- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care.
- 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 individually planned
- in specific cases when the admission exceeds 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 developmental delay 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 adolescents 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. post traumatic stress disorder (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 PTSD. 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 integrated clinical management (including community-based care) at a level 4/5 service.

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. 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.

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

- the AETRC director/delegated senior clinical staff
- referring specialist and/or Team Leader
- representative from Metro South CYMHS
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders (including local CYMHS as required)

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 AETRC

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
- ongoing significant substance abuse

When determining the admission of adolescents where recurrent absconding is a significant risk, the likelihood that the adolescent will experience a positive therapeutic outcome needs to be considered.

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 Metro South facilities (paediatric and adult health services) and/or QCH 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		• Dietetic services to liaise with and advise on the management of eating disorders, adequate nutrition,

Key Component	Key Elements	Comments
		obesity, interactions with psychotropic medications etc • 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 a reasonable suspicion of child abuse and neglect	• AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect
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
		• this process monitors changes

Key Component	Key Elements	Comments
Referral, Access and Triage		in acuity and the need for admission to help determine priorities for admissions
	• 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 following consultation with the treating team
	• 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	• 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
Mental Health Assessments	• 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
Family/Carers Assessments	• 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 will 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	

Key Component	Key Elements	Comments
Developmental Assessments	• the AETRC will obtain a comprehensive understanding of developmental disorders and their current impact	• this process begins with available information on referral and during the 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 and updated at case review	• 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

Key Component	Key Elements	Comments
	• *Mental Health Act 2000* assessments	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor
	• drug and alcohol assessments	• assessments of alcohol and 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 Case 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	• Interventions will be individualised according to the adolescent's treatment needs • individual verbal therapeutic interventions utilising a predominant 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

Key Component	Key Elements	Comments
Psychotherapeutic		understanding from Psychodynamic Therapies with respect to relationships) ◦ supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
	• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand 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)	• 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

Key Component	Key Elements	Comments
Family Interventions	◦ family therapy as appropriate	• therapist will have recognised training in family therapytherapists will have access to continuing supervision • 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	• support for parent/carer to access appropriate mental health care
	• monitor risk of abuse or neglect	• fulfil statutory obligations if child protection concerns are identified
	• promote qualities of care which enable reflection of qualities of home	• 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

Key Component	Key Elements	Comments
		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 • monitor evidence of effects
	• electroconvulsive therapy	• 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 **Clinical care coordination and review**	• 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)
Care Monitoring	• providing a detailed report of the adolescent's progress for the care planning meeting	• the frequency of monitoring will depend on the levels of acuity • monitoring will integrate information from individual and group interventions and observations
	• adolescents at high risk and require higher levels of observations will be reviewed daily	• this includes daily reviews by the registrar, and twice weekly reviews by the consultant

Key Component	Key Elements	Comments
		psychiatrist
Case Review	• 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 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	• personal and demographic details of the adolescent, their

Key Component	Key Elements	Comments
	documented dates, author/s (name and title) and clinical progress notes	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
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	

Key Component	Key Elements	Comments
	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	
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 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 Metro South Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Director, Child and Adolescent Mental Health Services, Metro South Health Service District. 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?

Consumers and carers 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)
- consumers and carers 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

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Queensland Government

Queensland Health

METRO SOUTH HEALTH SERVICE DISTRICT

Enquiries to: A Prof David Crompton
Executive Director
Mental Health Services
Metro South

Telephone
Facsimile.
Our Ref:

Judi Krause
Child & Youth Mental Health Services

Dear Judi

I thought it useful to confirm some of the issues raised at the recent meeting at Bayside. The current funding does not provide for a "parent's retreat" or a day therapy program. The current funding is for a 15 bed unit. There is potential to build an extra 5 beds in the second phase of the Mental Health Plan.

It would be appreciated if the Child and Youth Mental Health Services could continue with the development of the model of service as this is clearly an issue that needs to be resolved. The Governance of the new unit will be under the Management of Metro South Mental Health Service and therefore Metro South Health Service District.

Yours faithfully

Associate Professor David Crompton OAM
MBBS Grad Dip Soc Sci [Psych] FRANZCP FAChAM
Executive Director Mental Health
Metro South Health Service District
30 June 2010

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Statewide Mental Health Network: Child & Youth Advisory Group

Networking to reform mental health

AGENDA

Chair:	Erica Lee **(Acting)**	**Date:**	26 August 2010
Secretariat:	Jackie Bartlett	**Time:**	10.00 – 12.00 pm
Venue:	Seminar room, Child & Youth Mental Health Services, Cnr Rogers & Water St., Spring Hill		

1	Open & Welcome	Erica Lee
2	*Apologies*	Erica Lee
3	*Proxies*	Erica Lee
4.0	Guest speakers	
4.1	***Clinical Reform Project /Models of Service/Clinical Services Capability Framework***	**Kevin Fjeldsoe/Marie Kelly** **30mins**
4.2	***C&Y Consumer and Carer Workers Network/ C&Y Consumer and carer Participation Team*** CCPT C&Y AG Aug 2010.ppt	***Karen McCann*** **10 mins**
5.0	Previous minutes & business arising	
5.1	*Guiding Principles for Admission to Queensland Health CYMHS Acute Inpatient Units - update*	Erica Lee/Janet Martin
5.2	*Inpatient/Day Program/Partial Hospitalisation – update*	Erica Lee
5.3	*Guidelines for Acute Sedation in Child and Youth Mental Health Inpatient Settings work group – update*	Michael Daubney
5.4	*Workforce/PD Priority 5 Key actions – update*	Valda Dorries
5.5	***Child and Youth Eating Disorders Working Group- update*** • *Guidelines for admission of young people with eating disorders* • *Statewide Model for aggregating CYMHS ED positions*	**Erica Lee/Stephanie Heard** **10 mins**
5.6	*Intellectual Disability and Neuropsychiatry Working Group of Community Sub Network- Input into draft discussion paper*	Erica Lee/Jackie Bartlett

Queensland Government

Statewide Mental Health Network: Child & Youth Advisory Group

Networking to reform mental health

	C&YAG submission to II_DD and ABI Discus	
5.7	*Guidelines for the management of adolescents in adult psychiatry units- update on development of working group*	Erica Lee/Jackie Bartlett
5.8	*Confidentiality provisions of the Youth Justice Act-*	Cara McCormack 10 mins
5.9	***Tabling of DAC revised MOS.*** AETRC MOS final draft version tabled t	**Erica Lee/Trevor Sadler**
6.0	New Business	
6.1	***Model of Service for Child and Youth Community MHS. (see 4.1)*** MOS CYCMHS_AUGUST 1(10 POINT Draft MOS Template 2010.doc	Erica Lee **15 mins**
7.0	Standing Agenda Items	
7.1	*SWMHN update*	Erica Lee
7.2	*Cluster Child & Youth Subgroup updates*	Subgroup chairs
7.3	*Eating Disorders Advisory Group update*	Allie Perich
7.4	***CYMHS- Child Safety Services MOU work group update: partnership and QH work group- update*** • Implementation plan development	**James Scott/Jackie Bartlett**
7.5	*SWMHN Inpatient Advisory Group update*	Michael Daubney
7.6	*MHPPEI Advisory Group update*	Lauren Davis
7.7	***Dual Diagnosis Advisory Group update*** Memo_Ax of Intoxicated consumer updateDD_August20 10.doc	**Sophie Morson**
7.8	*CYMHS collaborative update*	Trevor Sadler

Queensland Government

Statewide Mental Health Network: Child & Youth Advisory Group

Networking to reform mental health

		5 mins
7.9	*Child &Youth Forensic Advisory Group update*	Nicole Mikulich
7.10	*Child and Youth Clinical Network update*	Trevor Sadler
8.0	*Other business and forward agenda items/documents for noting* • *September meeting: MOS:acute inpatient units (Child/Adolescent), Evolve Therapeutic Services, Day Programs* • *C&Y mental health first aid training – For noting*	
9.0	NEXT MEETING: 10.00 am – 12.00 pm, 23 September, 2010 REMAINDER FOR 2010: 28 October, 25 November	

NB. Please advise Jackie Bartlett on [redacted] of your video/tele conferencing requirements no later than **1 week** prior to the meeting.

Queensland Government
Queensland Health

Statewide Mental Health Network
Child and Youth Advisory Group

MINUTES

A/Chair:	Erica Lee, Executive Manager, Mater CYMHS, Mater Health Services	**Date:**	26 August 2010
Secretariat:	Jackie Bartlett, PPO CYMHS, Strategic Policy Unit (SPU), Mental Health Directorate (MHD)	**Time:**	10:00 am – 12:00 pm
Venue:	Seminar Room, Institute of Child and Youth Mental Health Services, Spring Hill		
Apologies:	Judi Krause, A/Executive Director, Child and Youth Mental Health Services (CYMHS), Children's Health Services (CHS) Suren Putter-Lareman, Child and Youth Psychiatrist, CYMHS Toowoomba, Darling Downs-West Moreton HSD Graham Martin, Clinical Director, CYMHS, CHS Amanda Gilmour, Program Coordinator, CYMHS, Townsville HSD Michael Daubney, Consultant Psychiatrist Logan CYMHS, Metro South HSD Lauren Davies, Principal Project Officer (Ed-LinQ), Queensland Centre for Mental Health Promotion, Prevention and Early Intervention (QCMHPPEI), SPU, MHD Brett McDermott, Executive Director, Mater CYMHS, Mater Health Services Judy Skalicky, Team Leader, Rural and Remote Area Mental Health Service, Cairns and Hinterland Health Service District (HSD) Christina Gobbo, Team Leader, CYMHS Bundaberg, Sunshine Coast-Wide Bay HSD Chris Lilley, Senior Medical Officer, CYMHS Sunshine Coast, Sunshine Coast-Wide Bay HSD Myfanwy Pitcher, Team Leader, Ipswich CYMHS, Darling Downs-West Moreton HSD Janet Martin, Manager, Integrated Care Team, SPU, MHD Josie Sorban, Principal Psychologist, CYMHS, CHS [redacted] Sophie Morson, Coordinator, Minding Young Minds Early Intervention Program, RCH CYMHS, CHS (Alcohol, Drugs and Mental Health Collaborative delegate) Gerry Howe, Team Leader, CYMHS Maryborough/Wide Bay, Sunshine Coast-Wide Bay HSD Ailie Perich, Principal Policy Officer, ICT, SPU,MHD		
Absent	Karyn Weller, Team Leader, Mental Health and Alcohol, Tobacco and Other Drug Services, North Queensland Mark Wheelehan, Team Leader, Central Queensland Mental Health Clinical Sub Network James Scott, Child /Adolescent Psychiatrist, ECYMHS & ETS Brisbane North		

Present:	Nigel Collings, Director of Psychiatry, CYMHS, Gold Coast HSD [redacted] Valda Dorries, Statewide Allied Health Professional Leader (CYMHS) [redacted] Gail Harvey Team Leader, CYMHS Southern Downs, Darling Downs-West Moreton HSD Judith Piccone, Statewide Allied Health Professional Leader (CYMHS) Paul Letters, A/Executive Director, Child and Youth Mental Health Services (CYMHS) Children's Health Services Trevor Sadler, Director, Barrett Adolescent Centre (BAC), Darling Downs-West Moreton HSD Raymond Ho, Team Leader, CYMHS Logan, Metro South HSD Suzie Lewis, Ed-LinQ Coordinator, QCMHPPEI, SPU, MHD (Proxy for Lauren Davies) Via VC Ngari Bean, Program Coordinator, CYMHS Rockhampton, Central Queensland HSD Cara McCormack, Team Leader, North Queensland Adolescent Forensic Mental Health Service Deb Flegler A/Team Leader, Townsville CYMHS David Hartman, Clinical Director, Townsville CYMHS Janelle Bowra Nurse Unit Manager (NUM), Adolescent Unit, Logan, Metro South HSD

Agenda Item	Action/Outcome/Update	Action/Person
4. Guest speakers		
4.1 Clinical Reform Project /Models of Service/Clinical Services Capability *Framework:* • Presentation by Kevin Fjeldsoe and Marie Kelly (Mental Health Plan Implementation Unit)	• Updated Power Point attached. • Queensland Plan for Mental Health 2007-2017: ➢ Expenditure of $600m for the implementation of stage 1 (1st 4 years) on track. ➢ 514 additional Community Mental Health staff equates to a 20% increase which is reduced by approximately half when factoring in population growth. ➢ 17 capital works projects in progress. ➢ Significant investment in PPEI, Workforce Quality and Safety and CIMHA. ➢ Cabinet Submission for Stage 2 (2nd 4 years) of the plan near completion, for submission in March 2011. ➢ Discussion held regarding the tracking of CYMH funding allocated to HSD's and how to ensure CYMHS receive funding. K Fjeldsoe recommended that FTE's are tracked not the $. HSD's are required to report FTE status quarterly to MHD so will have the information available and will be apparent if an FTE position drops off the recording template. • Clinical reform project renamed to *Working Together To Change: an initiative in clinical reform*, to better reflect change management theory requiring a collaborative rather than top down approach. ➢ Highlighted importance of slide 2 "Planning targets" - currently at 60% of Community Mental Health Services targets.	Working together to change Aug 2010.ppt

Agenda Item	Action/Outcome/Update	Action/Person
	➢ Key focus area is the identification of diagnostic target groups, obtaining clarity regarding the most efficient and effective interventions, increasing the provision of evidence based practice and articulating the outcomes expected. (see Gavin Andrews work). ➢ Need to implement an evaluation strategy that identifies that QH is providing services to a higher number of consumers and achieving improved outcomes. ➢ Treasury require QH to report against an evaluation strategy, not just the tracking of inputs in terms of FTE's but also outputs – need to demonstrate improvements in the areas of access to MHS, a greater frequency of services delivered (e.g. POS's), and numbers of consumers seen. Consideration needs to be given as to how these areas are to be measured that will allow for the reporting of statements such as "30-40% increase in activities for the seriously mentally ill" etc. ➢ CIMHA will deliver active measurements to assist in the evaluation process. ➢ Implementation strategy 1 is to develop a clear plan for service delivery within the HSDs. Will undertake service evaluation utilises MOS's as a benchmark for comparison. Local and statewide data will be used to set standards and identify measurement methods. A 5 to 6 year strategic implementation plan will then be developed. A performance/service agreement will be signed off between the DG and CEO of each HSD. ➢ Gold Coast HSD has agreed to be one of the first districts to commence the reform process. Three other HSD's have expressed interest and negotiations are ongoing. ➢ Regarding strategy 2 – statewide implementation of MOSD – agreement made to commence with ACT's. 1FTE allocated for a 12 month period to work with other Team Leaders in ACT's to develop a draft strategy. ➢ Unclear when project in Gold Coast is to commence but would be beneficial to have a C&Y MOS completed so that child and youth mental health services are included in the initial discussions about what aspects of the HSD will be included in the strategic planning and review process. • Version 3 of the Clinical Services Capability Framework has been posted on QHEPS with a request that all feedback be provided by 17 September 2010. J Bartlett undertook a quick review of the latest version and there are anomalies that will need to be addressed. A request to the CSCF Team to produce the documents previously submitted so that a comparison could be made to determine the amount of rework required was unsuccessful. Given the current work load, including the review of the MOS's suggestions on how to proceed with requesting an extension were canvassed. K Fjeldsoe suggested raising the issue with Bill Kingswell.	• J Bartlett to progress issue through J Martin to the MHD for resolution.
4.2 C&Y Consumer and Carer Workers Network/ C&Y Consumer and Carer Participation Team	• Held over until next meeting due to time restrictions.	• Karen McCann.
5. Previous Minutes & Business arising		
5.0 Confirmation of previous minutes	• May 2010 confirmed by T Sadler and G Harvey. • July 2010 confirmed by N Collings and P Letters.	
5.1 Guiding Principles for Admission to Queensland Health CYMHS Acute Inpatient	• Awaiting sign off by Executive Director, Mental Health Directorate.	Janet Martin.

Agenda Item	Action/Outcome/Update	Action/Person
Units - update		
5.2 Inpatient/Day Program/Partial Hospitalisation – update	• Gail Harvey to provide secretariat support to the group. • Meeting scheduled for September 2010: group to include representation from Tvl, Mater, Logan, Toowoomba and Adolescent Extended Treatment and Rehabilitation Centre.	• For noting.
5.3 Guidelines for Acute Sedation in Child and Youth Mental Health Inpatient Settings work group – update Michael Daubney	• Guidelines near completion – finalising flowchart, to be tabled at September meeting. • Noted that document is generating a lot of interest across the MHS sector.	• For noting.
5.4 Workforce Working Group Update Valda Dorries	• No change since last update provided in August.	• For noting.
5.5 Child and Youth Eating Disorders Working Group- update • *Guidelines for admission of young people with eating disorders* • *Statewide Model for aggregating CYMHS ED positions*	• CYMHS CC to assist in statewide data collection as similar needs and processes are needed for their own data collection requirements. Parameters need to be set before data download can occur. Lengthy process e.g., Collaborative have been waiting 3 months for data. • WG to draft options paper re State wide model aggregating CYMHS ED positions. (Refer mins April/May 2010).	• J Bartlett to contact T Sadler to discuss processes Evolve Therapeutic Services undertook to develop statewide outcomes report using HSD's CIMHA data • For noting.
5.6 Intellectual Disability and Neuropsychiatry Working Group of Community Sub Network- input into draft discussion paper Jackie Bartlett	• CYMH input submitted to WG. Thanks to R Ho, C McCormack and E Lee for their input. • Final opportunity for feedback to be provided to J Bartlett by C.O.B. 3.9.10. Submission circulated with August Agenda. • CYMHS representative to attend next working Group 7.9.10 to address submission – Bill Bor to be approached.	• Feedback to J Bartlett by 3.9.10. • CYMHS rep to attend WG meeting 7.9.10.
5.7 Guidelines for the management of adolescents in adult psychiatry units- update on development of working group	• First meeting scheduled for Friday 27 August. J Bartlett Secretariat. • Limited responses from invitation sent to nominated and interested parties. T Sadler and D Hartman provided apologies – unable to join membership due to work commitments.	• For noting.
5.8 Confidentiality provisions of the Youth Justice Act-1992	• P Letters to advise CHS HSD of decision to progress matter via the MHD and ensure that they have completed their examination of the matter to avoid double up. • J Martin an apology for meeting – Options paper submitted to J. Martin for consideration but not distributed to CYMHAG for feedback as further information was needed to ensure clarity and develop paper. There is a disparity in the legal advice that has been provided to CHS HSD regarding this matter. Advice has been sought from Crown Law, QH Legal Unit and the District Lawyer. • Expectation that resolution of the matter will be protracted. Advisory Group members stressed that interim	• P Letters to brief CEO CHS HSD and other relevant parties. • J Martin to submit brief to Dr Aaron Groves requesting interim

Agenda Item	Action/Outcome/Update	Action/Person
	advice on how to proceed needed to be provided by the MHD as each district is responding differently to the situation and is placing staff at risk of breaching legislation, which carries severe penalties.	directions.
5.9 *Tabling of BAC revised MOS.*	• Tabled.	• For noting.
6. New Business		
6.1 *Model of Service for Child and Youth Community MHS. (see 4.1)*	• E Lee and J Bartlett met with Marie Kelly to review status of all C&Y MOS's. The new format requires additional information and each will have to be reviewed. • Marie Kelly has transposed the data into the C&Y MOS's, SWMHN C&YAG to consider how best to manage the re-write e.g., one group per MOS – or one group per section of MOS to apply across all, as likely to be core similarities within each MOS. • Given Gold Coast HSD will shortly be commencing *Working Together To Change: an initiative in clinical reform* project suggestion is to focus on Community CYMHS as a priority. • Matter will be discussed this afternoon at the Southern Cluster group (Erica Lee).	• Decision required at September C&YAG on how to progress review of MOS's for CYMHS.
7.0 Standing Agenda Items - Updates on an as needs basis and time permitting		
7.1 Statewide Mental Health Network Update Erica Lee	• Presentation from Kevin Fjeldsoe/ Marie Kelly is reflective of what is currently occurring within MHS. • Recommended that CYMHAG members review the minutes in a timely manner. Minutes from these meetings are on QHEPS but may experience delays in posting.	• For noting. • Chair to send to J Bartlett for distribution to AG.
7.2 Cluster Child & Youth Subgroup Updates Northern: Cara McCormack Central: Paul Letters Southern: Erica Lee	• Northern- no update to provide. • Central – no update to provide. • Southern – Arranging a ½ day planning forum.	• For noting.
7.3 Eating Disorders Sub Network update	• Bi- monthly meetings, next update due September.	• For noting.
7.4 CYMHS Child Safety Services Update: Partnership Committee and working group	• Partnership Committee not met since last update. • Working group met 12 August, continue to develop tools, fact sheets etc for implementation. • James Scott resigned position, Raymond Ho appointed as Chair.	• For noting.
7.5 SWMHN Inpatient Sub Network Update Michael Daubney	• Not able to attend last inpatient meeting – no update to provide.	• For noting.

Agenda Item	Action/Outcome/Update	Action/Person
7.6 MHPPEI Sub Network update Suzie Lewis	• Bi monthly update due September. • Applications for Child and Youth Mental Health First Aid training now closed. Training to commence in October.	• For noting.
7.7 Dual Diagnosis Sub Network update Sophie Morson	• Written update circulated with agenda.	• For noting.
7.8 CYMHS Collaborative Update & Child and Youth Clinical Network Trevor Sadler	• Report completed, to be tabled at next meeting. • Monthly clinician meetings occurring.	• For noting.
7.9 Child and Youth Clinical Network Update Trevor Sadler	• Hold over due to time restrictions.	• For noting.
7.10 Statewide Child and Youth Forensic Network Update Nicole Mikulich	• Quarterly meeting scheduled for 20 August was cancelled. No update to provide.	• For noting.
8.0 Other Business and Forward Agenda Items/Documents for noting – o *C&Y mental health first aid training – applications closed.*		
Next Meeting: **Time:** **Venue:** **Future dates for 2010:**	**Thursday 23 September 2010*** **10.00 am – 12.00 pm** **Seminar Room, Institute of Child & Youth Mental Health, Corner Water & Rogers Sts, Spring Hill** **28 October, 25 November**	

*Please notify Jackie Bartlett ONE WEEK PRIOR TO THE MEETING at [redacted] if you require video or teleconference connections

N

1/1/18/5/13

QUEENSLAND HEALTH
MENTAL HEALTH CAPITAL WORKS PROGRAM

Agenda

Queensland Government
Queensland Health

Project	Redland – New 15 Bed Adolescent ETU, Day Centre & School	Project(s) No	51426
Meeting	Facility Project Team Meeting (FPTM)	Meeting No	18
Held at	Mental Health Video Conference Room	Date	16 February 2012
Author	Angela Sheehy	Time	2.00pm

		Actions cited in Previous Minutes
1.0	**Procedural Issues** 1. Welcome 2. Apologies 3. Confirmation of Minutes – G:\WORKGRP\ Bayside MH Manager. 4. Presentation 5. Membership	
2.(	**Land & Legals** 1. Site Acquisition & Property Issues 2. Adjoining Owners & Existing Tenants	
3.0	**Authorities** 1. Site Designation (required) 2. Building Application 3. Statutory Authorities 4. Native Title 5. Mater 6. Koalas/Dept ERM	
4.0	**Master Programme** 1. Progress Report 2. Upcoming Milestones 3. Delivery Methodology	KE to follow up on MOS with David Crompton and CYMHS
5.0	**PDP/Design** 1. Site Planning Issues 2. Progress Report 3. TCP/ID	G:\WORKGRP\ Bayside MH Manager. G:\WORKGRP\ Bayside MH Manager. G:\WORKGRP\ Bayside MH Manager.
6.0	**Financial** 1. Budget/Cost Report 2. Expenditure 3. Variations 4. Art-Built In Budget/Cost 5. FF&E & IT Budget/Cost	
7.0	**Decanting** 1. Decanting Strategy	
8.0	**Construction** 1. Progress Report 2. General	

	3. Industrial Relations & Safety 4. Contractual 5. Quality 6. Forecast Practical Completion	
9.0	Risk Analysis & Value Management 1. Peer Review 2. Project Services	
10.0	FF&E 1. Progress Report 2. Budget 3. Expenditure	
11.0	Operational /Commissioning 1. Staffing 2. Commissioning	Meeting to be arranged with key hospital staff and key mental health staff – update to be given  G:\WORKGRP\ Bayside MH Manager.
12.0	Communications (Media) 1. Communication Plan 2. Consultation	
13.0	Recurrent Costs 1. Building Operation & Maintenance Costs 2. Staff/Other Recurrent Costs	
14.0	New Business	

The next meeting is 15 March 2012 at 2.00pm at Bayside Mental Health Conference Room.

Judi Krause - FPTM Redland Adolescent Facility - Confidential - Not for Distribution

From: Katie Eckersley
To: FPTM Redland Adolescent ETU
Date: 7/25/2011 11:01 AM
Subject: FPTM Redland Adolescent Facility - Confidential - Not for Distribution
Attachments: 110719 MinBrf CID.doc

Hello All

Please be advised that the July & August FPTM Redland Adolescent Facility Meetings have been cancelled. The attached confidential brief details issues and decisions pending. At this stage we anticipate reconvening the meetings in September.

I am advised that the Mental Health Directorate has advised that the facility will no longer be built with capacity to expand to 20 beds it will be designed long term for 15 beds. David Crompton and Brett McDermott are revisiting the plans in conjunction with stakeholders. Terry Carter and David Pagendam are reviewing residential space and shared areas. The ICT and kitchen requirements will need to be reconfirmed to provide an accurate reflection of requirements and Education Queensland will be approached with a request to provide a capital contribution for the school component of the project.

Kind regards
Katie

Katie Eckersley
Manager
Bayside Mental Health Service
Metro South Health Service District
Ph: [redacted]

Minister's Office RecFind No:	
Department RecFind No:	
Division/District:	HPID
File Ref No:	CAPW000252

Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

Requested by: Deputy Director-General Health Planning and Infrastructure Division **Date requested:** 19 July 2011 **Action required by:** 19 August 2011

Action required
☒ For approval ☐ With correspondence
☐ For meeting ☐ For information

Other attachments for Ministerial consideration
☐ Speaking points ☐ Ministerial Statement
☐ Draft media release ☐ Question on Notice
☐ Cabinet related document

SUBJECT: MENTAL HEALTH CAPITAL WORKS PROGRAM
REDLAND 15 BED ADOLESCENT EXTENDED TREATMENT UNIT PROJECT
TOWN PLANNING ISSUES

Proposal

That the Minister:

Approve option (a), of the three options, detailed below. That is to delay seeking a Community Infrastructure Designation (CID) of Lot 30 Weippin Street, Cleveland until Phase One of the site master planning has been completed for Redland Hospital.

Note Phase 1 of the site master planning for Redland Hospital is scheduled to be completed at the end of October 2011 and Phase Two is scheduled to be completed in early 2012.

Note the CID process for Lot 30 Weippin Street, Cleveland has been commenced with an Initial Assessment Report for stakeholder (State and Local Government) consultation having been completed. This process will require recommencement as a consequence of additional facilities intended for the site.

Note that the Redland 15 bed Adolescent Extended Treatment Unit (ETU) project cost estimate at Project Definition Phase is $18,891,443 (GST exclusive) which is $2,763,011 (GST exclusive) over the budget allocated within the *Queensland Mental Health Capital Works Program* of $16,128,432 (GST exclusive) and although it was initially anticipated the Program would be completed by June 2012, the Adolescent ETU project is now scheduled to be completed in October 2013

Urgency

1. Routine approval of this brief is required to continue inline with the Redland 15 Bed Adolescent Extended Treatment Unit (ETU) and School project Master Program (Attachment 1).

Background

2. The Redland 15 Bed Adolescent ETU and School is 1 of the 17 projects funded under the *Queensland Mental Health Capital Works Program.*

3 The existing Adolescent ETU and School currently located at The Park – Centre for Mental Health has been identified as being inadequate and unsafe. A review by an Australian Council on Health Care Standards recommended an urgent replacement of this facility.

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4. An extensive Site Options Study (Attachment 2) was undertaken in 2007 to identify the most appropriate location for the Adolescent ETU and School. The Site Options Study identified Lot 30 Weippin Street, Cleveland to be the most suitable location for the redevelopment of the 15 Bed Adolescent ETU.

5. On 15 January 2009 Minister Robertson, Minister for Health approved BR040033 acquisition of Lot 30 Weippin Street, Cleveland for Health Service Delivery (Attachment 3).

6. Queensland Health acquired the property shown in the attached Google site plan, for expansion of health services from the Department of Infrastructure and Planning (DIP), on 11 March 2009 (Attachment 4).

7. DIP indicated its support for the transfer to the site to Queensland Health as the site was to be used to deliver critical infrastructure. Queensland Health obtained approval to undertake a Community Infrastructure Designation over the site in January 2008, which included assessment of environmental impacts. However, the process was placed on hold pending confirmation of funding to acquire the site.

8. In December 2008 the Minister for Sustainability, Climate Change and Innovation advised all Queensland Government Departments that a freeze had been placed on the disposal and clearing of State land until an appropriate Planning Policy had been developed to protect the South East Queensland Koala habitat.

9. In June 2010, DERM released the Koala Conservation in South East Queensland State Planning Policy (SPP) and State Regulatory Provision (SPRP) which now prevails over any other planning instrument and requires that government agencies and others must minimise the impact of all future development in South East Queensland on koalas and also offset that development if approved.

10. The site has been partially assigned to the relocation of the Adolescent ETU and School Schematic Design plan (Attachment 5) with the remainder of the land proposed for future Redland Hospital expansion.

11. The Adolescent ETU and School is planned to be located at the rear of the site to maximise the space remaining for further development. This is in a more heavily treed area and the building layout was designed to minimise koala habitation impacts while maintaining service functionality.

12. Planning Branch, Health Planning and Infrastructure Division in partnership with Metro South Health Service District are undertaking Site Master Planning for Redland Hospital. Phase One is scheduled to be completed at the end of October 2011 and Phase Two is scheduled to be completed in early 2012.

Key issues

13. DERM officer's advice is that the Minister for the Environment has received several letters from community members and conservation groups raising concerns over the proposed Redland Hospital (Attachment 6).

14. Given a substantial financial outlay of approximately $10 million in acquiring the site Queensland Health is seeking to maximise use of the site to attain best value for money and meet the future needs in the delivery of health services to the community.

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Department RecFind No:	
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15. Three options are available as follows:

    a. Await completion of Phase One of the master planning for Redland Hospital to identify all future required health facilities for the site and how this can be achieved with the assistance of DERM in meeting the State Planning Policy 2/10: Koala Conservation in South East Queensland.

    b. Continue now with the Community Infrastructure Designation process, for the Adolescent ETU facility only, to public consultation without the robust master planning information for the site and risk DERM being unsupportive in developing further facilities on the site and significant community backlash.

    c. Find a new site on which to locate the Adolescent ETU which would cause a long delay to delivery, make the previous Site Options Study redundant and still require a Community Infrastructure Designation to be undertaken.

Consultation

16. The Adolescent ETU Facilities Project Team Meetings have representation from Metro South Health Service District, including Redland Hospital staff, Education Queensland, the Barrett Centre at The Park and Mental Health Branch.

17. The development of the service model and the planning and design phases for the Adolescent ETU has included consumers and mental health staff.

18. Project Services are procuring the projects within the *Queensland Mental Health Capital Works Program* on behalf of Queensland Health. Ongoing consultation is occurring between Town planning officers from Project Services, Property officers from Queensland Health and Environmental officers from DERM.

Financial implications

19. The 15 bed Adolescent Extended Treatment Unit and School project is funded from the $148.351 million (GST exclusive) *Queensland Mental Health Capital Works Program.*

20. The project cost estimate (Attachment 7) at Project Definition Phase Schematic Design is $18,891,443 (GST exclusive) which is $2,763,011 (GST exclusive) over the budget allocated within the *Queensland Mental Health Capital Works Program* of $16,128,432 (GST exclusive) (Attachment 8).

21. The Schematic Design report was submitted by Project Services on 17 May 2011. As the cost estimate contained within the Schematic Design report is over budget the Schematic Design scope will be analysed and amended to reduce costs to within the allocated budget.

Legal implications

22. There are no legal implications.

Elected representative

23. State Government - Mr Peter Dowling MP, Member for Redlands

24. Federal Government - Mr Andrew Laming MP, Member for Bowman

Minister's Office RecFind No:	
Department RecFind No:	
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File Ref No:	CAPW000252

Remedial action

25. No remedial action required.

Attachments

26. Attachment 1: Master Program.
    Attachment 2: Site Options Study.
    Attachment 3: BR040033 land acquisition approval.
    Attachment 4: Google site plan.
    Attachment 5: Schematic Design plan.
    Attachment 6: DERM advice.
    Attachment 7: Project Cost Estimate.
    Attachment 8: *Queensland Mental Health Capital Works Program* Project Budgets.

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Department RecFind No:	
Division/District:	HPID
File Ref No:	CAPW000252

Recommendation
That the Minister

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Note Phase 1 of the site master planning for Redland Hospital is scheduled to be completed at the end of October 2011 and Phase Two is scheduled to be completed in early 2012.

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Note that the Redland 15 bed Adolescent Extended Treatment Unit (ETU) project cost estimate at Project Definition Phase is $18,891,443 (GST exclusive) which is $2,763,011 (GST exclusive) over the budget allocated within the *Queensland Mental Health Capital Works Program* of $16,128,432 (GST exclusive) and although it was initially anticipated the Program would be completed by June 2012, the Adolescent ETU project is now scheduled to be completed in October 2013.

APPROVED/NOT APPROVED **NOTED** **NOTED**

GEOFF WILSON
Minister for Health
/ /

Principal Advisor
/ /

Senior Policy Advisor/
Policy Advisor
/ /

Minister's comments

Author:	Cleared by: (SD/Dir)		Content verified by: (CEO/DDG/Div Head)	Endorsed by:
Michelle Walter	Rosemary Hood	Glenn Rashleigh	John Glaister	Dr Tony O'Connell Director-General
A/Director Statewide Projects	Acting program Director	Executive Director	Deputy Director-General	
Capital Delivery Program South Health Planning and Infrastructure Division	Capital Delivery Program South Health Planning and Infrastructure Division	Capital Delivery Program Health Planning and Infrastructure Division	Health Planning and Infrastructure Division	
19 July 2011	<Date>	<Date>	<Date>	/ /

Judi Krause - RE: Re: Redlands 15 Bed Adol ETU Redesign

From: "PAGENDAM David" <[redacted].au>
To: "Alan Mayer" [redacted]
Date: 9/29/2011 2:36 PM
Subject: RE: Re: Redlands 15 Bed Adol ETU Redesign
CC: "CARTER Terry" [redacted]
"EBZERY Justine" <[redacted].au>,
"LUTON Dean" [redacted]
Attachments: adolescent reduced footprint.pdf

Thanks for your various emails Alan.

I attach a "quick and dirty" plan showing a reduced footprint. The new building blocks are indicated in pink, road and car park in grey, and open recreational spaces in yellow. The footprint of the previous design is superimposed in blue.

The main features of this plan are:-

- Residential block not changed internally, just re-located on site.
- Therapies and admin blocks rationalised into simple rectangles, with admin placed on top of therapies in a two-storey block. Stairs and lift added to suit.
- School functions rationalised into a single one-storey rectangular block.
- Plant rooms placed over storage and gardening sheds in a two-storey configuration.
- Car parking made more compact and moved eastwards to reduce intrusion into the site.
- Bush fire clearance zones, 26m wide, have been maintained on the north and west sides of the buildings, as required by the bush fire report. A clearance zone may also be needed on the south side, if the rest of the site is not developed.
- The area of open space available to residents has been maintained at about the same total as previously, by utilising the bush fire clearance zones to maximum advantage.
- This proposal results in the preservation of a strip of bush approximately 27 metres wide along the western boundary, which previously required clearing as a bush fire break. This is about 12% of the site width.

We also looked at using the slope of the land to put car parking, storage, plant rooms etc under buildings. The problem is that access to the site from the main hospital roads is from the high side of the site to the east. The elevated parts of buildings are on the opposite side of the site. Putting parking under, say, the residential block, would result in a longer roadway, and this extra intrusion into the site would result in a larger footprint than the one we now have.

I note Hilary Hebblewhite's comments about some of the non-clinical features. These can be addressed at design development stage once we have resolved the current "big picture" issues.

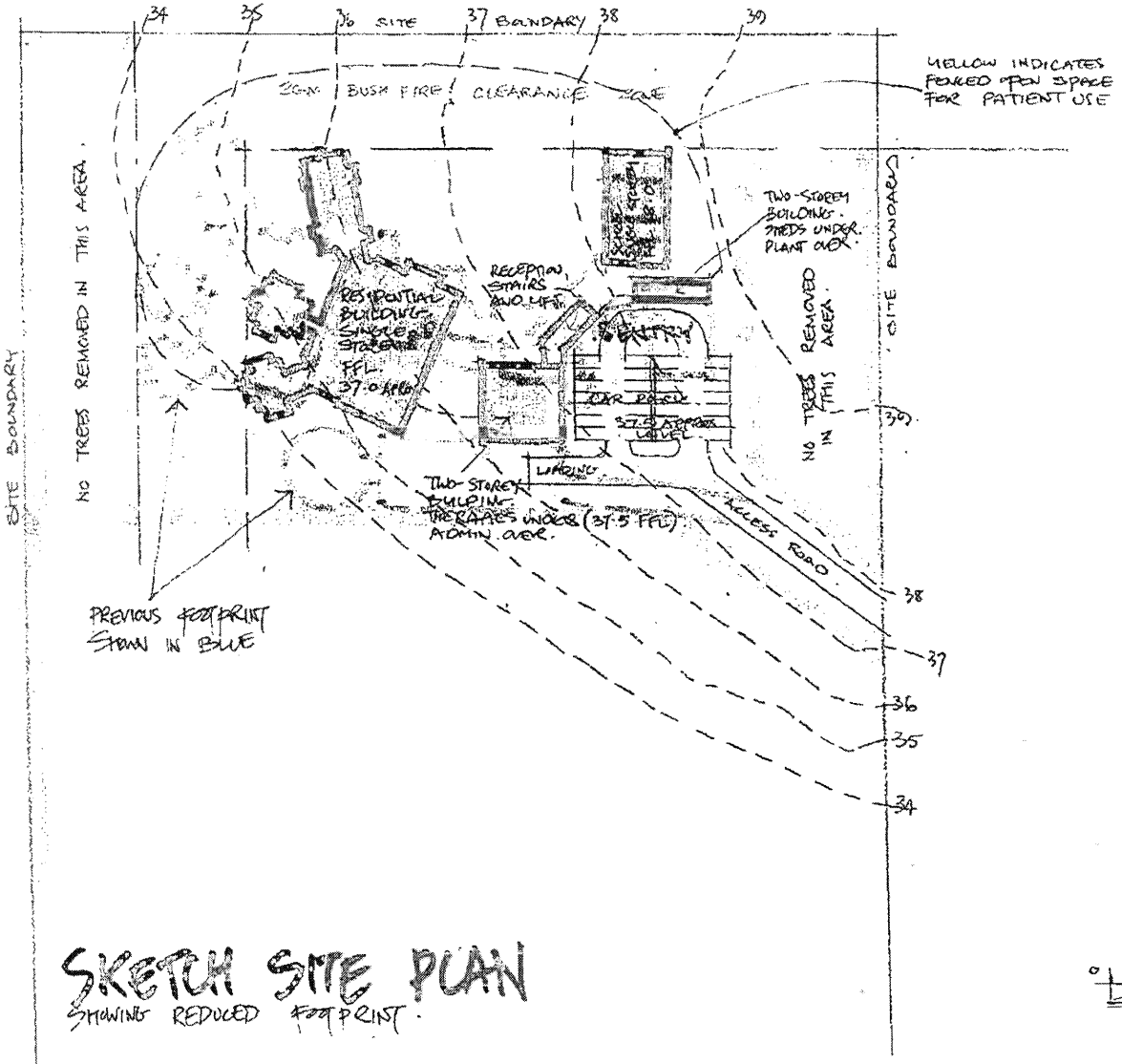
Having looked at this sketch plan again, I can see that there is scope for further refinement and compaction, but I will leave it like this to get some feedback before going further.

I hope this helps.

Regards

David Pagendam

Thank you.



NORTH

0 25 50 100m

SCALE.

SKETCH SITE PLAN

SHOWING REDUCED FOOTPRINT.

15-BED ADOLESCENT MENTAL HEALTH E.T.U.

AT REDLAND HOSPITAL.

DAVID PAGENDAM.
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Submission to Service Options Implementation Working Group, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

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"The aim of youth services should therefore be to reduce the need for transition into adult services." (McGorry, Bates, Birchwood, 2013)

"Estimates suggest that between one-quarter to one-half of adult mental illness may be preventable with appropriate interventions in childhood and adolescence. " (Kim-Cohen et al, 2003)

Introduction

The combined factors of geography, vast distances and population distribution in Queensland mean that no matter where services are located, some young people with severe and complex mental health problems will still need to travel to gain access to appropriate services and/or the services will need to travel to the young people. This means consistent, frequent and regular availability of services will still be difficult to provide. To say that young people shouldn't have to travel to get the kind of treatment and rehabilitation Barrett is idealistic and doesn't reflect reality or practicality. As people travel to access other specialist health services like specialist cardiac or cancer treatment, some young people will have to travel and maybe stay away from home to access the type and intensity of service required to meet their particular mental health needs. There simply aren't the amounts of experienced staff to service young people with complex needs right across the state and the comparatively small percentages of young people with the most complex needs makes multiple extended treatment and rehabilitation services not economically viable. Although parents would prefer their children close to home, and young people may not wish to leave their community, if it comes to a question of keeping your child alive, as it does for many parents, then there is no choice to make – you send your child wherever you need to, to save their life, and help them reclaim their life.

The hope is that with a greater emphasis on promotion, prevention and early intervention, is that young people receive appropriate care that prevents them from progressing to the point where there situation is severe and complex. Queensland spent only **1.7% of the $983.3 million** on Promotion, Prevention and Early Intervention, Action Area 1 of the COAG National Action Plan on Mental Health 2006-2011 funding allocations, a smaller portion of this would have been allocated to youth mental health. Other states spent three and four times this amount in this action area. Unless this situation drastically improves, it will take many years before promotion, prevention and early intervention strategies will have significant impacts on

reducing the numbers of young people with severe and complex needs. Even with a widespread system of well-funded, well-staffed, well-coordinated services for these young people existed state-wide, there will always be some young people who will fall through the gaps. Lack of staff, lack of funding, geographic isolation, unsupportive home environment, abuse, young person's avoidance of help, complexity of young person's mental illness (dual diagnosis) – many reasons will cause the young person to progress to a point where they will need the treatment and rehabilitation of a centre like Barrett. No system or model of care will be perfect and be able to catch every young person that needs help or treatment at the time they most need it. However these young people should be provided with the very best and most comprehensive treatment and rehabilitation available. They are the most vulnerable of all young people and the There must be extended treatment and rehabilitation services with onsite schooling for young people with severe and complex mental health problems.

1. Components of the current services available in Queensland that best meet the care requirements of adolescents with complex mental health needs.

(i) Education: Onsite Schooling.

It would be very easy to consider the Barrett School a separate entity, especially being operated by a separate government department. However the School is anything but separate. It delivers much more than merely maintaining access to an academic curriculum. To have a seamless integration between education and treatment, being onsite, has enormous positive benefits for recovery outcomes.

The education programme at Barrett is crucial to the effective treatment and recovery plan for each young person, helping them explore vocational options, develop life-skills, develop self-esteem and re-engage with education. It is uniquely integrated with each young person's individual treatment plan. The access to on-site schooling is a vital factor, in not just transitioning the young people back to a world from which they have long withdrawn, but in preparing them to live independent adult lives. And though it is referred to as 'on-site schooling', it's important to note that the learning experiences don't just take place in the classroom but in the extended community as well. Beyond the group activities where specialised teachers have developed ingenious methods to incorporate learning into therapy and social/personal development activities, the young people engage in a wide range of activities, go on excursions such as career expos, visit workplaces, visit community organisations, do community work, to provide them with broader community experiences. They do work experience in the community facilitated by teachers, and where appropriate for individual students, provide educational support for those attending school and further education such as TAFE off-site.

The School recognises the importance of physical activity in mental health and education of the young people and incorporates Physical Education in their school program as well as providing other physical activity opportunities when possible. The large grounds around the school are therefore an essential component of the onsite schooling, and would need to be catered for at any location to which the facility was relocated.

In addition, the school encourages the adjustment to a more 'normalised' daily routine. 'Patients' become 'students' away from the ward in an environment that leaves any medical/hospital atmosphere aside and allows interaction and the development of peer relationships – a key element of life but quite often something that young sufferers of severe mental illness have never experienced or not in some time. Inpatients live with, attend school and socialise with their peers. In a safe and supportive environment where their peers are often going through similar issues, many young people experience friendship with people their own age (who have not been able to 'fit' in socially) for the first time in their lives. Onsite schooling allows them to interact with their peers in the education environment, offering them the opportunity to learn and practice different ways of engaging and communicating in a different environment, with different expectations, but with the flexibility of being able to withdraw to the ward if they need to or for treatment needs. If the school was off-site this would be much more problematic. In some cases, young people early in their admission are reluctant to attend the school environment – or leave their room even. However with the school onsite, it is much easier to move between the two environments than if the school was off-site.This is particularly crucial for some if not most young people, particularly early in their admission.

The School, as with any organisation, is only as good as its people. All of the staff are highly experienced working with young people with complex mental health problems and the issues that creates for their education. They are extremely knowledgeable, committed and dedicated and know and understand the environment in the ward. This is further highlighted by current teaching staff volunteering their time to run the holiday program for inpatients – an important part of their rehabilitation – because WMHHS staff weren't provided to run the program, as they normally do. It is another of the reasons the Education department wishes to retain the school staff as a team as it recognises the value of the group as a whole, and why the onsite schooling is such an advantage to the overall program of care. The education staff are very connected and engaged with treatment staff. Onsite schooling facilitates the easy exchange of information, because both WMH and Education staff can easily move between the two environments when required. The full wrap around service model can really only be effective if the domains of treatment and care are working in partnership. Unfortunately this occurring in reality outside what has been the Barrett Centre is not evident.

Educators in this team are in a perfect position to be able to document practices and strategies, recognising the value of this information. For example some have commenced an action research project on *Pedagogy for adolescents with psychiatric disorders* and presented at a conference in Amsterdam. The research done ensures ever improving standards of specialised schooling and the opportunity to use this information throughout the broader education system. This capacity for research and consultation is definitely enhanced by the onsite location of the school which allows for easy collaboration and communication with clinical and therapeutic staff. **This further highlights that this model has been a leader in the field of education for adolescents with complex mental illness.**

The current education team are committed to remaining as a group to continue to offer their services as an integral part of the full treatment and rehabilitation program. This is supported by the Education Department. It is ironic that the recognition for the important work done by the onsite education stream of Barrett is recognised and valued by that Department as an essential part of the treatment and rehabilitation component of Barrett, as

identified by the ECRG, yet the Planning Group within the Health Departemnt did not acknowledge the need for the schooling to be onsite. Importantly, the school is well-placed onsite for future opportunities to examine the effect of mental health on their education, and conversely the influence re-engagement in education has on young people's recovery: the reciprocal benefits.

Rivendell is a jointly administered School (NSW Department of Health and Department of Education & Communities - www.rivendell-s.schools.nsw.edu.au) in Concorde West New South Wales. It offers inpatient and day-patient programs with an onsite school and "clinical and education staff work collaboratively on educational programs." Education staff also provide teaching to other offsite hospital inpatient services. Whilst inpatient times are shorter than Barrett, it provides an excellent demonstration of the benefits and capacities of a treatment facility with onsite schooling.

Finally, the incidence of withdrawal and disengagement by adolescents from school and other educational environments is a very common occurrence. It is identified as one of the most significant factors used in mental health assessments and further supports the need for on-site and highly specialised and accessible educational programs.

The close collaboration of Barrett treatment and rehabilitation and Barrett schooling would be a perfect example of what the Government is trying to achieve via Mental Health Commission's whole-of-government strategic mental health plan – the integration and collaboration between departments for better outcomes and coordination of services.

(ii) Services away from home:

Whilst the general thrust of contemporary mental health service provision is to locate services in or close to the communities where people live, the geography of Queensland – the distances - and the population distribution makes it difficult, if not impossible to do. It is not ideal, however this is not always a negative. Barrett patients have cited that there can actually be advantages to a NON-localised facility i.e. it can act as a circuit breaker for the young person to put an end to the cycle they have been stuck in – one of moving from acute facility to home back to acute facility, especially where there are limited other services. In some circumstances, in an all too familiar environment, a young person is destined to repeat destructive or stagnating patterns of behaviour. So moving to a totally new environment can not only give them a more conducive setting for understanding their condition and addressing their problems, but it can be a conscious trigger for them to acknowledge that they have NOT progressed in their previous situations and need to now apply themselves as fully as they can because their illness has reached a level that has warranted such a significant change. This is particularly relevant when a person comes from a regional area where the social and service systems are small. Being recognized in their home community because of the scars from self-harm or being bullied or ridiculed because of the stigma of mental illness and the public knowledge that the young person has been admitted to an acute ward can seriously exacerbate a young person's mental health issues. In addition, in circumstances where abuse or neglect in the home environment has actually been a significant factor in the mental health issue that young person is suffering, being away from unsupportive or, in some cases, an abusive home environment is clearly a positive step and one that is vital if any progress is to be made at all.

The benefits of leaving the home environment are also apparent for young people in the same location as the service. Becoming an inpatient provides the same circuit-breaker for destructive habits and behaviours, an opportunity to escape an unsupportive or abusive environment, a chance to re-engage with schooling and peers, develop social and community connections and access the level of clinical and therapeutic support they require.

(iii) Combined Inpatient/Day-patient capacity:

Not all inpatients will remain in Barrett to become day patients. But for those patients for whom returning to their home is not an option or young people who live locally who are not ready for discharge, the capacity to attend as a day-patient as they progress in their treatment and recovery is an advantage. The young person is able to begin gradually, starting with one day a week if needed. This allows them to maintain the connection with staff, school and treatment and try out their independence and self-management. The sense of belonging and support is maintained but progress is tested and consolidated as young people reconnect with home and community.

Staff can observe the effects of treatment and the associated changes that take place in adolescents who transition from full-time inpatient to day-patient. Barrett can continue to monitor the progress of day patients and adjust treatment level and type accordingly. The young person can be supported to further build on home and community links until full day-patient status. Likewise as a full day-patient, the treatment team can facilitate further reduction of day attendance, at the same time expanding the young person's engagement with other education or vocational options and service providers (including residential if required) as determined by their treatment plan. This allows for a seamless transition back into the community.

(iv) Community:

There is a risk of viewing Barrett as a one-dimensional facility – inpatient - and seeing it just as a collection of components – Psychiatrists, Psychologists, Doctor, associated Therapists, Mental Health Nurses, Educators, Support staff, residential facilities, other support services. A tick and flick list of these items would indicate that the young people have access to all the essential ingredients to help them move towards recovery. Just having all of these components in the one place does not mean that young people will recover, no matter how many years of experience the people have or how modern and purpose-designed the building is.

There is something at Barrett that isn't listed on anyone's job description, or activity or feature of the Centre, but is a function of the combination of all of these things in an environment and atmosphere of commitment, dedication, experience and passion to help these young people. It would be difficult to measure – difficult to qualify and quantify. It is probably defined best as 'the whole is greater than the sum of its parts'. It is the sense of **community** it provides to the young people. This helps them to overcome their social isolation, develop confidence in their interactions, feel acceptance and build relationships – make progress towards recovery: feel part of something.

Just like any community, there are rules, different environments, different people, different activities, different expectations etc., just on a smaller scale. There is safety, stability, consistency, reassurance, security and trust, even if the young person doesn't feel these things on admission, the structure, routines and relationships will allow them to develop. Not every aspect of this community will be positive or pleasant for the young person – as in the

the wider community, but they experience these things with the support, guidance and under the observation of staff – 24 hours a day. This will help build resilience and skills that can be used in the wider community.

The relationships formed in this 'micro-community' between staff (school, clinical, therapy) and adolescents are vital to their participation and engagement in – and effectiveness of – treatment, therapy and schooling – and are an extremely powerful component of the 'community'. Such relationships can take much longer to develop in the general community as contact with clinicians and other workers would be more brief, less frequent, and more variable. The young person's inclination to engage in treatment and school could be severely reduced without these substantial relationships.

Many of the aspects of life that have either eluded these young people, or they have actively disconnected from due to their mental illness is available to them within this community, and with treatment, rehabilitation and time, will enable them to return to their own communities to lead fulfilling lives.

2. Gaps within the current mental health service options available in Queensland.

(i) No/insufficient service available:

This is self-explanatory. Either the service doesn't exist, which is often the case in rural and regional services or the service does not have sufficient resources to provide the service: insufficient inpatient beds; lack/unavailability of staff; staff with lack of experience; demand for service creating waiting lists/long waiting times for appointments. This results in no access to services, inadequate services or the extreme outcome of young people being placed in adult facilities, which can result in further trauma to the young person and an exacerbation of their condition.

Inconsistency in staff and their training/expertise in the area of Adolescent Mental Health has been the biggest problem identified by parents and their young person. The variation in quality of service delivery needs to be minimal for young people to develop faith in the service they are receiving.

(ii) Lack of recognition of developmental theory:

The fact that young people with complex needs are required to access adult services either due to lack of services (as described above) or after the age of 18 shows a complete lack of recognition for latest research on adolescence. Patrick McGorry states "Emerging adulthood is now a more prolonged and unstable developmental stage" (2013). For youth with complex needs this if often magnified because they can be socially, mentally and emotionally developmentally delayed to varying degrees due to their social isolation and subsequent loss of contact with peers and associated social engagement. So even at 18 they may not be at a level of maturity equivalent to their same-age peers. This will particularly depend on the amount and quality of treatment and rehabilitation they have had access to, how long they have been accessing it, and how successful it has been. There must be alternatives for these young people besides adult facitilies, even after they turn 18.

(iii) Failure to access service:

In this case the service is available but not able to be accessed. It was recently stated at a Mental Health Commission forum that <50% of young people that present to the CYMHS do not get past intake. Investigations would need to be undertaken as to whether this was due to the service being full, or the young person was not assessed as needing the service. Whether the assessment is accurate would depend on the level of experience of staff and/ the preparedness of the staff to listen to the parent/carer presenting with the young person. If young people are being turned away from CYMH services, how does this demonstrate early intervention/prevention? There are many examples of these instances –

(iv) Lack of networking and collaboration between services:

In some communities/areas, there is a distinct lack of cooperation between services. Parents have reported incidents where CYMHS have not wanted to refer to other community-based services or recommended against using them. Reasons for this vary from being possessive of the patient and not wanting to relinquish control of treatment; resistance to referring patient on because of fear of scrutiny of treatment already provided; service and staff available but not experienced enough to handle young person with complex needs. At a recent mental health forum, comments were made about the almost 'competition' type atmosphere between services (competing for funding, payments for placements) that hinders the collaboration between services. This is a major objective of the Mental Heatlh Commission – to develop a whole-of-government strategic mental health plan that will facilitate (hopefully) the collaboration and better integration of associated government departments (health, education, justice, housing) and community mental health services. Unfortunately, and unbelievably, the development of a new model and the Minister's intention to set up 'residential' type or other services – his descritpions have never been specific - will not be part of this process.

(v) Lack of recognition of genuine family support

The experience of many families is that they have been 'demonised' by the existing service system. Many talk of feeling as though they are blamed for their child's condition or judged when their child presents with instances of self-harm in hospitals. While it is acknowledged that some incidents of trauma or abuse may have occurred in the home, it is also a very uncommon cause for most adolescents. There does not seem to be much recognition for experience/knowledge of the parent/carer and conversely in some cases, if the parent demonstrated any professional knowledge, they were expected to become the sole service provider for their child.

Family support is a fundamental part of supporting any person in need. Building up the capacity of families will continue to be the most effective way to support young people by providing training/mentoring/counselling/support pathways. Rather than become defensive when families and parents ask questions – the approach could be inclusive and respectful. Sadly, this is not the experience of many parents.

The family is who an adolescent is discharged home to after an admission in any hospital. Often this occurs without a discharge plan or timely/effective service responses post admission. There are limited referral options and CYMH services have been unable to

provide the range of services needed. This has left families desperate, worried and ill-equipped to keep their children safe or be working towards a recovery. When families keep asking for help, they are ignored or not believed leading to a growing lack of faith and belief in the system or the government stations over seeing it. In addition, the lack of consultation with families further embeds the lack of genuine family involvement and consideration.

3. Opportunities for new and/or enhanced services for adolescents with complex mental health needs.

(i) E-health/E-Therapy:

Barrett could develop models for interaction with young people via this medium. This could be integrated into the full range of treatment and therapy programmes for young people who are on leave from the centre, follow-up of recently discharged patients, even to commence contact with young people on the waitlist and their clinicians/therapists/family/supports. Offering the facility for family contact would enable to young people to have a more meaningful interaction with their families, especially when they are a long way from home. E-health modes could be used to facilitate contact/consultation with rural/regional clinicians who request or require consultation with the specialist team at Barrett, even so far as establishing case conferencing for young people on the waitlist or for consideration for referral.(Refer to attachment 1)

(ii) Family Units:

Family units could be attached to an extended treatment and rehabilitation service for families/carers of those who live outside the metropolitan area, to better facilitate the involvement and support of parents in their child's treatment, such as is available for parents of children with other health problems. (Refer to attachment 1)

(iii) Mobile Services

"There is a lack of appropriate and urgently-responsive mobile community-based services that would support children, young people and their families in the least restrictive place of intervention. Such services would reduce the likelihood of hospital admission, reduce the demands on hospital emergency departments, and support earlier discharge from hospital, thereby reducing the demands on inpatient beds." (Extract from Issues Paper submitted to Mental Health Commission 'Quality, integrated, responsive and recovery-focussed child and youth mental health services across Queensland' Prepared and submitted by:Queensland Children's Health Hospital and Health Service CYMHS in collaboration with partners)

(iv) Clinical Case Management Advisory Teams:

There needs to be communication between the services that work with and refer young people with severe and complex needs and a specialist facility like Barrett to minimise the risk of these young people being lost by being referred somewhere that can't help or being on a referral round-about or with just no service available at all. If you consider that the number of young people with the most severe and complex mental health problems could be around 1% (estimate), it is only logic to realise that clinicians may go through their career without ever having contact with this cohort of young people (depending on where they work) or at least see very few. A centre like Barrett should have a clinician who is available to consult with other clinicians and services around the state – especially regional services

where staff may not be experienced or have limited experience with severe and complex mental health cases. This would not be a casual arrangement relying on local clinicians' decisions to consult, but a formalised process with indicators that would trigger a consultation with an expert clinician. E-health and teleconferencing would easily enable this (refer question 3 (i)). There should be a team that meets – like Child Protection teams that operate in connections with hospitals (SCAN teams? or they used to be called that) that monitor the young people that are identified as at risk of deteriorating into a severe and complex condition so they don't get lost in the system. Again this would be a formalised process with protocols based on indicators to trigger referrals to the team to minimise the likelihood of these young people fall through the gaps and fail to access the appropriate clinical care. This would also increase the likelihood that young people could remain in their community if it was combined with direct clinical and therapeutic consultations with Barrett staff. This team would Case-manage a statewide caseload of the most at risk or most severely ill young people. Lack of local experienced clinicians would be much less of an issue and that clinician would meet regularly with the team to discuss the care and progress of young people on the caselist. That way, the expertise of Barrett is valued and used to inform the care/case management of these kids before they get worse. This team would have a state-wide caseload. The Health Minister stated in a radio interview in July, how eager he was to utilise the potential and benefits of E-consultations so this might be something he would support.

(iv) Establish Barrett (Tier 3 Service) with onsite schooling with a Research and Advisory Function

Refer to attachment

(v) How did they get here?

When a young person presents to an acute facility or is admitted to Barrett, the question should be asked – HOW DID THEY GET HERE? And in one way, it probably is, through the gathering of patient information on admission to get a case history, but not in order to work out which part of the system failed – what are the gaps that allowed this young person to deteriorate into this state? **And not so something can be done about it.** This information needs to be gathered and analysed to work out where the gaps are and why young people end up in this situation, in most case, despite desperate efforts by their parents/carers. Was it inexperienced staff, lack of service – all of the above issues recorded in question two. However there is a problem with this. Parents/carers tell clinicians, therapists, support services, doctors. And if you are lucky, you will get an understanding one who will really hear you and view you as their most important resource – someone who knows their patient better than anyone else. But in so many cases – as you would find if you asked parents/carers – they have to fight, advocate, push, pester. This is exhausting and heartbreaking.

Imagine if you finally found somewhere that could help after months, sometimes years of trying. Imagine if they were admitted and you started seeing changes that gave you hope. Imagine then, that you were told it was closing down.

4. Other comments for consideration.

(i) Barrett/Tier 3 and other services shouldn't be created/adjusted as the Minister is trying to do before the Mental Health Commission is finished with their process. In fact there should be a unique commission process specifically for youth mental health services, and how they might then integrate with adult services that should run parallel to the Commission's main process – it is too big to do in one group. Youth services will get lost again without a specific plan and process of their own. Especially if the government is emphasizing prevention and early intervention. In Western Australia, the WA Commission for Children and Young People commissioned an Inquiry into the Mental Health and Wellbeing of Children and Young People in Western Australia. The subsequent report (2011) specified that "The Inquiry has recommended that the **Mental Health Commission** become the lead coordinating body for the improvement of service delivery for children and young people's mental health – by developing a comprehensive and strategic plan for the mental health and wellbeing of children and young people and leading a whole-of-government implementation process:

Recommendation 10

"A whole-of-government collaboration to improve the mental health and wellbeing of children and young people across the State be led by the Mental Health Commission. (Page 63)". Queenslanders see this as an appropriate process, and singling out a specific service for closure WITHOUT such a thorough procedure is in complete contradiction to best practice.

On a National level, the National Mental Health Service Planning Framework (NMHSPF) Project, an initiative of the Fourth National Mental Health Plan, will provided its finalised Care Packages and Service Mapping on 30 September 2013. This is one part of a much larger process to develop national modelling for mental health services – involving consumers and community in the process – which will have implications for models of delivery and funding. The NMHSPF project is joint-led by the NSW Ministry of Health and Queensland Health. What implications, if any, does this National process have for the whole-of-government plan to be developed by QMHC, and if a Care Package describing service models for 12-17 year olds

has been designed, should Queensland wait to see what models are proposed before undertaking significant changes to youth mental health services, especially since funding will be tied to these models based on population demand for each service?

(ii) Health needs of any type become complex when they are neglected. If you leave any condition without treatment or inadequate treatment, eventually it will become chronic, acute and serious. In many cases, it will become life threatening. While there is significant recognition of this in much of the health sector (eg all forms of cancer, diabetes, heart conditions) with extensive methods and availability of 'early detection', low grade intervention and preventative treatments, this is still not a priority in adolescent mental health.

As with many human services, it is more appropriate and cost efficient to provide services in the community setting through localised community based organisations and agencies. These rely on funding from all three levels of government. Services such as CYMHS could be developed into portal services that are much better resourced and become a trusted first point if a young person shows any sign of an emerging mental health need.

The focus needs to be on genuine and fool proof intake and assessment and then coordination of a referral plan to the most suited treatment/program/specialised services for each individual need. This will require those services to exist. This requires reliable and ongoing funding and a reversal in the funding cuts that have been implemented in the last 18 months. If the aim is to diminish the need for complex care, then the action must be on the preventative and early response services.

Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK Patrick McGorry, Tony Bates and Max Birchwood. (British Journal of Psychiatry 2013)

Kim-Cohen, J. et al 2003, cited in Department of Health, Mental Health Division (England) 2010, New horizons: confident communities, brighter futures: a framework for developing wellbeing, England, p. 26.

Well meant or well spent? Accountability for the $8 billion of mental health reform, Rosenberg et al. 2012

http://www.ccyp.wa.gov.au/files/MentalWellbeingInquiry/CCYP%20Mental%20Health%20Inquiry%20-%20Report%20to%20Parliament.pdf