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17.04.13	James Scott	Comments Re preamble ▪ Mental illnesses do carry the greatest burden of illness into adult like, in fact only after back pain, depression causes the greatest loss of disability adjusted life years globally according to our GBD2010 study (published last year in the lancet). ▪ So I'd advise deleting "have the potential to" in the preamble. ▪ Secondly, health care funding to adolescent is minute in Australia. ▪ The historical lack of funding should be stated in the preamble to explain why we are in this current dilemma of asking for more	Preamble document amended to reflect suggested changes. ▪ 'have the potential to" deleted Added the following: *It should be noted that child and youth mental health services are historically under funded both at national and state levels. The constraints in resource and funding availability have therefore also been a key consideration in the final determination of the proposed service model elements.*
17.04.13	Philip Hazell	No comments	
19.04.13	David Hartman	Happy to support these documents but note the following: ▪ **Tier 2**: Townsville has a site for day program but doesn't at this time have a funded day program. ▪ **Length of stay**: I would suggest the same length of stay for tier 2 and tier 3, i.e. six months. One term may be sufficient for some clients but it is unduly optimistic to expect this to be an average. ▪ Agree with James's comments on the Preamble. **Slide 39** defining need - the % of population requiring this service. ▪ This is a difficult one to answer because the number of clients going through BAC is not an accurate reflection of state-wide need for this kind of service, and it would be a significant piece of work to do thorough state-wide needs assessment. ▪ I am not aware of any literature that would give population numbers for adolescents with this level of mental health problems.	Amend service element document to reflect the following: ▪ Added day program + residential to Townsville ▪ Amended Tier 2a length of stay to 'up to 6 months' ▪ Amended slide 39 to include: ○ At least equivalent to current BAC level of activity ○ BAC is not equitably accessed by regional QLD

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		▪ Might be better to just leave this out, or perhaps to indicate that the need is <u>at least</u> equivalent to BAC current level of activity, and note BAC waiting lists and that BAC is not equitably accessed by regional QLD. ▪ I would be interested in Trevor's thoughts on how many places / beds would be required for BAC to offer a service <u>without</u> waiting lists. This would give some indication of need, but would still be an under-estimate because the presence of the waiting list is a deterrent to making referrals.	
19.04.13	Michelle Fryer	Overall, happy to support documents ▪ Some of the preamble language is confusing. ▪ Agree with James Scott and David Hartman's comments ▪ Power ppt – Slide 13; talks about acute and subacute in-patient units. ▪ Not sure what the 'subacute' refers to? ▪ Should it just say acute units?	Noted reference to subacute - to be clarified at ECRG meeting? Suggested changes to preamble wording incorporated. *Funding for adolescent (and child) mental health services is neither historically nor currently proportional to the identified need and burden of disease that exists.*
19.04.13	Kevin Rodgers	▪ The preamble (which will include James' amendment) was clear and provides a good introduction. ▪ The service elements to me are unclear and I am concerned that if that is the case for me it may be even less clear for others who have not been involved in the process. ▪ I have a real concern that the ECRG has completed a task they were not asked to do. ▪ If you read the project plan written by Chris Thorburn (attached) it seems clear to me that the ECRG was tasked to provide a service model only for those adolescents presently served by BAC. ▪ By producing a tiered model of service delivery the task seems to have been extended to other adolescents in the state with mental health issues. ▪ The use of the common Queensland Health language of levels of service would be better than tiers. This was certainly discussed but perhaps had no resolution.	Amendment to Service elements document ▪ CSCF levels added to Tier 2a/2b as Level 5; Tier 3 as Level 6 ▪ Number of beds in Tier 3 amended to 15 ▪ *The Tier 3 service (P.4/5) does not articulate the Non Government accommodation services discussed.*- further discussion ▪ *The staffing profile for Tier 3 does not reflect the Non*

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		▪ The Tier 3 service (P.4/5) does not articulate the Non Government accommodation services discussed. ▪ The staffing profile for Tier 3 does not reflect the Non Government accommodation services discussed. ▪ As I indicated to the group a critical number of around 15 is important to maintain a DETE school with the service. This program would support those living in the more secure Unit and those accommodated in the Non Government accommodation service. If the Unit only has up to 10 adolescents you will have one teacher come from the local high school to support the complex educational needs of the group.	*Government accommodation services discussed.* – for further discussion
22.04.13	Trevor Sadler	I do have major concerns about the documents sent through, and the proposed draft. The question continually in my mind is "**If we were to close on 30 June, would the proposed model provide an acceptable alternative for the adolescents we have?" The answer is no.** I have outlined my concerns in the attached document. I will briefly highlight/outline the issues here.	

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		provide an alternative model for BAC. 2. It does not incorporate decisions made at ECRG meetings. This has been outlined in the attached document 3. There are many statements which are not evidenced based. This is a clear mandate of the ECRG 4. While acknowledging the long term need for an inpatient unit, it really glosses over interim arrangements for adolescents who either are in inpatient care or will require it in the future. 5. It does not outline risks if certain levels only are adopted, or the risks associated with various interim arrangements. 6. It appears that funding from the current + Redlands service will be re-allocated to future Level 2 a/b services. Although the evidence suggests that a replacement model for BAC requires an inpatient unit (which may be operated by a private provider under Government policy), there are no mechanisms to preserve this funding. Again, this reflects the strengths of this document as a Directorate planning document, rather than as an alternative to BAC document.	
22.04.13	Trevor Sadler	I endorse James' comments. I would make them even stronger. Not only does mental illness in adolescence carry the greatest burden of illness into adult life, but there is considerable evidence that those with severe, persisting illness are those most likely to carry a great burden of illness into adult life. There are several studies to show that young people with an eating disorder of three years or more have a considerably increased risk of developing a severe and enduring eating disorder (SEED). By 5 years, this probability increases to 90%. The Australian Institute of Health and Welfare in one of its publications stated that childhood sexual abuse is the leading contributor to burden of illness in women in their third and fourth decades. Certainly adult services in Queensland have multiple presentations for admission from adults (mainly	Amended to the following: *Mental health disorders are the most prevalent illnesses affecting adolescents today and in particular, there is considerable evidence that adolescents with persisting and severe and symptomatology are those most likely to carry the greatest burden of illness into adult life. Funding for adolescent (and child) mental health services is neither historically nor currently proportional to the identified need and burden of disease that exists.*

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		women) suffering from complex trauma. We treat young people who have been most severely impacted by their complex trauma. Our anecdotal evidence is that half will require only outpatient services, most of the other half will not need to access adult outpatient mental health services for their trauma, and only a couple have required recurrent admissions for some years. There is a considerable literature on the persistence of severe anxiety disorders into adult life and the subsequent impacts on long term impairment. I was hoping that we might be able to treat the anxiety disorder better with some young people - now I am resigned to helping them cope as well as possible in spite of their anxiety. Unfortunately the research on early psychosis features more on early intervention and less so on the range of interventions with those with a persisting disorder. I don't expect all of this to be added in. Just making the case that a reference to persistence into adulthood should emphasise persistence and impairment in those whom we have been discussing.	
22.04.13	Josie Sorban	I think I got as much out of the comments by other members as the document itself. Extra thoughts I had was that ▪ Defining the length of stay in Tiers 2 a&b makes the foci about school curriculum instead of the clinical and therapeutic milieu; also potentially disadvantage those commencing part-way through school term. Should be stated simply as months/weeks. ▪ Note also the limitations of referral sources for Tier 2a - only CYMHS is listed, yet power-point and principles talk about collaboration with external services. ▪ I remain concerned about the quality and capacity of the non-govt accommodation where minders are minimally trained - a far cry from the health-trained service in acute settings and BAC. ▪ The 4-bed week-end component of Tier 2b is far short of what currently available so wouldn't	▪ Length of stay in Tiers 2a & b amended to 'up to 6 months' ▪ CYMHS is identified as the single point of entry to the Day Programmes. Multiple points of entry is not advocated. ▪ Collaboration and partnership with external services is an essential component in the continuum of care. ▪ 3rd paragraph – amended to Michelle Fryer's suggested version. ▪ Power point Slide 39 amended to reflect David's

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		there be extra $s until the Tier 3 can be achieved? Should we make a point for quarantining this money to contribute to a Tier 3 facility? ▪ I agree with the corrections made by Michelle to the preamble, particularly the 3rd last paragraph which was confusing. ▪ Agree with David re making a statement about the under-estimate using BAC wait-list as there are so many who don't get put on the wait list (once you hear how long it is) but would be ideal candidates for BAC treatment. ▪ As Kev points out the objective was to replace existing BAC services, but in the Outcomes section of the document from Chris Thorburn, it appears to go broader, saying the endorsed model was to articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland and that the final endorsed model(s) of care will replace the existing services provided by BAC. ▪ We could make it clear that only Tiers 2b and 3 are the alternatives for current BAC funding? ▪ Kev also mentions the threat to the teaching allocation of 10 bed proposal for Tier 3. I'm thinking this would be co-located with either an acute care unit or the day programme so would still qualify for a f/t teacher? However the document does not address staffing numbers so this point can't be covered here. ▪ Re Trevor's point about proximity to local community. Perhaps what we need to acknowledge that with the constraints of geographical distances ease of access is the next consideration. We have not made mention of a consideration for accommodating family to mitigate the family and community isolation for the adolescent. This would use up quite a bit of funds.	points. ▪ *We could make it clear that only Tiers 2b and 3 are the alternatives for current BAC funding?* – Needs discussion with the group
22.04.13		I firstly would like to thank the members of the ECRG for the opportunity to participate in the Group's deliberations. Irrespective of outcome, the intensity of effort and commitment to a better future for mental health challenged adolescents in Queensland by all ECRG members is inspiring.	▪ Time limitations – Note that it is **average** length of stay ▪ Amended to *'up to 6 months but flexibility is important'*

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		I would like to make comment on the following two areas. ▪ Firstly, with regard to time limitations - many adolescents have only started to settle into a facility such as BAC in the first six months. Only after that time and when the inpatient's condition is stabilised sufficiently can educational and social initiatives be introduced. These sometimes work on two steps forward and one step back approach as well. Any mandated time limit on admission risks failure for many patients. ▪ Secondly, with regard to staff - commitment is the stand-out feature of the permanent staff at BAC. Patients develop positive relationships with staff and anecdotally they will not interact with casuals to the same extent as permanent staff with whom they have a close rapport. Any private service delivery organisation is under no requirement for consistency of staff. They will supply whom they presently have to hand. Their backgrounds may not necessarily be attuned to adolescents and their needs.	
22.04.13	Trevor Sadler	I specifically want to comment on David's comments about estimating need. As David says, there is no way to really estimate need. However, we can use some reasonable figures, I think. From the epidemiological perspective, there are about 300,000 adolescents in Queensland in the 13 - 17.11 year age group. Adult mental health epidemiology indicates that 1% of the population have a severe mental illness, meaning either schizophrenia or a severe disorder that is persistent and causes significant impairment. If that was applied to adolescents, that would be about 3000 adolescents in the state. Current rates of referrals are now running at about 30 per year or about 1% of those who could be at the severe end, or about 0.01% of the adolescent population. This certainly does not seem to be an excessive number. It would be at the low end of estimates.	

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		From the CYMHS Collaborative, we know that the average CYMHS clinician's workload is about 5% who are longer term i.e. longer than 6 months - about 450 per year. We could measure those who stay with the one service (but may need admission to a paediatric unit under that service), but not so well those who may have been admitted to an acute adolescent inpatient unit where the service is closed and re-opened on discharge. The best estimate was that this could be another 100 young people, although most of these would not have had multiple admissions. Private child and adolescent psychiatrists have a significant proportion (but ultimately unknown) of longer term young people. Altogether we might be looking at 500 - 800 adolescents needing longer term treatment. Of these, about 5% will be referred to BAC - again more likely to be a conservative estimate of need. There are some longitudinal studies of adolescent disorders and behaviours. A recent Australian study published in the Lancet found that 1 - 2% of young people in adolescence who self harmed continued to self harm into their early 20's. That is, about 0.1% of the population. Some of these would be referred to Barrett. Some studies indicate that after 3 years, 10% of young people with anorexia continue to struggle with the disorder. There is little estimation of the rates of those with severe incapacitating (as opposed to moderate or mild) anxiety disorders in adolescence. There is similarly scant data on adolescents with severe and persistent psychosis who need longer treatment and rehabilitation. However, from studies we do have, the figure of 30 per year is likely to be a conservative estimate. I agree with David that the actual BAC referral rates are probably an under-estimation of need. There are several factors - the length of the waiting list is sometimes a deterrent, high clinician turnover and junior clinicians are often less likely those at the severe end of the spectrum, the threshold for admission is higher in regional areas. A waiting list is useful - it sorts out those who benefit from another 3 - 6 months of community treatment, and those who are truly persistent. We are currently managing adolescents as inpatients or day patients, and have another on the waiting list. Are there adverse effects to not getting in? I have heard anecdotally of a number with whom we missed	

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		a window of opportunity, and the outcome was poor. There is little evidence of improvement (again anecdotally) without intensive intervention. I suspect the need could be closer to 40 referrals per year. There is no rationale for suggesting an inpatient unit of 10 beds. I wouldn't recommend going above 12 - 15 beds, but I would recommend to meet the demand, that there would also be a non-inpatient accommodation component and a step-down facility. Bed block is inevitable without these.	
23.04.13	Amanda Tilse	It isn't easy to consider changes and make recommendations of change to a service that has been part of our clinical lives for some time. ▪ I am happy to support the documents. I support the changes that Michelle and James have made to the preamble. ▪ I am pleased that we have included the tiered approach and that consideration to enhancing services in regional areas has been included in the document. This gives families a greater opportunity to remain involved in treatment, perhaps also assists in reintegrating the young person with their local community. ▪ However, I think there needs to be more emphasis in relation to the education component in Tier 3. For fear that we may lose this valuable resource. ▪ Is it possible to suggest that young people who are attending Tier 2a in some districts may also access the educational component in Tier 3 as a step up or step down alternative depending on geographical location? Management of waitlists I think remain a challenge going forward no matter what the bed a capacity is. ▪ I also feel we do need some further discussion and recommendations in relation to allocation of funds and service provision if Tier 3 is not available for some time and Barrett does close.	Education component to be discussed further

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		▪ Utilising existing CYMHS resources which already are stretched and where there are not adequate alternatives for the young people that are currently accessing Barrett both from a mental health and educational perspective is a concern.	
23.04.13		I'd also like to echo some of the thoughts and others have raised in regards to the time limit of six months.	▪ Time limitations – Note that it is **average** length of stay ▪ Amended to *'up to 6 months but flexibility is important'*

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		back in education. I'd also like to advocate for the importance of having the education facility available at BAC. For some this school can sometimes be the first engagement back in education in a long time.	
23.04.13	James Scott	Leanne, I would really like the people who make the decisions to hear this feedback from parents and consumers. In other areas of health care, patients aren't excluded from services because their illnesses don't respond to arbitrary time frames. Can you imagine the outcry if we did this to adolescents with leukaemia who don't go into remission quickly enough. I am an apology for tomorrow (I am overseas) but the contributions by deserves some serious consideration	
23.04.13	David Hartman	I would like to particularly support Amanda's point about education. ▪ Education is a key component of the BAC service and would need to be a key component of anything	*Any redeployment of BAC resources should ideally come with an agreement from DETE to also redeploy the BAC*

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		that replaces it. ▪ Our recent experience in Townsville has been that it has been far from straightforward to obtain DETE support for a teacher position in our inpatient unit / day program. ▪ Any redeployment of BAC resources should ideally come with an agreement from DETE to also redeploy the BAC education resources.	*education resources.* – Needs further discussion and solution
23.04.13	David Hartman	▪ I can see that a rough time-line for admissions is required from a planning point of view, but at the same time it should be recognised that in this group of high risk, high complexity clients, we should be open to having some long term day program attendees. We might get out of this dilemma by talking of average durations of treatment, recognising that there will be wide variation	Amended to average length of stay to *average duration of treatment* Amended to *Up to 6 months; recognising that there will be wide variation in treatment*