EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	consultant at Mater CYMHS will be approached to provide support and debriefing for the consumer and carer representatives as required. **Representation** ▪ Agreement that the consumer and carer representatives are separate from the BAC parent group. There should be a different process driven by West Moreton HHS for the views of the parent group to be considered. ▪ The ECRG are seeking a broader perspective that includes the perspectives of the parents of clients that have not or cannot access BAC. Actions 18. Progression of consumer and carer nominations and proposal for their support to the Planning Group	Leanne Geppert	By next meeting
4.2 Broader group of consumers	▪ Identifying the broader group of adolescent consumers that meet the criteria of severe and persistent symptoms but not accessing local CYMHS or BAC. ▪ Not improbable that there may be up to 10-15 adolescents, as in Townsville, in every town that may be sitting at home, not attending school with psychiatric symptoms that may be difficult to identify, engage with services or if they are, not able to access BAC. ▪ Townsville CYMHS have aspirations to look after this high needs group within their alternative model of service. This model proposes a partnership between the local acute adolescent mental health unit, child and youth community services and a non government residential provider. ▪ Consider whether this alternative model would have utility elsewhere in Queensland especially the south east corner. ▪ Noted the Adolescent Drug and Alcohol Withdrawal Service (ADAWS) residential facility works very well and recognise the value of using an alternate workforce such as non clinical support staff. ▪ Noted that an alternative model should have its governance managed by a consortium. Actions 19. Forward ADAWS model of service to secretariat for distribution to the group 20. Further development of service elements with reference to alternative models in preparation for discussion at the next scheduled meeting.	Amanda Tilse Chair & Secretariat	Asap By next meeting
5.0	**Forward Agenda Items**		
5.1	1. Service model options 2. Budget and staffing profile		
Next Meeting:	**Date:** 30 January 2013 **Time:** 9.00 – 10.30 am **Venue:** Butterfield St Level 2 Conference Room (Room 2.2 LMR)		

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Expert Clinical Reference Group: Action Table – 2012 - 2013				
Item	**Actions**	**Accountable Officer/s**	**Due Date**	**Status**
3	Forward feedback to the Barrett Adolescent Strategy Planning Group regarding changes/recommendations to the ECRG terms of reference.	Leanne Geppert	18/1/2013	Recommendations have been forwarded. Planning Group to consider at meeting on 18/1/2013. Changes made to the TOR and forwarded to Sharon Kelly for the Planning Group 25/01/2013
5	▪ Profile of Profile of current BAC consumers. ▪ Cumulative demographic profile of consumers in BAC over a period of 1-2 years. ▪ Any BAC consumer or carer satisfaction surveys. ▪ Any investigations or reports by students etc on longer term outcomes of BAC consumers.	Trevor Sadler Kevin Rodgers	14/12/2012	Demographic data received for January 2011 – December 2012 from Dr Sadler.
17	Members to review the draft service elements table using track changes and forward to the Secretariat for collating	ECRG members	Ongoing	Chair and Secretariat to further develop service elements table based on comments received from members and in reference to current models including the Oslo Model
18	Chair to follow up with WMHHS re: remuneration and support processes consumer and carer representatives.	Leanne Geppert	By next meeting	
19	Chair to forward consumer and carer rep. names to WMHHS for invitation to the ECRG.	Leanne Geppert	By next meeting	
20	Forward ADAWS model of service to secretariat for distribution to the group	Amanda Tilse	Asap	

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda			
Chair:	Dr Leanne Geppert	**Date:**	Wednesday 27 February 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	**Time:**	9.00 – 10.30am
Secretariat:	Vaoita Turituri		
Venue:	Level 2 Conference Room (Room 2.2 LMR), Butterfield St, Herston		
Tele/Videoconference Details	Local Dial in no. National Dial in no. Participant code:		
Invitees	▪ Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital ▪ Amelia Callaghan, State Manager Qld NT and WA, Headspace. ▪ ▪ Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service ▪ Dr James Scott Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service ▪ Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS ▪ ▪ Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School ▪ Dr Leanne Geppert, Director, Planning & Partnerships Unit ,QH Mental Health Alcohol & Other Drugs Branch (MHAODB) ▪ Dr Trevor Sadler ,Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service ▪ Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts ▪ Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (FCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		
Guests			
Apologies:			

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	**Welcome, Apologies and Introductions**		
1.1	**Open and Welcome**	Leanne Geppert	
1.2	**Previous minutes**		
2.0	**Business arising**		
2.1	**Action Sheet** Action sheet_master 2013.doc	Members	
3.0	**Standing agenda**		
3.1	**Communication**		

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	▪ e-petition link – Save the Barrett Adolescent Centre http://www.parliament.qld.gov.au/work-of-assembly/petitions/e-petitions		
3.2	**Updates** 1. Extension of time frames for ECRG to complete its work  WMHHS Extension of Timeframes Request. 2. Consumer & carer representative	Leanne Geppert	
4.0	**New Business**		
4.1	**Target group/ Client profile continued**  Service Elements comparison.xls  Service Elements_5_Feb 13.c	Members	
4.2	**Service Model options** Informed by the above		
5.0	**Forward Agenda Items**		
5.1	1. Budget & Staffing profile		
Next Meeting:	**Date:** 13 March 2013 **Time:** 9.00 – 10.30 am **Venue:** Butterfield St Level 2 Conference Room (Room 2.2 LMR)		

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

MINUTES

Chair:	Dr Leanne Geppert	**Date:**	13 March 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	**Time:**	9.00 – 10.30am
Secretariat:	Vaoita Turituri		
Venue:	Level 2 Conference Room (Room 2.2 CR), 15 Butterfield St, Herston		
Tele/Videoconference Details	Local Dial in no. National Dial in no. Participant code:		
Attendees	▪ Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital ▪ Amelia Callaghan, State Manager Qld NT and WA, headspace ▪ ▪ Dr James Scott, Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service ▪ Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland ▪ Dr Leanne Geppert, Director, Planning & Partnerships Unit, QH Mental Health Alcohol & Other Drugs Branch (MHAODB) ▪ Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service		
Teleconference:	▪ Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service ▪ Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service ▪ Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts		
Guests:			
Apologies:	▪ ▪ Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS ▪ Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	**Welcome, Apologies and Introductions**		
1.1	**Open and Welcome** ▪ Members present and on teleconference were welcomed by the Chair	Leanne Geppert	
1.2	**Previous minutes** ▪ The draft minutes of the last meeting (27.02.2013) were endorsed as an accurate record of proceedings by Cheryl-Ann Wilson and Kevin Rodgers		
2.0	**Business arising**		
2.1 **Action Sheet**	**Outstanding actions to be addressed:** ▪ Nil of note ▪ Amanda Tilse to forward ADAWS model of service to secretariat for dissemination. Action Secretariat to disseminate ADAWS model to members.	Secretariat	
2.2 **Clarification of parameters and scope of proposed model**	▪ Clarification was sought in relation to determining whether the proposed service model should be an aspirational model that depicts the ideal without budgetary constraints. ▪ Funds to implement a proposed model will be limited to operational funds from the BAC and operational funds allocated to the cancelled Redlands facility. ▪ Agreement that only one model will be presented to the Planning Group. ▪ It was noted that there may be elements within the recommended model that may not be supported or implemented by the Planning Group e.g. inpatient beds or residential component.		
3.0	**Standing agenda**		
.1 **Communication**	**Communication Log** ▪ No further communication received.		
3.2 **Updates**	▪ The e-petition has well over 1900 signatures and was tabled in Parliament on 5 March 2013. ▪ The Planning Group has not met since the last ECRG meeting, hence, nothing to report.		
4.0	**New Business**		
4.1 **Final meeting & write up**	▪ Agreement that the recommended service model will be presented to the Planning Group as a written report and power point presentation. ▪ A presentation by the ECRG will provide the ability to capture the nuances and complexities that are often difficult to convey in a text narrative.		
4.2 **Workshop**	▪ As in the previous meeting, a workshop format was used to work through the service description and critical elements of the service model. ▪ Feedback from current and past BAC clients indicates that there is a need for consistency in staffing. This is supported by carers and families.		

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Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	▪ Agreement that the proposed model should have an emphasis on: 1. flow through 2. family involvement 3. medium term therapy ▪ Inclusion of the Non Government sector as a component of the recommended model was not unanimously supported by members. The risks and benefits were robustly debated. **The risks were as follows:** 1. Noted that an NGO partnership arrangement with public services is a comparatively new concept to Queensland as compared to other states such as Victoria. 2. There was a concern that an NGO will not be able to manage the acuity and crises in this particular cohort. 3. In addition, there was concern regarding the 'quality' and stability of the NGO workforce given the traditionally lower pay scales. **The benefits were as follows:** 1. The NGO sector has indeed managed a high level of complexity with the support of the public sector and clinical teams 2. The public sector can support the NGO sector to maintain and improve the residential component and enable 24 hour support. 3. This is an opportunity to enhance the mental health component in the NGO sector and develop greater partnership and better flow and continuum of care to and from the community. 4. Will address the 'flow through' issues associated with existing CYMHS bed based services. ▪ Agreement that while contentious, the NGO option will be included in the proposed model. ▪ Noted that there were basically three components required for the NGO option to be viable: 1. balance – equity in pay rates 2. support within roles – from clinical services 3. culture and underlying philosophy ▪ Other options include capacity for families/carer/support worker to stay within the unit to support the adolescent. This option could be included in the inpatient/NGO component.		
4.3 **Closing discussions**	▪ The Chair reinforced the need to deliver a proposal for an alternative model at the earliest possible time so that BAC staff can access opportunities associated with the West Moreton HHS restructure and to lessen the impact on consumers and carers. ▪ Noted that an alternative and feasible model needs to be endorsed before BAC can close. There will no gaps in service delivery. ▪ Presentation will be developed by the Chair and Secretariat based on collated discussion and feedback. Will attempt to send out a draft presentation as soon as possible. Action Draft power point presentation to be developed and sent to members as		

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	soon as possible.	Leanne Geppert Secretariat	
5.0	▪ Forward Agenda Items		
5.1	1. Service model options 2. Budget and staffing profile		
Next Meeting:	**Date:** 27 March 2013 **Time:** 9.00 – 10.30 am **Venue:** Butterfield St Level 2 Conference Room (Room 2.2 CR) **Future dates:**10 April **(TBC)**		

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Barrett Adolescent Strategy

Expert Clinical Reference Group

Expert Clinical Reference Group: Action Table – 2012 - 2013				
Item	**Actions**	**Accountable Officer/s**	**Due Date**	**Status**
19	Forward ADAWS model of service to secretariat for distribution to the group	Amanda Tilse	Asap	
20	Further development of service elements with reference to alternative models in preparation for discussion at the next scheduled meeting	Members	By next meeting	Revised service elements with reference to alternative models developed for discussion **27.02.2013** Members to work out of session to revise the service elements table. **13.03.2013** Workshop to progress service elements and model components
21	Develop a draft power point presentation of a proposed service model based on workshop discussions	Chair Secretariat		

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda

Chair:	Dr Leanne Geppert	**Date:**	Wednesday 27 March 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	**Time:**	9.00 – 10.30am
Secretariat:	Vaoita Turituri		
Venue:	Level 2 Conference Room (Room 2.2 CR), Butterfield St, Herston		
Tele/Videoconference Details	Local Dial in no. National Dial in no. Participant code:		
Invitees	▪ Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital ▪ Amelia Callaghan, State Manager Qld NT and WA, Headspace. ▪ ▪ Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service ▪ Dr James Scott Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service ▪ Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS ▪ ▪ Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School ▪ Dr Leanne Geppert, Director, Planning & Partnerships Unit ,QH Mental Health Alcohol & Other Drugs Branch (MHAODB) ▪ Dr Trevor Sadler ,Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service ▪ Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts ▪ Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (FCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		
Guests			
Apologies:			

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	**Welcome, Apologies and Introductions**		
1.1	**Open and Welcome**	Leanne Geppert	
1.2	**Previous minutes**		
2.0	**Business arising**		
2.1	**Action Sheet**	Members	
3.0	**Standing agenda**		
3.1	**Communication**		
3.2	**Updates** ▪ Planning Group update	Leanne Geppert	

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
4.0	**New Business**		
4.1	**Revised time frames** Revised GANTT chart.doc	Leanne Geppert	
4.1	**Target group/ Client profile continued**	Leanne Geppert	
4.2	**Service Model options**	Members	
4.3	**Final meeting**	Leanne Geppert	
5.0	**Forward Agenda Items**		
5.1	1. Budget & Staffing profile		
Next Meeting:	**Date:** TBA **Time:** 9.00 – 10.30 am **Venue:** Butterfield St Level 2 Conference Room (Room 2.2 CR)		

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

MINUTES			
Chair:	Dr Leanne Geppert	**Date:**	27 March 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	**Time:**	9.00 – 10.30am
Secretariat:	Vaoita Turituri		
Venue:	Level 2 Conference Room (Room 2.2 CR), 15 Butterfield St, Herston		
Tele/Videoconference Details	Local Dial in no. National Dial in no. Participant code:		
Attendees	▪ Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital ▪ ▪ Dr James Scott, Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service ▪ Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS ▪ Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland ▪ Dr Leanne Geppert, Director, Planning & Partnerships Unit, QH Mental Health Alcohol & Other Drugs Branch (MHAODB) ▪ Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP) ▪ Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service		
Teleconference:	▪ Amelia Callaghan, State Manager Qld NT and WA, headspace ▪ Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service ▪ Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts		
Guests:			
Apologies:	▪ Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service ▪		

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Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	**Welcome, Apologies and Introductions**		
1.1	**Open and Welcome** ▪ Members present and on teleconference were welcomed by the Chair	Leanne Geppert	
1.2	**Previous minutes** ▪ The draft minutes of the last meeting (13.03.2013.) were endorsed as an accurate record of proceedings by		
2.0	**Business arising**		
2.1 Action Sheet	**Outstanding actions to be addressed:** ▪ Amanda Tilse to forward ADAWS model of service to secretariat for dissemination. Action Secretariat to disseminate ADAWS model to members.	Amanda Tilse Secretariat	
E-petition	▪ It was noted that there is a second e-petition regarding the Barrett Adolescent Centre. ▪ Please see attached link to this petition for information. ▪ http://www.communityrun.org/petitions/don-t-close-the-barratt-centre-for-adolescents-with-severe-mental-health-issues		
3.0	**Standing agenda**		
3.1 Communication	**Communication Log** ▪ No further communication received.		
3.2 Updates	**Planning Group** ▪ The Chair spoke to the proposed the draft service elements table noting only the salient points of the proposed model. ▪ The Planning Group were not provided with a written draft as it has not been discussed by the ECRG. ▪ The Planning Group are purported to be agreeable to the presentation of an ideal model however, some of the elements included in the ideal may not be supported (although may be implemented in the future). ▪ It was reiterated that there is no funding for a capital project and no identified location.		
4.0	**New Business**		
4.1 Revised time frames	▪ Changes to the time frames for completion of tasks and objectives were noted and highlighted by the Chair. ▪ Noted that the construction of the Extended Forensic Treatment Unit (EFTRU) at Wacol has been completed and due to open in July 2013. ▪ With the opening of EFTRU, it is likely that there will be forensic patients on the grounds with access to BAC. This is seen as a risk for young people. ▪ EFTRU is a new model of service and there is uncertainty as to whether the risks to adolescents in BAC have been assessed for patients likely to transition to EFTRU. ▪ It was noted that there are differing opinions to whether these		

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	consumers will pose a risk to the adolescents on site and a comment that there are ongoing myths being perpetuated about forensic consumers. ▪ Furthermore, it was noted by staff from BAC that currently, forensic patients on leave already have access to the BAC grounds with no incident and question the validity of the claim around increased risk due to forensic consumers.		
4.2 **Draft model of service**	The following discussions were noted in reference to the draft model of service. (Please see attached) Service Elements_LMG_22 Ma **Discussion** **Education components** ▪ A concern was raised regarding the sustainability of a stand alone school with proposed changes to the current model. ▪ An 8 – 10 bed adolescent unit would not have the critical mass required for a school and would not be sustainable. Queensland Education (QED) would require at least 15 beds before it will allocate funds for a school. ▪ In this scenario, responsibility for adolescent schooling is with the locality where the consumer is from or the local high school. There are issues with this arrangement particularly regarding continuity, priority and time commitment from teachers. Actions Kev Rodgers to provide further words to the core educational component to strengthen this statement. **Child & Youth funding** ▪ Concern was raised regarding the allocation of any future funds that may become available to child and youth mental health services with proposed changes particularly in reference to Tier 2a. ▪ Confirmed that funding for child based services would not be transferred to adult mental health services. **Tier 2 - Day Program Services (Mon – Fri business hours)** ▪ There are already several day programs available across the state. The recommendation is to fund further additional programs. ▪ The challenge will be to determine where these additional programs will be located and the supporting infrastructure that may be required. ▪ The introduction of the term 'tiers' could cause confusion and should be aligned with the Clinical Services Capability Framework ▪ Noted that Level 6 of the CSCF aligns closer to the Tier 3 option. ▪ There was discussion regarding possible locations and configurations of day programs across the state. Funds from BAC could be used to establish day programs in areas such as the Gold Coast, Children's Health QLD CYMHS, West Moreton etc. However, any proposed locations, funding etc would need to be determined through a planning process. ▪ The addition of new day programs across the state i.e. Tier 2a and possibly the addition of a residential component (Tier 2b) should	Kev Rodgers	ASAP

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	meet the needs of these adolescents. ▪ There was a question regarding whether acute child & youth inpatient units could be utilised in the interim to meet the needs of adolescents prior to the establishment of a Tier 3 service. ▪ It was suggested that adolescents requiring more intensive services than possible from a Tier 2 service would not have their needs met if only Tier 2 is available. ▪ Furthermore, the issue of having long stay adolescent consumers in a short stay environment with unintentional consequences in an inpatient setting was again highlighted. o Staff burnout o Acutely unwell adolescents mixing with long stay patients o Increased incidence of seclusion **Tier 2b – Residential component** ▪ Some members were concerned with the Tier 2b option (NGO residential component). Primarily, that there were good and not so good benefits for this option. ▪ The residential component needs to be considered and explored in further detail. There will be some adolescent consumers that will require Tier 3 type services but not be acutely unwell however may require accommodation. ▪ Noted that if this was an option put forward, governance needed to remain with the Department of Health to maintain quality. ▪ One option considered is for the Department of Health (DoH) to have a residential contract. A service provider (whether private or non government) provides back up staff and accommodation and DoH provides clinical staff. ▪ A day program and accommodation provider combination would be similar to a step down arrangement. The accommodation provider does not necessarily have to be an NGO; it could be a private provider. **Tier 3** ▪ The majority of members were supportive of both Tier 2 and 3 with some concern regarding the inclusion of a NGO residential component. There is value in having a Tier 3 service because of long term benefits due to the constant care provided. ▪ Day programs need to be an appendage to a 24/7 model. The extended nature of such a program is conducive to development of culture and consistency and dedicated staff. ▪ The Chair clearly clarified with the ECRG members that Tier 3 will be included in the recommended model however, in the short term, the Tier 3 option will not be considered due to the absence of capital funding and location. ▪ Therefore, the ECRG needs to consider how to make Tier 2 work. ▪ Kevin Rodgers, PSM noted the following: o There is a cost to losing BAC including 25 years of culture, knowledge and experience. o There is a seamless relationship between education and health that will be forever lost.		

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Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	▪ The Chair acknowledged this statement and clarified again that the reality is that in the foreseeable future, Tier 3 will not be progressed. **Member opinions** ▪ A possible impact on inpatient beds if the Tier 3 is not implemented is that long stay patients will take up acute beds. This will need to be managed carefully and should include scoping of the current occupancy rates of adolescent units across the state. ▪ It was suggested that the current bed stock is not the issue but rather increasing capacity and having a combination of acute presentations with long term patients in the same unit. ▪ Hence, mixing two the types of consumers is not helpful. ▪ There is currently no evidence based alternative model for adolescents with mental health issues at the very severe end of the spectrum. It was suggested that rehabilitation cannot be implemented in an acute inpatient unit without the inclusion of activities and programs required. ▪ If however, there is no Tier 3/Level 6 available, the acute inpatient unit may be the only option. ▪ In reply to the two main reasons for BAC to close, Dr Sadler noted the following: o The Australian Council on Healthcare Standards (ACHS) regarding facility issues were not serious in his opinion. o The Extended Forensic Treatment Unit (EFTRU) will open soon. However, most patients of BAC have suicidal ideation and the risk of not having BAC as opposed to chance of an incident with a forensic client has not been weighed up. ▪ **Members of the ECRG unanimously supported the retention of the Tier 3 option in the recommended service model.**		
Current Day Programs	1. **Townsville** – 12 places in the day program. There is physical ability for more however the limiting factor is staff capacity. 2. **Mater –** 12 -15 places; always full 3. **Toowoomba –** approximately 14 places in its day program		
Preamble	▪ Dr Sadler offered to develop a preamble to include with the service model recommendations. Suggested that the following should be included: ▪ Existing service needs to be expanded rather than contracted ▪ Statements regarding the challenges faced by the ECRG in developing a recommended model ▪ The ideal model includes a full spectrum of services; this includes Tier 3. ▪ Combination of Tier 2 and Tier 3 as a compromise	Trevor Sadler	ASAP
5.0	**Forward Agenda Items**		
5.1	1. Budget and staffing profile	MHAOD	
Next Meeting:	**Date: 24 April 2013**		

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Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	Time: 9.00 – 10.30am **Venue:** Butterfield St Level 2 Conference Room (Room 2.2 CR)		

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Expert Clinical Reference Group: Action Table – 2012 - 2013				
Item	**Actions**	**Accountable Officer/s**	**Due Date**	**Status**
19	Forward ADAWS model of service to secretariat for distribution to the group	Amanda Tilse	Asap	
20	Further development of service elements with reference to alternative models in preparation for discussion at the next scheduled meeting	Members	By next meeting	Revised service elements with reference to alternative models developed for discussion **27.02.2013** Members to work out of session to revise the service elements table. **13.03.2013** Workshop to progress service elements and model components
21	Develop a draft power point presentation of a proposed service model based on workshop discussions	Chair Secretariat		

Terms of Reference: Expert Clinical Reference Group – Barrett Adolescent Strategy					
Date:	30.11.12	Review Date:	N/A	Version:	Final

1. Purpose:

1.1 The purpose of the Expert Clinical Reference Group is to:
Provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptomatology that significantly interferes with social, emotional, behavioural and psychological functioning and development.

2. Scope and functions:

2.1 The Expert Clinical Reference Group will consider that the model(s) of care:

- will clearly articulate a contemporary model(s) of care for subacute mental health treatment and rehabilitation for adolescents in Queensland
- will be evidenced based, sustainable and align with Queensland mental health policy, current statewide models of service, National mental health policy, National mental health service planning frameworks and future funding models.
- will take into account the Clinical Services Capability Framework (for Mental Health) and
- will replace the existing Statewide services provided by Barrett Adolescent Centre – The Park.

3. Membership (position held only):

3.1 Members:

- Dr Michelle Fryer, Faculty Child and Adolescent Psychiatry
- Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North HHS
- Dr David Hartman, Clinical Director, CYMHS, Townsville HHS
- Dr Trevor Sadler, Clinical Director, BAC, West Moreton HHS
- Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts
- Ms Josie Sorban, Director of Psychology, CYMHS, Children's Health Qld HHS
- Ms Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital
- Ms Amelia Callaghan, State Manager Qld NT and WA, Headspace
- Ms Emma Hart, NUM, Adolescent Inpatient Unit and Day Service, Townsville HHS
- Mr Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School
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Ms Kerry Geraghty, Carer Consultant will provide support to the consumer and representative will on the Expert Clinical Reference Group.

The Chair on behalf of the Expert Clinical Reference Group, will invite additional nominated National experts on an as needs basis to provide additional input into the development of a contemporary evidence based model of care.

3.2 Proxies:
Due to the time limited nature of this reference group, it is unlikely that the use of proxies will be effective.

4. Chairperson

4.1 Dr Leanne Geppert, Director Planning and Partnerships Unit, Mental Health Alcohol & Other Drugs Branch (MHAODB)

5. Secretariat (position held only):

5.1 MHAODB will provide the secretariat to the Expert Clinical Reference Group.

6. Reporting relationships:

6.1 The Expert Clinical Reference Group will provide its recommendation regarding contemporary model(s) of care to the planning group as per the Project Plan for the Barrett Adolescent Strategy.

7. Sub Committees:

7.1 Nil.

8. Frequency of meetings:

8.1 Given the expected short duration of this forum, it is anticipated that the Expert Clinical Reference Group will meet on at least a fortnightly basis (in person or tele/videoconference) until a recommended model of care is developed. It may reconvene on an as needs basis to examine plans regarding the implementation of an endorsed model of care.

9. Quorum:

9.1 The quorum for Expert Clinical Reference Group meetings will be half of membership plus one.

10. Authorisation:

These Terms of Reference may be altered following committee consultation and endorsement by the Chief Executive West Moreton HHS and A/Executive Director MHAODB on the recommendation of the Expert Clinical Reference Group.

Chairperson: Dr Leanne Geppert, Director Planning and Partnerships Unit, MHAODB

Date: Signature:

EXHIBIT 119

Barrett Adolescent Strategy

Expert Clinical Reference Group

Proposed Service Model

Adolescent Extended Treatment and Rehabilitation Services

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

Background

A range of child and youth mental health services are provided by Queensland Health (QH) to deliver mental health assessment and treatment across the spectrum of mental illness and need.

EXHIBIT 119

- **Community Child and Youth Mental Health Services**
  - Teams located throughout the state – single practitioner to large multidisciplinary teams.
  - Moderate to severe and complex mental health disorders.
- **Acute adolescent inpatient units**
  - Acute mental health needs; involuntary admissions regulated by the *Mental Health Act (2000).*
  - Royal Brisbane, Logan, Robina, Mater, Toowoomba and Townsville (June 2013).
- **Barrett Adolescent Centre**
  - Located at The Park Centre for Mental Health (TPCMH)
  - Statewide
  - Specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness.

EXHIBIT 119

- In the 2010 – 11 financial year, community CYMHS in Queensland had a face to face service with over 9,000 children and adolescents. In addition, specialised CYMHS – Evolve Therapeutic Services provide therapeutic services to young people in the Care of the Department of Child Safety in most Health and Hospital Services (HHS).

- Private child and adolescent psychiatrists see more than 4,000 young people. They are predominantly in south-east Queensland, from the Sunshine Coast to the border and west to Toowoomba.

- An unknown number of young people see private psychologists and social workers under the Better Access scheme. They are more likely to be in all major regional areas.

Policy Context

National Mental Health Policy (2008)

- 'non acute bed-based services should be community based wherever possible'

EXHIBIT 119

Key Principle for Child & Youth Mental Health Services

Young people are treated in the least restrictive environment possible which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to their family, educational, social and community networks.

EXHIBIT 119

Policy direction

- National and state mental health reforms supports the decentralisation of services.
- Only forensic and secure services will be offered at TPCMH.
- Barrett Adolescent Centre can no longer operate into the future at this location.
- Alternative models of care need to be considered to align adolescent mental health services with the current policy and direction for mental health.

EXHIBIT 119

Expert Clinical Reference Group

- Consumer and carer representation.
- Child and Youth mental health clinicians across QLD and New South Wales.
- Consideration of contemporary evidence based models of care including additional day programs and alternatives provided by community based mental health services.
- Proposed model of service – way forward for adolescent mental health extended rehabilitation services.

EXHIBIT 119

Proposed Service Model Elements

EXHIBIT 119

Service Delivered

- Medium term, recovery oriented treatment and rehabilitation for young people aged 13- 17 years with;
- Severe and persistent mental health problems which significantly interferes with;
- Social, emotional, behavioural and psychological functioning and development.

Service Delivered cont'd

- Offered across a range of environments
- Tailored to individual needs with regard to:
  - Safety
  - Structure
  - Therapy
  - Community participation
  - Autonomy and
  - Family capacity to provide care for the young person

Service Delivered cont'd

- Functions as part of the broader, integrated continuum of care that includes:
  - Acute and subacute inpatient units
  - Day programs
  - Community mental health services (public, private and other community based providers)

EXHIBIT 119

Overarching Principles

The delivery of an AETRS will:

- Provide service in or close to the young persons community.
- Is recovery based; promotes holistic well being.
- Collaborate with the young person and their family or support people.
- Integrate with other services as required.

Overarching Principles cont'd

The delivery of an AETRS will:

- Offer continuity of care and seamless service delivery.
- Recognise that young people need help with a variety of issues; not just illness.
- Utilise and access community based supports and services.
- Encourage engagement of positive and supportive social, family educational and vocational connections.

Overarching Principles cont'd

The delivery of an AETRS will:

- Provide flexible and targeted programs that can be delivered across a range of contexts and environments.
- Have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches.
- Treat consumers and their families/carers in a supportive therapeutic environment.

EXHIBIT 119

Key Distinguishing Features of an AETRS within the Public Sector

Services are accessed via a **tiered**, least-restrictive approach, and may involve **combinations of service types across the tiers**.

EXHIBIT 119

Tier 1

Public Community Mental Health Services (Sessional)

- Existing Locations: Access at HHS level.
- Access ambulatory care at a public community based mental health service within a local area.
- Interventions should consider shared-care options with community based service providers including General Practitioners and *headspace*.

Tier 2a: **Day Program Services**
(Mon – Fri business hours)

Existing locations

- Townsville,
- Mater,
- Toowoomba

Possible new locations

- Gold Coast
- The Prince Charles Hospital (TPCH)
- Sunshine Coast

EXHIBIT 119

Tier 2a – Distinguishing features

Funds

- From existing operational funds from Barrett Adolescent Centre and Redlands facility

Locations

- Final locations to be determined through a planning process

EXHIBIT 119

Tier 2a – Distinguishing features

- Individual, family and group therapy.
- Core educational/vocational component for each young person.
- Flexible and targeted programs in combination with integration into school, community and/or vocational programs.
- Integration with local child & youth mental health services (acute inpatient and community support services).

EXHIBIT 119

Tier 2a – Distinguishing features

- Therapeutic milieu delivered in a range of settings e.g. family home, school etc.
- Supports and work with family to assist in the young persons recovery.
- Consumers may require admission to the Adolescent Acute Inpatient Unit and attend the Day Program during business hours.
- Proposal of 12-15 places per Day Program (final places and budget to be determined as part of formal planning process).

EXHIBIT 119

Tier 2b: **Day Program + Community Residential Provider (24h/7d)**

Existing Locations:

- Nil service that includes both Day Program and Community Residential Service for this age group.
- NB: Cairns TOHI for 18+

Possible new locations:

- Toowoomba (for residential)
- Sunshine Coast (for Day Program + Residential)
- Townsville (for residential)
- Gold Coast (for Day Program + Residential)

Funds

- From existing operational funds of BAC and Redlands facility.

EXHIBIT 119

Tier 2b: Distinguishing Features

- Day Program attendance as in Tier 2a during business hours.
- After-hours and week end care and support provided by a community-based support service provider that provides a 4-bed residential component.
- Integration with local child & youth mental health services (acute inpatient and public community mental health teams)

EXHIBIT 119

Tier 2b: Distinguishing Features

- Partnership model between QH and residential provider.
- Multidisciplinary staffing profile including clinical (Day Program) and community support staff (community-based provider).
- Clinical governance, training and in-reach by QH staff.
- Residential component only provides accommodation, not service provision.
- On-site extended hours visiting service from QH Day Program staff.

Tier 3: **Statewide in-patient Extended Treatment and Rehabilitation Unit (24h/7d)**

Features:

- **Location: SE Qld.** Source of capital funding and potential site not available.

- For young people whose needs could not be met by Tiers 1 and 2 above, due to risk, severity or need for inpatient extended treatment and care.
- These young people's needs are not able to be met in an acute setting.
- In-patient therapeutic milieu, with capacity for family/carer admissions. All other appropriate and less restrictive interventions considered/tested first.
- Proposal for approx. 10 beds – this requires formal planning processes.
- Medium term admissions, up to approximately 6 months.
- Delivers integrated care with the local CYMHS of the young person.
- Individualised, family and group rehabilitation programs delivered through day and evening sessions, available 7 days/week.
- Activity based programs
- Focus on assisting young people to return to a typical developmental trajectory.
- Consumers will only access the day program if admitted
- Programs maintain family engagement with the young person.
- Flexible and targeted programs that can be delivered across a range of contexts.

EXHIBIT 119

Tier 3

Education component

- Young people will have access to a range of educational or vocational support services delivered by on site school teachers and will be able to continue their current education option.
- There is an intentional goal that young people are integrated back to mainstream community and educational/vocational activities
- The provision of education at this level requires focused consideration; an on site school is one option, however, other options may also need to be considered.

EXHIBIT 119

Tier 3

Education component

- Queensland Health acknowledges the dedicated school and expertise provided by the Department of Education Training and Employment (DETE).

- The Department of Health values and supports partnership with DETE to ensure that adolescents have access to appropriate educational and vocational options to meet their educational/vocational needs.

- Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (i.e. utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established).

EXHIBIT 119

Service specifications

Target Age:

- 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.

EXHIBIT 119

Service specifications

Diagnostic Profile

- Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development.

EXHIBIT 119

Service specifications

Diagnostic Profile

- Treatment refractory/non responsive to treatment:
  - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment.

EXHIBIT 119

Service specifications

Diagnostic Profile

- Mental illness is persistent and the consumer is a risk to themselves and/or others.
- Medium to high level of acuity

Suggested modelling attributes

% Occupancy

- Staffing profile and funding based on a 95% occupancy rate.

Suggested modelling attributes

Average Length of Stay:

Tier 2a: Day Program Services (Mon – Fri business hours)

– 1 to 2 school terms.

EXHIBIT 119

Suggested modelling attributes

Average Length of Stay

- **Tier 2b: Day Program Service + Residential Provider (24h/7d)**
  - 1 to 2 school terms in Day Program, but flexibility important.
  - Up to 6 months in community residential.
  - Day Program attendance may continue following discharge from community residential.

EXHIBIT 119

Suggested modelling attributes

Average Length of stay

- **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)**
  - Up to 6 months.
  - Young people may be discharged from this Unit to a Day Program in their local community.

EXHIBIT 119

Suggested modelling attributes

Staffing Profile

- **Tier 2a: Day Program Services (Mon – Fri business hours)**
  - Multidisciplinary, clinical.
  - Staffing from community sector.
  - Department of Education Training and Employment (DETE)
- **Tier 2b: Day Program Service + Residential Provider (24h/7d)**
  - Multidisciplinary, clinical.
  - Staffing from community sector.
  - DETE
- **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)**
  - Multidisciplinary, clinical.
  - DETE

EXHIBIT 119

Referral Sources and Pathways

- **Tier 2a: Day Program Services (Mon – Fri business hours)**
  - CYMHS
- **Tier 2b: Day Program Service + Residential Provider (24h/7d)**
  - CYMHS
- **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)**
  - CYMHS
  - Statewide Clinical Referral Panel – all referrals to be received and assessed by the Panel, which has statewide representation from multidisciplinary mental health clinicians and community sector.

Complexities of presentation

- Voluntary and involuntary mental health patients who present with the highest level of risk and complexity.

Defining need - the % of population requiring this service

- XXX

Key Considerations and Issues

EXHIBIT 119

- Contemporary models of care for adolescent extended treatment and rehabilitation services.
- Educational/vocational components.
- Alignment with national and statewide reforms.
- Accessibility issues for young people outside SE QLD
- Decentralisation and transition of consumers closer to their local communities
- National Mental Health Service Planning Framework.
- Consumer and carer perspectives.

Thank you

Acknowledgements

- ECRG members
- Sponsors
- Adolescent consumers and their families

Questions ?

In-patient treatment: "The Oslo model" for adolescents and families

A 7-day 'flexi' unit with 6 beds and capacity for day treatment and ambulant approaches.
A place where adolescents and their parents can get support to face their challenges – not a place for asylum from them.

Course of treatment

Referrals are to the leader of adolescent services who names a patient-responsible doctor or psychologist as 'coordinator'.
A mini-team is created with coordinator, 2 milieu therapists, and a contact teacher from 'our' school.

Preadmission: meeting with the patient, parents and referring out-pt dept. at the out-pt. dept. with focus on

- Defining the adolescent's suffering
- What approaches have been tried with or without what form of usefulness
- Sharing of information about what treatment on the unit entails
- Our stand: clarifying details and working towards the adolescent taking responsibility for change and success with support.

During further preadmission treatment goals are refined and fletted into a treatment plan which is coherent with the aims of patient, parents and CAMHS.

Introductory period of investigation ncludes with joint 'treatment' meeting .vith CAMHS after 4 wks.

Informed consent to treatment after meeting.
7 døgn → 5 døgn → smooth transition to day and ambulant approaches, with initial possibility of 'retreat'.

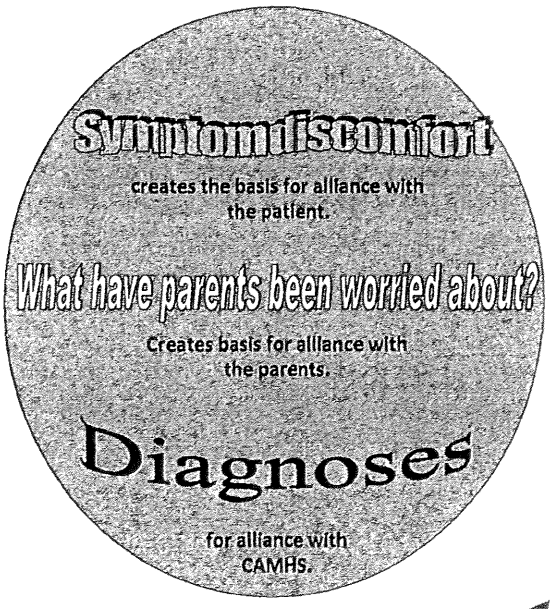
Post admission: Transfer of treatment responsibility to out-pt. dept. does not preclude our m.t. facilitating further consolidation in home milieu, depending on resources, for up to 2 m.

Target patients

Adolescents (12-13) 14-18 yrs with their carers

- Investigation (ca 4 wks)
- Treatment

Focus on identifying what prevents effective out-patient treatment which, for example, can be resolved through 24hr availability of here-and-now responses from milieu therapists (m.t.).
No diagnoses alone are contraindications for admission, but substance use is problematic.
Patients from the acute unit have priority.
Must have serious drop off in function.



Quality assurance

- Joint project with user organisations.
- Weekly feedback in assoc. with up-dating of treatment plans.
- Adapted use of Maudsley Hospital "Your feedback to us" after initial investigation phase and end of treatment.
- Membership in QNIC (Quality Network of In-patient CAMHS – www.qnic.org.uk)

QNIC named our model "The Oslo model" during an audit visit.

Possible barriers to out-patient treatment which can be resolved with admission.

Adolescent developing personality disorder can hinder adequate treatment of axis I diagnoses.
When combined with little reflection from the parents, this can lead to lack of success with family approaches to change contingencies to the adolescent's behaviour.
This demands a here-and now response to what happens in the unit milieu + family based approaches.

•The goal is to influence the adolesc *implicit learning*.
•Ensure continued development through modifying the contingencies to the adolescent's behaviour at home.

Goal directed milieutherapy

Clear priorities made between observable treatment goals.
Concrete treatment plan updated after feedback each monday (ideally after a weekend at home).
Telephone consultation to adolescents and parents when on leave of absence at the wknd.
Analyse the barriers to progress from a multisystemic perspective.
All achievements are planned generalised to home, school and free-time activities.
All adolescents participate in weekly skills group based on.
Regular parent group.

Oslo University Hospital

Unit for Adolescents and Families, Dept. of Adolescent Mental Health
Centre for child and adolescent mental health
tel. +47 23 49 21 00, uxsiwt@ous-hf.no

UiO : University of Oslo

EXHIBIT 119

I

Institute of Child Health

Great Ormond Street Hospital for Children NHS Trust

The Mildred Creak Unit
Department of Child and Adolescent Mental Health
Great Ormond Street Hospital for Children NHS Trust
Great Ormond Street, London WC1N 3JH

020 7829 8679 (Direct line)
020 7829 8657 (Fax)

Information Sheet for Parents, Carers & Patients

This leaflet provides information about the Mildred Creak Unit at Great Ormond Street Hospital and what to expect when your child is staying here. The Mildred Creak Unit is named after the hospital's first child psychiatrist and is an in-patient psychiatric unit for seven to fourteen year olds.

Why is my child being admitted?

Children tend to be admitted to the Mildred Creak Unit with various behavioural or emotional difficulties, where community based treatments have been insufficient. They may have a variety of difficulties, which usually interfere with their capacity to function at home and school. In particular, these often include somatoform disorders – where a child has unexplained medical symptoms, which may have an emotional/psychological basis, eating disorders – like anorexia, or mood disorders – like depression.

Referral and Assessment

On receipt of a referral one or more members of the team will discuss the case with the referrer and generally arrange to meet with the family and other people involved locally, usually the psychiatrist, your child's school and others as appropriate. Following that meeting we may suggest a course of action that does not involve admission to the Mildred Creak Unit or if admission seems the best way forward we will invite you and your son or daughter to attend the unit in order to make a decision about admission and clarify the assessment and treatment goals.

The nursing team will then arrange to visit you at home, in order to begin the process of getting to know you better. The teachers will also be in contact with your child's current school in order to find out more about that aspect of their life.

Children often come to the unit initially for a short stay of around six weeks so they can be assessed fully. The aim of this assessment is to learn about your child's difficulties through discussions with you and your family, by observing your child and by talking to your local team. Once your child has been assessed, we would decide, in discussion with you, whether a longer-term admission to the Mildred Creak Unit would be of benefit. If an on-going admission were agreed by us all, your child would simply remain on the unit.

Members of the team

The team caring for your child is multidisciplinary and includes child and adolescent psychiatrists, nurses, therapeutic care workers, teachers, a family therapist, social worker, psychologist and child and adolescent psychotherapist. Other members of staff from within Great Ormond Street Hospital are also called in if needed, like dieticians and physiotherapists.

How will my child be treated?

The aim of the unit is to be a therapeutic environment, so everything we do is aimed at addressing your child's difficulties. For example, we provide a consistent and structured programme for your child, which includes lots of opportunities for putting their feelings into words, both individually and as a group. We aim to provide an appropriate balance of therapeutic, educational and leisure activities. This structure provides a safe framework for individual, family and group work that will also take place.

Although the unit is open seven days a week, most children return home at weekends. During the week, your child will have a timetable of activities, carried out both individually and as a group. The usual length of admission is around six months.

Can we visit our child?

As well as weekends at home, staying in contact with your child is, of course, very important. Parents normally visit one or two days each week (usually on a tues or wed evening), however, your child can telephone you each day when the day's activities are finished.

What facilities are there on the unit?

The unit has a homely atmosphere where patients and staff come together to create a therapeutic environment. We have a lounge area with comfy chairs, TV, DVD, video and a Playstation. There is a dining room where staff and patients eat together. There is also a school on the unit, as well as the main school at GOSH, so children have good access to education. We work and play on the unit, and make good use of our roof garden and local parks. Children sleep in either single rooms, or share a room with another child of a similar age.

How will you tell us about our child's progress?

Each child is allocated a 'core team' who meet every one or two weeks to discuss your child's treatment and progress in more detail. As part of this, your child will have a 'Core Team Manager' who is your main point of contact. He or she will report back to you regularly and also liaise with your local team. You will receive daily feedback from nursing staff on how your child's day has been.

We hold review meetings, to which you are invited, every six weeks or so, when we discuss your child's progress, hear your views and make future treatment plans. We will send you a copy of the report of this meeting. Relevant professionals involved in your child's care are also invited to attend this meeting.

On admission, the doctor writes a summary of the information known at that point, and on discharge various members of the team who have worked with you compile a discharge report. We may also provide specialist reports, for example those requested by the education department.

How else can I stay involved?

Each child and family has regular family sessions with the family therapist and other members of the team, which is an important part of their treatment. Parents are also invited to regular meetings with the Consultant Child and Adolescent Psychiatrist and Core Team Manager for your child, which gives you a chance to ask questions and be updated about your child's treatment.

In addition, you will also be invited to the fortnightly MCU parents' group, which is a place to exchange ideas and support with other parents, facilitated by MCU staff. This currently takes place fortnightly on a Friday from 12-1pm in the hospital's Social Work Department.

If your child remains in hospital for 12 weeks and over, the hospital has a legal duty under the Children Act 1989 to inform your local Social Services Department. The hospital administration will automatically write to the SSD and you will get a copy of that letter.

The local SSD has a duty to ensure that your child is receiving a reasonable quality of care while they are in hospital and, that an adequate discharge plan is in place. Where possible the social worker on MCU will speak to your local SSD and give them the information they need. However in some cases the local SSD will want to speak to you as the parent, and may contact you directly. If you wish to discuss this further please ask to speak to the MCU Social Worker.

What happens when my child is discharged?

When your child is discharged from the Mildred Creak Unit, he or she will be discharged to the care of your local team. As part of this process, we will write a discharge plan and send you a copy. While we cannot generally offer ongoing therapy, we are always happy to discuss your child's treatment with the local team and offer suggestions. If necessary, your child can be re-referred for assessment and treatment at any time until he or she is fourteen years old.

Services at GOS Hospital

- Cafés are open to parents and families in the hospital, which serve hot and cold meals, snacks and drinks. Snacks and drinks can also be bought from vending machines.
- The hospital shop is open from 8:00am to 6:45pm.
- There are coin and card operated telephones at various points throughout the hospital. Please turn off mobile phones while in the hospital.
- Please smoke only in the designated smoking areas within the hospital.
- The hospital has an interpretation service. Please let us know in advance if you need an interpreter.
- Volunteers are available opposite the main outpatients reception desk from 9:30am to 3:30pm, and can show you around.
- If you or your child have mobility difficulties please ring the Voluntary Services Organiser on 020 7829 8861 before your visit and to make any necessary arrangements.
- Travel expenses: Those parents who are on Income Support, Family Credit, Job Seekers Allowance or Disability Working Allowance, fare reimbursements are available from the family services department. Opening hours are 9.30am - 12pm and 1pm-5pm Monday to Friday.

Questions, comments or complaints

Please address these to your child's key nurse, member of the core team, the clinical team leader or the consultant as appropriate.

If you have any questions about the unit, please contact the Ward Manager on 020 7405 9200 extension 8836.

EXHIBIT 119

MISSION STATEMENT

Primary Task:

"The assessment and treatment of children in the context of their family, with severe and complex mental health difficulties, who cannot manage in outpatient settings, in order to help them improve their functioning to the point where they can.

The primary task is to assist and empower children, working collaboratively with their families, in developing skills, coping mechanisms and insight into their own difficulties. Without a necessary focus on cure we encourage age-appropriate healthy functioning and reintegration back into normal life."

EXHIBIT 119

Mildred Creak Unit: Information for Referrers

This leaflet provides information about the Mildred Creak Unit at Great Ormond Street Hospital for referring doctors.

The Mildred Creak Unit is named after the hospital's first child psychiatrist and is an in-patient psychiatric unit for seven to fourteen year olds. We have up to ten beds available on the unit and we accept children with a range of behavioural and emotional difficulties. In particular, these include somatoform disorders, eating disorders, mood disorders and other psychiatric conditions. The proximity of paediatric services enables us to manage co-morbid medical problems.

Referrals

Referrals should be sent in writing to the Consultant Child and Adolescent Psychiatrist, Mildred Creak Unit. We accept referrals from Consultant Child and Adolescent Psychiatrists in Tier 3 CAMHS services, and also from Consultant Paediatricians within Great Ormond Street Hospital. Dr Jon Goldin, Consultant Child and Adolescent Psychiatrist, is happy to discuss cases on the telephone prior to the decision to refer. We have a fortnightly referral meeting, where referrals are discussed by our team and a senior team member is allocated to liaise with the referrer. If the referral is for a patient with an eating disorder, it should be addressed to Dr Dasha Nicholls, Consultant Child and Adolescent Psychiatrist, in the first instance.

Before the admission

Ideally, a consultation is arranged locally initially with the referrer/family, and if admission seems likely, the child and family will come to meet members of the MCU team at Great Ormond Street Hospital. Sometimes the initial meeting is at Great Ormond Street, in which case it is helpful if the referrer is also able to attend. A home visit and a visit to the unit are also arranged before the admission.

The initial six weeks of an admission focuses on assessment of the child's difficulties. During this time we will consider whether a longer-term admission is appropriate. This will be a joint decision involving the Mildred Creak Unit team, the referring team and the child and family.

About the Mildred Creak Unit

The unit is open seven days a week, although we encourage children to spend weekends at home with their family or carers. Based in a major paediatric hospital setting, the unit is particularly well placed to take on paediatric liaison cases that require in-patient psychiatric treatment. We are therefore one of the few children's in-patient units equipped to take children with significant medical problems as well as mental health disorders. We have regular input from a consultant paediatrician on the unit and liaise regularly with paediatric colleagues where appropriate. Although we have a particular interest in somatoform disorders, we treat a wide range of child psychiatric conditions including mood disorders,

eating disorders, psychotic disorders, attachment disorders and pervasive developmental disorders.

About the team

We work as a multidisciplinary team comprising child and adolescent psychiatrists, nurses, therapeutic care workers, teachers, a family therapist, a child and adolescent psychotherapist, a clinical psychologist, a social worker, a physiotherapist and a dietician. Our nurses come from a range of backgrounds encompassing both mental health and paediatric training.

Treatment

The treatment plan is individually designed according to the individual needs of the child and family. We provide a therapeutic milieu on the unit and within this framework, an eclectic treatment programme is delivered. Available treatment includes individual and group psychotherapies, family therapy, pharmacotherapy and a range of creative therapies. An individual education plan is implemented for each child.

During the course of the admission, a regular written update is sent to the family, referrer, and relevant professionals. In addition, full admission and discharge summaries are prepared and sent to the referrer, family, GP and others as appropriate.

Urgent referrals and emergencies

We are not able to accept emergency admissions, but we do respond as quickly as possible to all referrals, usually within 24 hours. Cases are prioritised in discussion with the referrer.

Informal enquiries

If you wish to discuss a case before deciding whether to refer, please contact

Dr Jon Goldin
Consultant Child and Adolescent Psychiatrist
Mildred Creak Unit
Department of Child and Adolescent Mental Health
Great Ormond Street Hospital for Children NHS Trust
London WC1N 3JH

Tel:
Fax: