to the impacts of admission.

2. Specific treatments for disorders

2.1 School refusal

I have noted previously that there is not a one to one correspondence between treatment and this behaviour, even if a specific disorder, e.g. social anxiety disorder is present. This is in part due to the extent of the disorder, the adolescent's degree of defensiveness about or acknowledgement of it, the interaction of the disorder with other disorders e.g. Asperger's or other anxiety disorders, whether a learning disorder is present, the interaction of the disorder with parenting factors, and whether the disorder was an extension of a long term pattern of behavioural inhibition (likely to evolve into avoidant personality disorder) or whether there was a fairly clear onset in late puberty or early adolescence.

Given those caveats the treatment for this behaviour or of social anxiety disorder (which predominates in school refusal) are:

- $ behavioural interventions for graded exposure in various areas of anxiety
- $ cognitive therapies for anxiety
- $ general pscyhotherapy for related emotional factors
- $ educational involvement and remediation where possible and necessary
- $ graded exposure to community involvement (e.g. outside schools)
- $ family therapy both with respect to roles, communication, practical issues on leave as well as tasks with re-integration to school.

2.2 Anorexia nervosa

Typically the management of anorexia nervosa has several components:

- $ Weight restoration - this is preferably through a behavioural program which is as least restrictive as possible. (This is not the strict operant behavioural program for the 70's and 80's, but seeks to implement the principles without the punitive aspects. I was interested that an almost identical approach is used at the Pine lodge unit in Chester - a leading disorder for eating disorders in the UK.) Naso-gastric re-feeding is only used as an extreme resort. (Again similar to Pine Lodge.) This program is devised in conjunction with the psychologist, the dietitian and the care co-ordinator and myself. As with all behavioural programs the effects are continually monitored.
- $ Nutritional stabilisation and normalising eating. This is an individual collaboration between the dietitian and the adolescent. This includes three meals and three snscks a day, with liquid supplements only if necessary to reduce anxiety.
- $ Nursing staff with experience in anorexia provide epert supervision at meal times.
- $ Cognitive therapies including motivational change for eating disorders, general therapy at examing eating cognitions, acceptance commitment therapy as well as therapy for reducing specific anxiety, therapy for exploring issues with parents (many of the parents have significant pscyhopathology, and are difficult to engage)

- Behavioural interventions to provide graded exposure for various aspects of social anxiety. This includes a food challenges group which helps adolescents with anorexia and social phobia begin to eat out in public.
- Psychotherapy to facilitate exploration of various issues of trauma where this is a significant factor.
- Family therapy is rarely of the Maudsley type because adolescents tend to be older, and other aspects of the program encourage the adolescent to actively take on the responsibility of managing their own eating. The aim of the family therapy is to explore general family communication, roles etc. Our social worker has a background in a number of schools of family therapy, and utilises whatever is the most applicable for a family.

The minutes of the first MOSD recorded a comment that we did not have the experience to treat anorexia. This statement puzzled me as to what evidence this is based on.

We certainly do not have experience in treating anorexia in its most complicated phases. I have treated adolescents with severe and persistent anorexia for the past 23 years. Two dietitians over the past five years provide a minimum of a day a week time to adolescents with anorexia. A psychologist of eight years experience at the severe end provides most of the individual treatment. We can undoubtedly aquire further skills, but this is a very solid basis on which to build further expertise.

In the UK, a service for those with severe and persistent anorexia is provided only in the private sector. Units such as Pine Lodge at Chester refer some of the 12% of their adolescents with persistent anorexia to them. I will visit some of these specilaist units for adolescents with the most persistent disorders over the next fortnight. Certainly, from what I saw at Pine Lodge, there is strong similarity in the specific elements of treatment for eating disorders. I believe it is likely the non-specific elements or our program contribute to significant improvement in at least 50% of this difficult group.

2.3 Symptoms and behaviours associated with abuse

- Self harm is reduced through a combination of behavioural programs to reduce at self harm, individual therapy to understand causes of distress, recognise early warning signs and utilise alternate coping mechanisms. Adolescents seldom utilise DBT principles as first line interventions. They often appreciate and begin to assimilate them after a period of psychotherapy. This is in line with what my UK colleagues observe.
- General psychotherapy facilitates exploration of parenting issues; interactions with peers both in the present on the unit and peer interactions in the past; emotional responses and boundaries in the current environment (very important in adolescents with the avoidant disorder of childhood who have internalised emotions). Often this can be facilitated by non-verbal therapies at various points.
- Specific management for PTSD symptoms including dissociation, exploration of hallucinoses, flashbacks nightmares etc. Strong therapeutic relationships with a number of staff and certainty of safety and capacity for staff to contain distressing emotions are important preludes to this process. Nursing staff with skills in this area are critical to this process as these symptoms are more prevalent in the evening.
- EMDR is available but seldom utilised by adolescents
- Where an adolescent will accept stress innoculation therapy is offered prior to specific

trauma exposure therapy.

$ Trauma exposure therapy occurs towards the end of treatment. The process has been outlined before to the adolescent. The adolescent requests therapy before it is commenced. This is sometimes after a period after discharge, and they will return to the unit for the therapy for a matter of weeks because it is so emotionally difficult.

Individual therapy for specific disorders typically occurs once or twice a week, although in the phase of exposure to abuse, it may be up to three times a week in the most acute phase.

3. "Generic" elements

I term these as "generic" because they are interventions for a number of adolescents irrespective of disorder. They are not applied generically, but individualised to an adolescent or for a group of adolescents.

$ education program. This program is very flexible, providing for continuing education (primarily english, maths, science, history, geography, cimputer) for adolescents who continue to have links with their own schools; remedial education; graded exposure to doing schoolwork for adolescents who have anxious avoidance of school; non-academic subjects physical education, music, home economics, TAFE modules; guidance officer support with subjects, educational and vocational options for school return and finally are integral to the process of integration into school.

$ Groups may be tailored in their content for the whole group of adolescents who are not selacted for the group. The DBT group is an example. We find that adolescents of this severity and complexity often lack the cognitive and emotional awareness to benefit from a formal DBT approach. It has been modified and adapted, and the skills elements delivered in a group format over about 32 sessions. All adolescents are expected to attend, although their involvement and utilisation of the skills is highly variable some understand principles after six months. Adolescents who have experienced abuse find issues of awareness of themselves difficult because an important coping mechanism has been to block out awareness of sensations. They benefit the least until they are ready to work through some of their abuse issues. (The relationship issue which I believe is a significant component of DBT is not an issue in a long term unit.) Staff are made aware of the particular focus of the group for a week, and the skills generalised where possible in day to day settings throughout the week.

$ Other groups are tailored for a specific sub-group with particular needs e.g. the community access group. Adolescents are selected because of lack in a number of competencies in accessing community events for adolescent appropriate activities. Their individual difficulties are assessed. The group becomes a group format for desensitisation, although activities for each adolescent are individualised for that activity.

$ Some groups are verbal - e.g. a "boys to men" group for adolescents who have had poor experiences of fathering to help understand some of the issues they are facing about growing up to be a man, sexuality etc.

$ Other groups have high activity components e.g. the various components of the adventure therapy program. Skills for this were described earlier. The principles learned are enunciated in debriefing sessions, and then generalised in the day to day program.

$ Physical activities and interventions are an important part of the program. Some of

these are active exercise for building health and fitness into daily routines or learning new skills or participating in a new range of activities to increase their range of potential leisure activities. These are under the direction of both occupational therapists (who conduct physical skills assessments in consultation with a physiotherapist) and a part time phyical education teacher. Some of these are passive e.g the multi-sensory room for which there are multiple uses e.g. self control in reducing anger, practical supplementation in the early stages of relaxation techniques in the highly anxious adolescent to help them grasp the principles to regaining somatic sensory control in the abused adolescent. These are often delivered in association with nursing staff under the supervision of an occupational therapist.

- $ General psychotherapy differs from disorder specific psychotherapy in that it deals more with emotions and behaviours in the day to day settings, relationships with parents and other issues which may arise. It may be exploratory, supportive or general cognitive. It is characteristic of psychotherapy with adolescents with severe and complex disorders that disorder specific psychotherapy will proceed for a time, and then interpersonal, family or other issues will need to be explored for a time to allow the disorder specific psychotherapy to occur.
- $ Behavioural analyses were mentioned in the previous paper. This is obviously relevant to analyses of disturbed behaviour - self harm, aggression, absconding, but also occurs with other behaviours e.g. extreme passivity, extreme compliance etc. Good analysis of behaviours is critical to understanding a number of issues for the adolescents with poor verbal ability in terms of emotions they have difficulty expressing, care eliciting behaviours vs behaviours exploring care issues, whether the illness serves a function for the adolescent etc. It is important to analyse the context of both single behaviours, and patterns of behaviour.
- $ Behaviour modification beyond modification of disorder specific behavoirus and anxiety reduction often facilitates insights into necessities to adopt different strategies for both emotional expression and interpersonal functioning.
- $ Finally the day to day program of life on the ward is important. For example, there are constant opportunities for peer interactions. Some of it will be positive, some negative. Reflections on the day to day interactions with peers are important to enable the socially anxious adolescent to develop and practice skills. (The evidence is that with support this can be generalised into their contact with peers in community settings.) Adolescents who internalise blame for interpersonal relationships with significant people can have alternate emotions validated by clinicians who have observed a negative interaction occurring to the adolescent. This is the most powerful intervention I know of in altering their schemas about attributions for events. Another example is the necessity to practice self care and organisational skills. This is not an issue for some, but an important intervention for change for others. There are multiple such activities in day to day routine which support change in various areas.

These last three interventions are built into the day to day program.

4. Integration of assessments and interventions into a coherent framework.

We observe that therapeutic work with adolescents necessitates:

- $ synthesising and integrating information from the variety of assessments with both disorder specific and generic interventions
- $ integrating the discipline specific and generic inputs of a multidisciplinary team into a cohesive team framework.

- having a conceptual framework for both treatment and rehabilitation.
- observing moratoriums in one area of progress while therapeutic or rehabilitative work in another area continues
- it is useful to work utilising the adolescent's strengths as well as working on their deficits.
- although there is no clear evidenced based treatments for this group, it is vital that throughout there is evidenced based practice to guide interventions.

This requires development of a cohesive framework in which:

- interventions, both therapeutic and rehabilitative can be understood, planned for an implemented
- difficulties in progress can be examined and alternate strategies developed
- absolute limitations in function which are not likely to respond to further interventions can be accepted and alternate strategies planned.
- discharge can be be planned.

Over the years we have developed an integrated framework which utilises a component familiar to all CYMHS clinicians with two components which are familiar to some clinicians, but not to all. The first is probably the least recognised - an evidenced based knowledge of adolescent development. The second is a knowledge of parenting functions - this is more familiar to many clinicians, although many myths abound.

The first component familiar to all CYMHS clinicians.

- The DSM-IV-R or ICD-10 diagnoses. The former is not highly reliable in adolescents. The latter is perhaps too non-specific for use. As outlined above, one to one correspondence and a particular therapy is problematic.
- Behaviours consequent on this diagnosis, e.g. anorexia is often accompanied by food restriction, excess solitary exercise, sometimes purging, soemtimes laxative use, sometimes preoccupation with food etc. All diagnoses are associated with a particular range of behaviours. These behaviours have an impact on the adolescent's development and family or carers. It is important to catalogue behaviours to enable intensive interventions to be performed, and programs to be individualised. (For example, there is no point in a program to restrict excessive exercise in an adolescent for whom this is not an issue.)
- Understanding the family and school environments through which they have passed including the functioning of the adolescent as a child over the years, and the impact of the environment on the adolescent. Basic to all child and adolescent mental health.
- Understanding biological factors contributing to the development of the adolescent. These include temperament, levels of impulsivity/attention, sociability, language and learning deficits. These will interact with development, life events and mental illness in a variety of ways which is often ignored by treatment protocols.
- Family therapy is sometimes important, but often parents have abused and colluded in the abuse or abandoned and neglected their adolescent.

The major headings for the second component (developmental tasks of adolescents) are:

- adjust to physical changes (including sexual characteristics)
- negotiate schooling
- negotiate cognitive maturity
- negotiate emotional maturity
- negotiate peer relationships

- negotiate boundaries
- negotiate moral maturity
- develop self care skills
- develop leisure skills
- develop competencies for independence
- negotiate individuation within the family
- develop identity
- develop life schemas
- plan for the future

Within each of these are numerous sub-headings.

The **basis** for these is

- direct observation of various components of adolescent development in clinical and non-clinical populations and from literature on adolescent development from across cultures and centuries
- an extensive search of the literature on adolescent development both from short term cross sectional studies, and also from large longitudinal studies of non-clinical populations of adolescents across several countries including Australia.

There is a fairly substantial base for this. In general, new research validates existing literature rather than changing it substantially.

The **purposes** for this analysis of tasks of adolescent development are

- to provide an evidence-based framework for adolescent development. Mythology about this is not uncommon within CYMHS and outside of it.
- to provide for an analysis of an adolescent's strengths. Unless this is formally documented, strengths may be overlooked. The general literature on rehabilitation emphasises using strengths as a springboard where possible for rehabilitation.
- to provide a framework for analysis of impairments. The purpose of this is to gain an insight into those which may be suitable for rehabilitation and those which cannot be changed to enable either acceptance of the issue or some way of ameliorating its effects. Currently there is no framework for rehabilitation in adolescent mental health. The seems a reasonable start to develop a model for rehabilitation, because it is built on substantial evidence of the impact of these tasks.
- to develop a framework for rehabilitation.

The major headings of the third component (the tasks of parenting) are:

- commitment to the adolescent
- bonding style
- adequacy of nurturance
- meet appropriate dependency needs
- meet appropriate protection needs
- establishment of boundaries
- capacity to supervise, monitor
- style of correction
- communication of values, schemas
- capacity to contain emotions
- capacity to facilitate transitions
- capacity to understand

The **basis** for these is similar to that for adolescent development:

- $ direct observation of various components of parenting in non-clinical populations and from literature on adolescent development from across cultures and centuries
- $ an extensive search of the literature on parenting both from short term cross sectional studies, and also from large longitudinal studies of non-clinical populations of adolescents across several countries including Australia.

A substantial literature has been reviewed to develop this. Again, as with the tasks of adolescent development, new research on parenting validates existing literature rather than changing it substantially.

The **purposes** for this analysis of tasks of parenting are:

- $ to provide an evidence-based framework for parenting. Mythology about parenting is rife both within CYMHS and outside of it.
- $ to provide for an analysis of an parent function. There have often been substantial family interventions over the years prior to admission. This provides a framework as to what has and has not changed (indeed, may be incapable of change).
- $ to understand the strengths of the family for the adolescent, and what the adolescent may have to accept in the family, including moving outside of home.
- $ to provide a more evidence based understanding of transference behaviours that arise in some adolescents, and minimise speculation.

These three components form the basis for a problem solving matrix in which to analyse interventions, rehabilitation, treatment, moratoriums, challenges, and the path towards discharge.

Research and Training

Although BAC has had clinicians with a strong interest and track record in research, clinical demands have rarely afforded opportunities for research to be developed. Although we are currently in an institution with a strong research component, research collaborations have not resulted in spite of our strong approaches. Research requires a strong infrastructure which we do not currently have.

There are multiple issues for training from this document. A psychologist, for instance, would need to be trained in multiple approaches to anorexia, not just one framework. The same is true for other training. Numerous specific areas can be identified for nursing staff. I do not have time to analyse this, in order to get it off in time.

{ SEQ CHAPTER \h \r 1}**REFERRAL SOURCES**

The decision to take referrals only from CYMHS raise grave concerns on a number of areas.

- The AITRC would be the only Level 6 child and adolescent unit to admit on the basis of referral source as well as severity of the illness and need for specialised treatment.
- Some Queensland adolescents would be ineligible for the most intensive levels of intervention of simply on the basis that they chose private treatment rather than public treatment. Currently all the service is available to all Queensland adolescents who require it.
- Some families we have seen at the Mater initially go to a CYMHS, and then opt for private treatment, steadfastly refusing to return to the original CYMHS. They are thus ineligible for the service because fo this decision.
- Under current Medicare arrangements, private child and adolescent psychiatrists have the option of working closely with other professionals - psychologists, social workers, dietitians, nurses. I know some have taken up this option, essentially replicates the function of a multidisciiplinary team. Yet they would not be eligible to refer to a service.
- If a competent child psychiatrist feels that admission to the AITRC is indicated, they would have no option bit to refer to the local CYMHS. There is a fair chance that this will be difficult for the adolescent to establish relationships with a new therapist, and may not add anything in treatment, but simply prolong the time until admission.
- We regularly involve CYMHS clinicians in the management of ongoing management of their adolescents. I observe that many CYMHS clinicians are the sole case manager, with little involvement of other clinicians in the team. This concurs with observations when I have provided cover for community CYMHS. Rather than being true multidisciplinary teams with discipline specific functions and utilising discipline specific strengths, some CYMHS are essentially multiple solo practitioners from a range of disciplines. Multidisciplinary input is largely limited to comments at case reviews, case conference. This comment is often more generic than discipline specific. Yet these solo practitioners have access to the AITRC, whereas a private child psychiatrist does not.
- CYMHS teams operate with considerable differences in levels of expertise and experience. Because clinicians often perform generic roles, some will perform functions outside of that for which their undergraduate training has prepared them. With time their knowledge and experience will develop. A CYMHS team with a significant proportion new graduates, or clinicians new to CYMHS will have the right to refer to the AITRC. A private child and adolescent psychiatrist with at least six years of supervised clinical training does not. They would need to refer to the CYMHS.
- Private child psychiatrists are able to admit to adolescent acute inpatient units

A well functioning multidisciplinary team is undoubtedly the ideal. It may not be the rule. A competent child psychiatrist may make an equally valid referral as a CYMHS clinician in a poorly functioning team.

EXHIBIT 43

MSS.900.0002.0223

Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

(Group changed name from Adolescent Integrated Treatment and Rehabilitation Centre to Adolescent Extended Treatment and Rehabilitation Centre AETRC as this better reflected where the service is positioned in the CYMHS continuum of care).

Model of Service

1. What does the Service intend to achieve?

Mental disorders are the most prevalent illnesses in adolescence and they have the potential to carry the greatest burden of illness into adult life.

The Child and Youth Mental Health Service (CYMHS) Adolescent Extended Treatment and rehabilitation Centre (AETRC) is a statewide service providing specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness/es. The majority of consumers present with severe psychosocial impairment as a result of their mental illness/es, and presentations are often complicated by developmental co-morbidities. Many also experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

The AETRC is part of the Statewide CYMHS continuum of care that includes community based treatment teams, Adolescent Day Programs and Acute Child and Adolescent Inpatient units.

The key functions of the AETRC are to:

- build upon existing comprehensive assessment of the adolescent (obtaining a thorough treatment history from service providers and carers) with a view to assessing the likelihood of therapeutic gains by attending AETRC
- provide individually tailored evidence based treatment interventions to alleviate or treat distressing symptoms and promote recovery
- provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness
- provide a 6 month targeted and phased treatment program that will ultimately assist recovery and reintegration back into the community
- provide day programs that will provide adolescents with skills to reintegrate back into their community

Treatment programs undertaken by the AETRC will include an extensive range of therapeutic interventions and comprehensive activities to assist in the development and recovery of the consumer. The program will follow structured phases incorporating assessment, establishing a therapeutic alliance and developing realistic therapeutic goals, treatment, and assertive discharge planning to facilitate reintegration back to community based treatment.

Programs will include:

- phased treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers

- targeted 6 month treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff
- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care in a day program.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services

Length of Admission:

- admissions will be for a maximum of 6 months
- in some specific cases an admission beyond 6 months may be considered, if clinically indicated
- where the length of stay is proposed to exceed 6 months the case must be presented to the intake panel for review following the initial 6 month admission

Level of Care:

The level of care is determined by:

- providing care in the least restrictive environment appropriate to the adolescent's developmental stage
- acuity of behaviours associated with the mental illness with respect to safety to self and others
- capacity of the adolescent to undertake daily self care activities
- care systems available for transition to the community
- access to AETRC

2. Who is the Service for?

The AETRC is available for Queensland adolescents;

- aged 13 – 17 years
- eligible to attend high school
- with severe and complex mental illness
- who have impaired development secondary to their mental illness
- who have persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including CYMHS community clinics, Evolve, day programs and acute inpatient child and youth mental health services
- who will benefit from a range of clinical interventions
- who may have a range of co-morbidities including mental illness and intellectual impairment

Severe and complex mental illness in adolescents occurs in a number of disorders. Many adolescents present with a complex array of co-morbidities. AETRC typically treats adolescent that can be characterised as outlined below:

1. Adolescents with persistent depression, usually in the context of childhood abuse. These individuals frequently have concomitant symptoms of trauma eg. PTSD, dissociation, recurrent self harm and dissociative hallucinoses.

2. Adolescents diagnosed with a range of disorders associated with prolonged inability to attend school in spite of active community interventions. These disorders include Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder and Oppositional Defiant Disorder. It does not include individuals with truancy secondary to Conduct Disorder.

3. Adolescents diagnosed with complex post traumatic stress disorder. These individuals can present with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour resistant to treatment within other levels of the service system.

4. Adolescents with persistent psychosis who have not responded to community based interventions

5. Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder. Community treatment will have included the input of practitioners with specialist eating disorders experience prior to acceptance at AITRC. Previous hospital admissions for treatment of the eating disorder may have occurred. Any admission to AETRC of an adolescent with an eating disorder will be linked into the Queensland Children's Hospital (QCH) for specialist medical treatment. Adolescents requiring nutritional resuscitation will be referred to QCH. For adolescents over 15 years of age specialist medical treatment may be met by an appropriate adult health facility. (Comment: Depending on clinical governance arrangements yet to be determined and negotiations with QCH in regard to medical management of adolescent mental health clients)

Suitability for admission will be undertaken by an **intake panel** that will consist of:

- the AETRC director
- referring specialist and/or Team Leader
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders

In making a decision the panel will consider the:

- likelihood of the adolescent to experience a positive therapeutic outcome
- potential for treatment at AETRC to assist with developmental progression
- potential adverse impacts on the adolescent of being admitted to the unit (e.g. isolation from existing supports and/or cultural connection; possibility of escalation of self harm behaviour) posed by the adolescent to other inpatients and staff, this includes evidence of inappropriate sexualised behaviour
- potential adverse impacts on other adolescents if they were to be admitted
- possible safety issues

A comprehensive recovery and discharge management plan that includes community reintegration will be in place prior to admission for all adolescents.

Adolescents who reach their 18th birthday during admission will be assessed on a case by case basis by the panel. The panel will consider whether:

- continued admission is likely to produce the greatest clinical outcome in terms of symptom reduction and developmental progression
- admission will pose any risk to the safety of other adolescents in the AITRC

Admission Risks
Some young people may pose considerable risk to others. Admission to AETRC will be decided on an individual case basis by a multidisciplinary review panel.
Admission risks include but are not restricted to:
- substantiated forensic history of offences of a violent or sexual nature
- adolescents with Conduct Disorder

3. What does the Service do?

AETRC will provide a range of evidence based treatments tailored to meet the individual's mental health needs. Interventions will be delivered by appropriately skilled multidisciplinary staff that has access to professional development and clinical supervision.

The key components of AETRC are defined below:

Key Component	Key Elements	Comments
Working with other service providers	• the AETRC will develop and maintain strong partnerships with other components of the CYMHS network	• at an organisational level, this includes participation in the Statewide Child and Youth Mental Health Sub Network
	• shared-care with the referrer and the community CYMHS will be maintained	• in the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AETRC
	• the AETRC panel will develop and maintain partnerships with other relevant health services who interact with adolescents with severe and complex mental illness	• this includes formal agreements with QCH and relevant adult health services to provide medical services for treating medical conditions which may arise e.g. medical management of overdoses; Surgical management of severe lacerations or burns from self injury
Working with other service providers		

Key Component	Key Elements	Comments
		• this may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • this includes but is not limited to The Department of Communities (Child Safety), The Department of Communities (Disability Services) and The Department of Communities (Housing & Homelessness) and Education Queensland
	• mandatory child protection reporting of suspected abuse or harm	• AETRC staff will comply with Queensland health (QH) policy regarding mandatory reporting of suspected abuse or harm
Referral, Access and Triage	• Statewide referrals are accepted for planned admissions	• this supports continuity of care for the adolescent
	• responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the AETRC	
	• all referrals are made to the Clinical Liaison, Clinical Nurse and processed through the panel	• a single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on appropriateness • it expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted
	• the adolescent is assessed after referral either in person or via videoconference	• the pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission • this assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity
Referral, Access and Triage		• this process monitors changes in acuity and the need for admission to help determine priorities for admissions

Key Component	Key Elements	Comments
	• if there is a waiting period prior to admission, the Clinical Liaison, Clinical Nurse will liaise with the referrer until the adolescent is admitted	• the Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness
	• priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral	
Key Component	**Key Elements**	**Comments**
Assessments **<u>Mental Health Assessments</u>**	• the AETRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness	assessment begins with the referral and continues throughout the admission
	• the AETRC panel will obtain a detailed history of the interventions to date for the mental illness	• this is obtained by the time of admission
<u>Family/Carers Assessments</u>	• the AETRC will obtain a detailed history of family structure and dynamics, or history of care if the adolescent is in care	• this process begins with the referral and continues throughout the admission
	• parents/carers will have their needs assessed as indicated or requested	• parents or carers will be involved in the mental health care of the adolescent as much as possible • significant effort should be made to support the involvement of parents/carers
	• if parent/carer mental health needs are identified the AETRC will attempt to meet these needs and if necessary refer to an adult mental health service	
<u>Developmental Assessments</u>	• the AETRC will obtain a comprehensive understanding of developmental disorders and their	• this process begins with available information on referral and during the

Key Component	Key Elements	Comments
	current impact	admission
	• the AETRC will obtain information on schooling as it is available	• this occurs upon admission
Assessments of Function	• the AETRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development	• this assessment occurs throughout the admission
Physical Health Assessments	• routine physical examination will occur on admission • physical health is to be monitored throughout the admission • appropriate physical investigations should be informed as necessary	
Risk Assessments	• a key function of the panel will be to assess risk prior to admission • risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team	• all risk assessments will be recorded in the patient charts and electronic clinical record (CIMHA)
	• documentation of all past history of deliberate self harm will be included in assessment of current risk • will include a formalised suicide risk assessment	• risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation
General Aspects of Assessment	• assessment timeframes	• routine assessments will be prompt and timely • initial assessments of mental health, development and family are to be completed within two weeks of admission
	• Communication	• the outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents)
	• Care Plans	• all assessment processes will be documented and integrated into the care plan
	• *Mental Health Act 2000* assessments	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner
	• drug and alcohol assessments	• assessments of alcohol and

Key Component	Key Elements	Comments
		drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service
• **Information from the Mental Health, Family/Carer, Developmental and Functional assessments is integrated into a comprehensive formulation of the illness and impairments. Further information from continuing assessments is incorporated into developing and refining the original formulation at the Care Review Meetings**		
Recovery Planning	• an initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission	• during admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery • continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other relevant agencies
Clinical Interventions		
Psychotherapeutic	• individual verbal therapeutic interventions utilising predominantly a specific therapeutic framework (e.g. Cognitive Therapy)	• therapists will receive recognised, specific training in the mode of therapy identified • the therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness • the therapist will have access to regular supervision • specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate understanding from Psychodynamic Therapies with respect to relationships)
Psychotherapeutic	• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand	• supportive therapies will be integrated into the overall therapeutic approaches to the

Key Component	Key Elements	Comments
	play, art, music therapies etc.) • individual supportive verbal or non-verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)	adolescent • used at times when the adolescent is distressed or to generalise strategies to the day to day environment • staff undertaking supportive interventions will receive training in the limited use of specific modalities of therapy and have access to clinical supervision • supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
	• psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy)	• as for individual verbal interventions
Behavioural interventions	• individual specific behavioural intervention (e.g. desensitisation program for anxiety)	• behavioural program constructed under appropriate supervision • monitor evidence for effectiveness of intervention
	• individual general behavioural interventions to reduce specific behaviours (e.g. self harm)	• review effectiveness of behavioural program at individual and Centre level
	• group general or specific behavioural interventions	• monitor evidence for effectiveness of intervention
Psycho-education Interventions	• includes general specific or general psycho-education on mental illness	• available to adolescents and their parents/carers
Family Interventions	• family interventions to support the family/carer while the adolescent is in the AETRC	• supportive family interventions will, when possible be integrated into the overall therapeutic approaches to the adolescent • includes psycho-education for parents/carers
Family Interventions	• family therapy as appropriate	• therapist will have recognised training in family therapytherapists will have access to continuing supervision

Key Component	Key Elements	Comments
		• review evidence for effectiveness of the intervention • family therapy will be integrated into the overall therapeutic approaches to the adolescent
	• monitoring mental health of parent/carer • monitor risk of abuse or neglect • promote qualities of care which enable reflection of qualities of home	• support for parent/carer to access appropriate mental health care • fulfil statutory obligations if child protection concerns are identified • review of interactions with staff • support staff in reviewing interactions with and attitudes to adolescent
Interventions to Facilitate Tasks of Adolescent Development	• interventions to promote appropriate development in a safe and validating environment • school based interventions to promote learning, educational or vocational goals and life skills • individual based interventions to promote an aspect of adolescent development	
	• group based interventions to promote aspects of adolescent development which may include adventure based and recreational activities	• individualised according to adolescents in the group • goals to be defined • under the clinical direction of a nominated clinician
Pharmacological Interventions	• administration of psychotropic medications under the direction of the consultant psychiatrist	• education given to the adolescent and parent(s)/carer about medication and potential adverse effects • regular administration and supervision of psychotropic medications • regular monitoring for efficacy and adverse effects of psychotropic medications
	• administration of non-psychotropic medications under medical supervision	• includes medications for general physical health
Other Interventions	• sensory modulation	• utilised under the supervision of trained staff

Key Component	Key Elements	Comments
	• electroconvulsive therapy	• monitor evidence of effects • a rarely used intervention, subject to a specific policy compliance with Australian clinical practice guidelines • administered in accord with the *Mental Health Act 2000*
Care Coordination **<u>Clinical care coordination and review</u>**	• prior to admission a Care Coordinator will be appointed to each adolescent The Care coordinator will be responsible for: • providing centre orientation to the adolescent and their parent(s)/carer(s) • monitoring the adolescent's mental state and level of function in developmental tasks • assisting the adolescent to identify and implement goals for their care plan • acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process • assisting the adolescent in implementing strategies from individual and group interventions in daily living	• the Care Coordinator can be a member of the treating team and is appointed by the AITRC director • an orientation information pack will be available to adolescents and their parent(s)/carer(s)
<u>Care Monitoring</u>	• providing a detailed report of the adolescent's progress for the care planning meeting • adolescents at high risk and require higher levels of observations will be reviewed daily	• the frequency of monitoring will depend on the levels of acuity • monitoring will integrate information from individual and group interventions and observations • this includes daily reviews by the registrar, and twice weekly reviews by the consultant psychiatrist
<u>Case Review</u>	• the case review meeting formally reviews the Care Plans which will be updated at intervals of not more than two months	• the Community Liaison Clinical Nurse is responsible to ensure adolescents are regularly reviewed • the adolescent, referring agencies and other key

Key Component	Key Elements	Comments
		stakeholders will participate in the Case Review process
	• all members of the clinical team who provide interventions for the adolescent will have input into the case review	• the consultant psychiatrist will chair the case review meeting • documented details to include date, clinical issues raised, care plan, contributing team members, and those responsible for actions
	• ad hoc case review meetings may be held at other times if clinically indicated	• these will be initiated after discussion at the case conference or at the request of the adolescent
	• progress and outcomes will be monitored at the case review meeting	• where possible this will include consumers and carers • appropriate structured assessments will be utilised • the process will include objective measures • annual audits will ensure that reviews are being conducted
Case Conference	• a weekly case conference will be held to integrate information from and about the adolescent , interventions that have occurred, and to review progress within the context of the case plan	• a consultant psychiatrist should be in attendance at every case conference
	• risk assessments will be updated as necessary in the case conference	• the frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed • risk will be reviewed weekly or more frequently if required
Record Keeping	• all contacts, clinical processes and care planning will be documented in the adolescent's clinical record	• progress notes will be consecutive within the clinical record according to date
	• clinical records will be kept legible and up to date, with clearly documented dates, author/s (name and title) and clinical progress notes	• personal and demographic details of the adolescent, their parent/carer(s) and other health service providers will be up to date
	• there will be a single written clinical record for each adolescent	• the written record will align with any electronic record

Key Component	Key Elements	Comments
Record Keeping	• all case reviews will be documented in the adolescent's clinical record	• actions will be agreed to and changes in treatment discussed by the whole team and recorded
Discharge Planning	• discharge planning should begin at time of admission with key stakeholders being actively involved.	• the adolescent and key stakeholders are actively involved in discharge planning • discharge planning should address potential significant obstacles e.g. accommodation, engagement with another mental health service
	• discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family	• the AETRC School will be primarily responsible for and support school reintegration
	• discharge letters outlining current treatments and interventions need to be sent to any ongoing key health service providers within one week of discharge	• the Registrar and Care Coordinator will prepare this letter • it should identify relapse patterns and risk assessment/ management information • follow-up telephone with any ongoing key health service providers will occur as well as the discharge letter
	• a further comprehensive Discharge Summary outlining the nature of interventions and progress during admission will be sent at full transfer from the AETRC	• this will be prepared by the clinicians involved in direct Interventions
	• if events necessitate an unplanned discharge, the AETRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord with their risk assessments	
	• in the event of discharge the AETRC will ensure they have appropriate accommodation, and that external services will follow up in a timely fashion	

Key Component	Key Elements	Comments
Transfer	• depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit • transfer to an adult inpatient unit may be required for adolescents who reach their 18th birthday and the AETRC is no longer able to meet their needs	
Continuity of Care	• referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission	• referrers and significant stake holders are invited to participate in the Case Review meetings • the Care Coordinator will liaise more frequently with others as necessary
Team Approach	• specifically defined joint therapeutic interventions between the AETRC and the Referrer can be negotiated either when the adolescent is attending the Centre or on periods of extended leave	• joint interventions can only occur if clear communication between the AETRC and external clinician can be established
	• responsibility for emergency contact will be clearly defined when an adolescent is on extended leave	• this will be negotiated between the AETRC and the local CYMHS
	• case loads should be managed to ensure effective use of resources and to support staff	
	• staff employed by the Department of Education and Training will be regarded as part of the team	

4. Service and operational procedures

The AETRC will function best when:

- there is an adequate skill mix, with senior level expertise and knowledge being demonstrated by the majority of staff
- strong internal and external partnerships are established and maintained
- clear and strong clinical and operational leadership roles are provided
- team members are provided with regular supervision
- AETRC is seen by all CYMHS staff as integral and integrated with the CYMHS continuum of service

Caseload
Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team.

Under normal circumstances, care coordination will not be provided by students or staff appointed less than 0.5 FTE. Typically Care Coordinators are nursing staff.

Staffing
The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry, nursing, psychology, social work, occupational therapy, speech pathology and other specialist CYMHS staff. While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills.

Administrative support is essential for the efficient operation of the AETRC.

All permanently appointed medical and senior nursing staff be appointed (or working towards becoming) authorised mental health practitioners.

Hours of Operation

- access to the full multidisciplinary team will be provided weekdays during business hours and after hours by negotiation with individual staff
- nursing staff are rostered to cover shifts 24 hours, 7 days a week
- an on-call consultant child and adolescent psychiatrist provided through the Queensland Children's Health Services District will be available 24 hours, 7 days per week
- 24 hours, 7 days a week telephone crisis support will be available to adolescents on leave is available A mobile response will not be available
- routine assessments and interventions will be scheduled during business hours (9am - 5pm) 7 days a week

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

- written, up to date policies will outline procedures for managing different levels of risk (e.g. joint visiting)
- staff safety will be explicitly outlined in risk assessment policy
- risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team

Staff Training

Consumers and carers will help inform the delivery of staff training where appropriate.

Staff from the AETRC will engage in CYMHS training. On occasion AETRC will deliver training to other components of the CYMHS where appropriate.
Training will include:

- Queensland Health mandatory training requirements (fire safety, etc)
- AETRC orientation training
- CYMHS Key Skills training
- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.)
- principles and practice of other CYMHS entities; community clinics, inpatient and day programs
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

Where specific therapies are being delivered staff will be trained in the particular modality of the therapy e.g. family therapy, cognitive behaviour therapy.

5. Clinical and corporate governance

The AETRC will operate as part of the CYMHS continuum of care model.

Clinical decision making and clinical accountability will be the ultimate responsibility of the appointed Consultant Psychiatrist - Director. At a local level, the centre is managed by a core team including the Nurse Unit Manager, Senior Health Professional, the Consultant Psychiatrist, an Adolescent Advocate a Parent Representative and the School Principal. This team will meet regularly in meetings chaired by the Consultant Psychiatrist.

The centre will be directly responsible to the corporate governance of the Queensland Children's Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Executive Director, Child and Adolescent Mental Health Service, Queensland Children's Hospital. Interim line management arrangements may be required.

- maintain strong operational and strategic links to the CYMHS network
- establish effective, collaborative partnerships with general health services, in particular Child and Youth Health Services and services to support young people e.g. Child Safety Services
- provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder;
- develop the capacity for research into effective interventions for young people with severe and complex disorder who present to an intensive and longer term facility such as AETRC

6. Where are the Services and what do they look like?

The Adolescent Integrated Treatment and Rehabilitation Centre is currently located at Wacol (the Barrett Adolescent Centre). It is anticipated it will move to Redlands Hospital in 2011.

7. How do Services relate to each other?

- formalised partnerships
- Memorandum of Understandings between government departments
- guidelines
- statewide model of CYMHS
- The AETRC is part of the CYMHS network of services in Queensland as described in Section 3

8. How do consumers and carers improve our Service?

Consumer and carer will contribute to continued practice improvement through the following mechanisms:

- consumer and carer participation in collaborative treatment planning
- consumer and carer feedback tools (e.g. surveys, suggestion boxes)
- consumer and carer's will inform staff training

Consumer and carer involvement will be compliant with the National Mental Health Standards.

9. What ensures a safe, high quality Service?

- adherence to the Australian Council of Health Care Standards (ACHS), current accreditation standards and National Standards for Mental Health Services
- appropriate clinical governance structures
- Skilled and appropriately qualified staff
- professional supervision and education available for staff
- evidence based treatment modalities
- staff professional development
- clear policy and procedures
- clinical practice guidelines, including safe medication practices

The following guidelines, benchmarks, quality and safety standards will be adhered to:

- Child and Youth Health Practice Manual for Child Health Nurses and Indigenous Child Health Workers: http://health.qld.gov.au/health_professionals/childrens_health/child_youth_health
- Strategic Policy Framework for Children's and Young People's Health 2002-2007:

http://health.qld.gov.au/health_professionals/childrens_health/framework.asp.

- Australian and New Zealand College of Anaesthetists (interim review 2008) Recommendation of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations T1: http://anzca.edu.au/resources/professional-documents/technical/t1.html
- Guidelines for the administration of electroconvulsive therapy (ECT): http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf.
- Royal Australian and New Zealand College of Psychiatrists, Clinical memorandum #12 Electro-Convulsive Therapy, Guidelines on the Administration of Electro-Convulsive Therapy, April 1999: http://health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars02-03-799_528.htm/$FILE/799_528a.pdf.

Legislative Framework:

The Adolescent Extended Treatment Centre is gazetted as an authorised mental health service in accordance with Section 495 of the *Mental Health Act 2000*.

10. Key resources and further reading

- Queensland Plan for Mental Health 2007-2017
- Clinical Services Capability Framework - Mental Health Services Module
- Building guidelines for Queensland Mental Health Services – Acute mental health inpatient unit for children and acute mental health inpatient unit for youth
- Queensland Capital Works Plan
- Queensland Mental Health Benchmarking Unit
- Australian Council of Health Care Standards
- National Standards for Mental Health Services 1997
- Queensland Mental Health Patient Safety Plan 2008 – 2013
- Queensland Health Mental Health Case Management Policy Framework: Positive partnerships to build capacity and enable recovery
- *Mental Health Act 2000*
- *Health Services Regulation 2002*
- *Child Protection Act (1999)*
- State-wide Standardised Suite of Clinical Documentation for Child and Youth Mental Health Services.
- Mental Health Visual Observations Clinical Practice Guidelines 2008
- Council of Australian Governments (CoAG) National Action Plan on Mental Health 2006-2011
- Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services
- Disability Services Queensland – Mental Health Program
- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)

- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

EXHIBIT 43

MSS.900.0002.0242

QUEENSLAND HEALTH
MENTAL HEALTH CAPITAL WORKS PROGRAM

Queensland Government
Queensland Health

minutes of meeting

Project(s)	Redland – New 15 Bed Adolescent ETU, Day Centre & School	Project(s) No	51426
Meeting	Formation of Facility Project Team Meeting (FPTM) and User Group Meeting (UGM)	Meeting No	3
Held at	Conference Rooms 1 & 2, Redland Hospital	Date	15th October 2009
Author	Jacqueline Smith	Time	3.00 PM to 5:00pm

Present Name	Role	Company	Telephone/Mobile Email
Assoc. Prof David Crompton (DC)	Executive Director	Division of Mental Health, Metro South	
Brett Bricknell (BB)	Executive Director	ED Redland and Wynnum Hospitals	
Denisse Best (DB) via video-conference	Executive Director	Child and Youth Mental Health	
Janelle Bowra (JB)	Nurse Unit Manager	Mental Health	
John Quinn (JQ)	Manager	Mental Health Branch	
Assoc. Prof Brett McDermott (BMcD)	Executive Director	Mater Child & Youth Mental Health Service	
Francis Maher	Project Manager	Pre Commissioning Project	
Kerry Ward	Program Support Officer	Pre Commissioning Project	
Marissa Stewart	Senior Admin Officer	Pre Commissioning Project	
Michelle Giles	A/Manager	Bayside Mental Health, Metro South	
Neil Pratt (NP)	Director of Nursing	Logan-Beaudesert Mental Health Service	
Paul Clare (PC)	Principal Project Officer	Mental Health Branch	
Sanjib Baruah (SB)	A/Clinical Director	Bayside Mental Health, Metro South	
Shirley Wigan	Executive Director Mental Health	Darling Downs – West moreton Health Service District	
Sue Leggate (SL)	Director, Corporate Services	Corporate Services	
Trevor Sadler (TC)	Psychiatrist	The Park Centre for Mental Health	
Vedran Vladusich	A/Team Leader	Bayside CYMHS, Metro South	

Apologies Name	Role	Company	Telephone/Mobile Email
Michael Daubney (MD)	Psychiatrist	Child & Youth Mental Health	
Tamara Madsen (TM)	Carer Liaison Representative	Logan-Beaudesert Mental Health Service	
Terry Carter (TC)	MHCWP Project Manager/Procurement Manager	Project Services	

Item	Topic	PN 51426 New 15 Bed Adolescent ETU, Day Centre & School	Action By

Agenda & Meeting Topics

Generic topics included add others as required, indicate where not applicable (N/A).

Previous Minutes to be used as Agenda Items with new items/topics to be raised under 15.0 New Business.

Minutes of Previous Meeting

Confirmed true and correct

Outstanding Business from Previous Meeting

No outstanding business

1.0	<u>Procedural Issues</u> **1. Welcome**	1. All members welcomed by DC	
2.0	<u>Land & Legals</u> **1. Site Acquisition & Property Issues** **2. Adjoining Owners & Existing Tenants**	1. BB advised members that he attended the program team meeting which discussed location of the centre. The unit will be located at the back of the block. BB to email diagram out to members. 2. Members discussed issues that may arise with chopping of trees due to koalas. BB advised members that the water flow issues have been resolved.	
3.0	<u>Authorities</u> **1. Site designation (required)** **2. Building application** **3. Statutory authorities** **4. Native Title** **5. Mater**	To be discussed at a later date	
4.0	<u>Master Programme</u> **1. Progress Report** **2. Upcoming milestones** **3. Delivery methodology**	The design process has started.	
5.0	<u>PDP/Design</u> **1. Site Planning issues** **2. Progress Report** **3. TCP/ID**	To be discussed at a later date	

Item	Topic	PN 51426 New 15 Bed Adolescent ETU, Day Centre & School	Action By
6.0	**Financial** **1. Budget/Cost Report** **2. Expenditure** **3. Variations** **4. Art-Built In Budget/Cost** **5. FF&E & IT Budget/Cost**	To be discussed at a later date	
7.0	**Decanting** **1. Decanting strategy**	To be discussed at a later date	
8.0	**Construction** **1. Progress Report** **2. General** **3. Industrial Relations & Safety** **4. Contractual** **5. Quality** **6. Forecast practical completion**	To be discussed at a later date	
9.0	**Risk Analysis & Value Management** **1. Peer Review** **2. Project Services**	To be discussed at a later date	
10.0	**FF&E** **1. Progress Report** **2. Budget** **3. Expenditure**	To be discussed at a later date	
11.0	**Operational /Commissioning** **1. Staffing** **2. Commissioning**	1. TS advised members that it is anticipated that they will loose 70% of senior staff that will not make the transition to the new location. Discussed options of variations of work hours or package for staff to make it more desirable to make the transition. SW discussed the importance of training and development around industrial framework.	FM to organize plan and meet with key stakeholders to address issues
12.0	**Communications (Media)**		

Item	Topic	PN 51426 New 15 Bed Adolescent ETU, Day Centre & School	Action By
	1. Communication Plan **2. Consultation**	1. Members discussed the importance of media and communication. The need to tell local councils, local members etc. This helps keep everyone informed. Helps address community concerns.	JQ to talk to Sharyn and organise meeting with West Moreton/Bayside to discuss media and communication SW to talk to West Moreton Media & Communication
13.0	**Recurrent Costs** **1. Building Operation & Maintenance Costs** **2. Staff/Other recurrent costs**	To be discussed at a later date	
14.0	**New Business** **1. UGM Meeting** **2. Ligature points** **3. Pre Commissioning Project staff**	TS sent nominees to DC for the UGM Meeting. DC forwarded nominations on to FM. Members to email FM with nominations. DB raised the potential issue of ligature points. DC assured any risks would be incorporated with the planning side and discussed in 9.0 MS advised members that they can be contactable on the following email [redacted]	

Meeting Closed: 5:10 pm

Next Meeting – 3:00 pm on 19th November 2009, Conference Rooms 1&2, Redland Hospital

EXHIBIT 43

QUEENSLAND HEALTH
MENTAL HEALTH CAPITAL WORKS PROGRAM

Queensland Government
Queensland Health

Minutes of Meeting

Project	Redland – New 15 Bed Adolescent ETU, Day Centre & School	Project(s) No	51426
Meeting	Facility Project Team Meeting (FPTM)	Meeting No	7
Held at	Conference Rooms 1 & 2, Redland Hospital	Date	4 March 2010
Author	Kerry Ward	Time	3.00pm to 4.00pm

Present

Name	Role	Company	Telephone/Mobile	Email
Katie Eckersley (KE)	Manager	Bayside Mental Health		
John Quinn (JQ)	Manager	Mental Health Branch		
Paul Clare (PC)	Principal Project Officer	Mental Health Branch		
Sue Leggate (SL)	Director	Corporate Services Redland & Wynnum Hospitals		
D[illegible]mmon (DS)	A/Director of Nursing	Bayside Mental Health		
Judi Krause (JK)	A/Executive Director	Royal Children's Hospital CYMHS		
Terry Carter (TC)	MHCWP Project Manager/ Procurement Manager	Project Services		
Dean Luton (DL)	Senior Architect	Project Services		
Francis Maher (FM)	Project Manager	Pre Commissioning Project		
Anne Steginga (AS)	A/Executive Director	Division of Mental Health, Metro South		
Peter Kohleis (PK)	Principal Project Officer	Pre Commissioning Project		
Michael Daubney (MD) via video-conference	Psychiatrist	Logan Child & Youth Mental Health		
Janelle Bowra (JB) via video-conference	Nurse Unit Manager	Logan Mental Health		

Apologies

Name	Role	Company	Telephone/Mobile	Email
A[illegible]c. Prof David Crompton (DC)	Executive Director	Division of Mental Health, Metro South		
Brett Bricknell (BB)	Executive Director	Redland and Wynnum Hospitals		
Shirley Wigan (SW)	Executive Director Mental Health	Darling Downs – West Moreton Health Service District		
Dr Sean Hatherill (SHa)	Psychiatrist	Bayside Child & Youth Mental Health		
Leianne McArthur (LMc)	A/Director of Nursing	Logan-Beaudesert Mental Health Service		
Trevor Sadler (TS)	Psychiatrist	The Park Centre for Mental Health		
Vedran Vladusich (VV)	A/Team Leader	Bayside Child & Youth Mental Health		
Sanjib Baruah (SB)	A/Clinical Director	Bayside Mental Health		
Assoc. Prof Brett McDermott (BMcD)	Executive Director	Mater Child & Youth Mental Health Service		
Andy Monk (AM)	Representative	Education Dept		
Val Brown (VB)	Regional Facilities Manager	Education Dept		

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Item	Topic	PN 51426 New 15 Bed Adolescent ETU, Day Centre & School	Action By

Darren Williams (DW)	A/Director Statewide Projects	Health Planning & Infrastructure Division
Michelle Walter (MW)	Manager Statewide Projects	Health Planning & Infrastructure Division
Vaoita Turituri (VT)	Team Leader	South Qld MH Clinical Network

Agenda & Meeting Topics

Generic topics included, add others as required, indicate where not applicable (N/A).

Previous Minutes to be used as Agenda. Items with new items/topics to be raised under 14.0 New Business.

Minutes of Previous Meeting

The minutes from the previous meeting dated 4 February 2010 were confirmed and accepted.

Outstanding Business from Previous Meeting

Nil

1.0	**Procedural Issues** **1. Welcome**	1. All members welcomed by KE Noted Tamara Madsen resigned from FPTM. Replacement to be nominated by Parinitha Jayashankar, Team Leader at Bayside.	
2.0	**Land & Legals** **1. Site Acquisition & Property Issues** **2. Adjoining Owners & Existing Tenants**	Not discussed at this time (2.1 and 2.2)	
3.0	**Authorities** **1. Site Designation (required)** **2. Building Application** **3. Statutory Authorities** **4. Native Title** **5. Mater** **6. Koala/DERM**	Not discussed at this time (3.1 to 3.5) 6. TC reported process initiated. First step is obtaining a koala report.	
4.0	**Master Programme** **1. Progress Report**	1. MOS Update – JK gave brief overview of CYMHS group's deliberations. Recommendations primarily re clinical governance, length of stay and continuity of care. Will formally report to DC. No Adolescent UGMs until MOS determined.	When information available, to be circulated to committee. KE feedback to DC to convene asap: 1. Meeting with key stakeholders to finalise MOS. 2. Once MOS finalised, discuss impact on design elements with CYMHS input.

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	2. Upcoming Milestones **3. Delivery Methodology**	Not discussed at this time (4.2 and 4.3)	
5.0	**PDP/Design** **1. Site Planning Issues** **2. Progress Report** **3. TCP/ID**	Not discussed at this time (5.1 to 5.3)	
6.0	**Financial** **1. Budget/Cost Report** **2. Expenditure** **3. Variations** **4. Art-Built In Budget/Cost** **5. FF&E & IT Budget/Cost**	1. Kitchen facilities/food preparation logistics: SL reported no progress until MOS determined. Not discussed at this time (6.2 to 6.5)	
	Decanting **1. Decanting Strategy**	Not discussed at this time (7.1)	
8.0	**Construction** **1. Progress Report** **2. General** **3. Industrial Relations & Safety** **4. Contractual** **5. Quality** **6. Forecast Practical Completion**	Not discussed at this time (8.1 to 8.6)	
9.0	**Risk Analysis & Value Management** **1. Peer Review** **2. Project Services**	1. Pending completion of MOS review. Not discussed at this time (9.2)	TC to initiate Peer Review once MOS review completed.
10.0	**FF&E** **1. Progress Report** **2. Budget** **3. Expenditure**	Not discussed at this time (10.1 to 10.3)	
11.0	**Operational /Commissioning** **1. Staffing** **2. Commissioning**	Not discussed at this time (11.1 and 11.2)	
12.0	**Communications (Media)** **1. Communication Plan** **2. Consultation**	1. FM reported draft Communication Plan still not available. 2. KE reported recent meetings with local Councillors and MPs re CCU; also able to discuss Adolescent Unit. Positive responses and offers of assistance. Hospital Site Expansion: SL advised public forum will be organised for August 2010.	FM to follow up with Susan Scott

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13.0	**Recurrent Costs** 1. Building Operation & Maintenance Costs 2. Staff/Other Recurrent Costs	Refer to 6.1 Not discussed at this time (13.2)	
14.0	**New Business** Nil		

Meeting Closed: 3.40pm

The next meeting is scheduled for Thursday, 1 April 2010 at 3pm, Conference Rooms 1 & 2, Redland Hospital.