4.7 I would also attend the wards from time to time and talk to staff about their concerns.

4.8 I would also meet with the QH Director of Mental Health Dr Groves (Dr Bill Kingswell came into that role at a later time).

(c) Any of the parents, friends or carers of the inpatients or outpatients of the BAC.

4.9 I cannot recall any specific meetings with any parents or carers. I consider it likely I would have made myself accessible to parents or carers if they required.

5 Explain what involvement, if any, did Ms Lane have in:

(a) The decision to close the BAC announced on 6 August 2013 (Closure Decision);

(b) The bases of the Closure Decision;

(c) The decision making process related to the Closure Decision.

5.1 I was not involved in the Closure Decision.

6 Explain what involvement, if any, did Ms Lane have in the inpatients and outpatients of the BAC transitioned to alternative care arrangements in association with the closure or anticipated closure whether before or after the announcements of the Closure Decision.

6.1 I had no involvement in the inpatients and outpatients of the BAC transitioned to alternative care arrangements in association with the closure or anticipated closure before or after the announcements of the Closure Decision (save those referred to above).

7 Outline and elaborate upon any other information and knowledge (and the source of that knowledge) Ms Lane has relevant to the Commission's Terms of Reference.

7.1 Nil.

8 All documents referred to in my witness statement are exhibited.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

Taken and declared before me by)
Pam Lane at Brisbane in the State of)
Queensland this 23 day)
of October 2015)
Before me:)

[redacted]..... [redacted].....

Signature of authorised witness Signature of declarant

A Justice of the Peace/
Commissioner for Declarations

STATUTORY DECLARATION OF PAM LANE

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PL-2	West Moreton South Burnett Health Service District – Role Description for District Chief Executive Officer, undated (for the period 2008 to 2011).	WMS.5000.0017.00045	5-8
PL-3	Email from Michelle McKay to TDDHSD District, copied to Pam Lane dated 11 September 2008	WMS.5000.0017.00088	9
PL-4	Minister for Health - Ten Year Mental Health Strategy for Queensland dated 1996	WMS.5000.0017.00005	10-49
PL-5	Queensland Mental Health Policy Statement – Future Directions for Child and Youth Mental Health Services dated 1996	WMS.1006.0101.00001	50-64
PL-6	Wolston Park Hospital Transition Team and the Hospital Redevelopment Project Team – Critical Pathways for the Decentralisation of Wolston Park Hospital and the Redevelopment of Associated Mental Health Services dated April 1998	WMS.6000.0006.00338	65-76
PL-7	Queensland Health Memorandum from Kevin Fjeldsoe to Dr Peggy Brown (Director of Mental Health), copied to Pam Lane, Ann McMillan and Trevor Sadler dated 1 November 2001	WMS.6000.0002.02697	77-78
PL-8	Letter from Dr Peggy Brown to Kevin Fjeldsoe dated 19 December 2001	WMS.6000.0002.02747	79
PL-9	Queensland Health – Report on the Need for Child & Adolescent Secure Inpatient Services and the Re-development of Extended Treatment Adolescent In-Patient Services dated October 2002	WMS.6000.0002.02760	80-93

[redacted]

[redacted]

Pam Lane **Witness**

PL-10	Emailed Memorandum from Dr Terry Stedman to Dr Peggy Brown dated 5 November 2002, attaching: • Reply to the Draft Report on the Need for Child & Adolescent Secure Inpatient Services and the Re-Development of Extended Treatment Adolescent In-Patient Services by the Barrett Adolescent Centre	WMS.6000.0002.02750 WMS.6000.0002.02752	94-95 96-103
PL-11	Queensland Health Memorandum from Dr Arnold Waugh to Jenny Stone, copied to Pam Lane, Kevin Fjeldsoe and Karen Roach, dated 16 March 2004	WMS.5000.0017.00288	104
PL-12	Queensland Health – Options Study for Barrett Adolescent Centre at The Park Centre for Mental Health prepared by Project Services, Department of Public Works dated December 2004	WMS.6000.0002.02774	105-128
PL-13	Queensland Health Briefing Note for Noting from Pam Lane to Mark Mattiussi dated 10 January 2006	WMS.6000.0002.02742	129-131
PL-14	Queensland Health – Child and Youth Mental Health Plan 2006 – 2011, undated	WMS.6000.0004.00253	132-215
PL-15	Queensland Health Briefing Note from Pam Lane to Gloria Wallace dated 1 October 2007	WMS.0012.0001.13009	216-219
PL-16	Queensland Health Briefing Note from Pam Lane to Ms Uschi Schreiber, undated	WMS.1002.0009.00666	220-227
PL-17	Queensland Health Memorandum from Aaron Groves to David Theile and Pam Lane, copied to David Crompton, Bill Kingswell and Monica O'Neil dated 28 October 2008	WMS.1005.0001.00311	228-231
PL-18	Queensland Health – Report of the site evaluation subgroup – Site Options Paper for the development of the Barrett Adolescent Centre	WMS.1003.0046.00144	232-299
PL-19	Queensland Health Memorandum from Pam Lane to Aaron Groves, copied to David Thiele and Monica O'Neill, undated	WMS.1005.0001.00307	300-303

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Pam Lane **Witness**

PL-20	Queensland Health Memorandum from Aaron Groves to David Theile and Pam Lane, copied to David Crompton and Monica O'Neil dated 1 April 2009	WMS.5000.0017.02486	304-305
PL-21	Queensland Health – Adolescent Extended Treatment Site Selection Summary of Consultation on Site Selection dated March 2009	WMS.5000.0017.02512	306-318
PL-22	Queensland Health Memorandum from Pam Lane to Aaron Groves, copied to David Theile and Monica O'Neill dated 22 April 2009	WMS.5000.0017.02510	319-320
PL-23	Queensland Health Memorandum from Pam Lane to David Theile, copied to Shirley Wigan, John Quinn, David Crompton, Bill Pepplinkhouse and Jim Sams dated 22 December 2010	WMS.6000.0006.00011	321-328
PL-24	Queensland Health Memorandum from Pam Lane to David Theile, copied to Shirley Wigan, John Quinn, David Crompton, Bill Pepplinkhouse and Jim Sams dated 13 April 2011	WMS.6000.0006.00001	329
PL-25	Queensland Health Briefing Note for Information from Pam Lane to Gloria Wallace dated 25 June 2008	WMS.5000.0017.02483	330-331
PL-26	Queensland Health Briefing Note for Information from Pam Lane to Director-General copied to Aaron Groves dated 26 June 2008	WMS.5000.0017.02480	332-333
PL-27	Briefing Note to Minister for Health dated 13 April 2011	WMS.5000.0017.00148	334-336
PL-28	Briefing Note to Director-General dated 3 February 2012	WMS.1000.0005.00096	337-339
PL-29	Mater Children's Hospital Brisbane – Kids In Mind – Mater Child and Youth Mental Health Service – Barrett Adolescent Centre Consultation on Aggression and Violence at the BAC dated August 2003	WMS.1005.0001.00381	340-437
PL-30	Queensland Health –Proposed Admission Criteria to the Barrett Adolescent Centre	WMS.5000.0017.02508	438-439

	Discussion paper, undated		
PL-31	Child and Youth Mental Health Services – Guiding Principles for Admission to Queensland Health Child and Youth Mental Health Acute Inpatient Units dated 2010	WMS.5000.0017.01944	440-462
PL-32	The Park – Centre for Mental Health – Operational Plan dated July 2003 to June 2004	WMS.5000.0017.02501	463-469
PL-33	The Park – Centre for Mental Health – Operational Plan dated 2006 - 2009	WMS.1007.0358.00001	470-474
PL-34	Document entitled 'Terms of Reference – External Investigation Review of Consumer Incidents – Barrett Adolescent Centre' dated 27 January 2009	WMS.1005.0001.00127	475
PL-35	Garry Walker, Martin Baker and Michelle George - 2009 Review of Barrett Adolescent Centre (Final Report), undated	WMS.1005.0001.00128	476-493
PL-36	Document entitled '2009 Review of Barrett Adolescent Centre', undated	WMS.6010.1000.16267	494-509
PL-37	Briefing Note to Minister for Health dated 21 June 2011	WMS.0012.0001.13002	510-512
PL-38	ACHS, Advanced Completion within 60 day Survey Form dated 26 August 2008	WMS.5000.0017.00377	513-525
PL-39	West Moreton South Burnett Health Service District – ACHS IDR Mental Health Survey Recommendations Action Plan	WMS.1001.0062.00001	526-541
PL-40	West Moreton South Burnett Health Service District – Barrett Adolescent Centre Work Program, undated Letter from Certis Building Certification to Michael Thompson dated 30 April 2009 Certis Building Certification – Engagement Form, undated Certis Building Certification – Company Profile & Capability Statement Letter from TTBS to Michael Thompson	WMS.5000.0018.00019	542-581

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Pam Lane **Witness**

	dated 8 May 2009 Letter from Philip Chun to Michael Thompson dated 30 March 2009 Document entitled 'Scope of Work – Adolescent High Dependency Unit', undated Queensland Health The Park – Centre for Mental Health Workplace Instruction dated 2 July 2009 Queensland Health The Park – Centre for Mental Health Workplace Instruction dated 2 July 2009 Document entitled 'The Park – Centre for Mental Health Emergency Drill Schedule 2009 CODE RED' dated 2009 West Moreton South Burnett Health Service District – Evacuation Exercise (Evaluation Form) dated February 2008 Document entitled 'Register of Code Red Drills – 2009' Queensland Health Darling Downs – West Moreton Health Service District The Park – Centre for Mental Health – General Evacuation Instruction Checklist to Unit Emergency (Fire) Procedures dated April 2009 Plan dated 15 May 2003 Plan dated February 2009 Plan, undated Plan dated 1996 Plan dated 9 March 2009		
PL-41	The Australia Council on Healthcare Standards – Report of the In-depth Review of the West Moreton South Burnett Health Services District Mental Health Services (incorporating the National Standards for Mental Health into EQuIP dated 8 October 2008	WMS.1008.0077.00001	582-627

PL-42	The Australia Council on Healthcare Standards – Report on Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program dated 14 October 2008	WMS.6006.0001.29920	628-716
PL-43	Email from Avis Macdonald to Terry Hughes, copied to Pam Lane dated 23 July 2009, attaching: • DSCF0512 • DSCF0513 • DSCF0516 • DSCF0517	WMS.5000.0017.02525 WMS.5000.0017.02527 WMS.5000.0017.02529 WMS.5000.0017.02528 WMS.5000.0017.02526	717-721
PL-44	The Australia Council on Healthcare Standards – Report on the Conditional Survey for the ACHS Evaluation and Quality Improvement Program for West Moreton dated 4 November 2009	WMS.1004.0033.00001	722-759
PL-45	Commission for Children and Young People and Child Guardian –community visitor report dated March 2003	WMS.5000.0017.00170	760-766
PL-46	Commission for Children and Young People and Child Guardian – community visitor report dated December 2006	WMS.5000.0017.02533	767-776
PL-47	Queensland Health – Special Investigation Report – Allegations of Misappropriation of a Schedule 8 Drug, "Dexamphetamine" from the Barrett Adolescent Centre, The Park – Centre for Mental Health at West Moreton Health Service District dated December 2003	WMS.6000.0002.02817	777-793
PL-48	Queensland Health – Special Investigation Report – Allegations of Mismanagement of Grant Money and Unauthorised Banking Procedures at the Barrett Adolescent Centre, Wolston Park Hospital at West Moreton Health Service District dated December 2002	WMS.5000.0017.00158	794-810
PL-49	Queensland Health Memorandum from Joanne King to Pam Lane, copied to Monica O'Neill dated 21 June 2007	WMS.5000.0017.00299	811-812

PL-50	Queensland Health Memorandum from Sue Cardy to Pam Lane dated 26 November 2007	WMS.5000.0017.00154	813
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PL-52	Queensland Government Memorandum from Elizabeth Edge to Pam Lane, copied to Monica O'Neill dated 16 December 2008	WMS.5000.0017.00117	818-826
PL-53	Queensland Government Memorandum from Katrina Mathies to Pam Lane, copied to Bill Jelacic and Julie Trewin dated 2011	WMS.5000.0017.00303	847-828

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Pam Lane **Witness**

RESUME

OF

PAMELA LANE

Profile
Qualifications
Professional and Queensland Health State Committee Activities
Community Involvement
Career Summary
Referees

Pamela Lillian Lane

PROFILE

I have had over 25 years of success in leading and managing a diverse range of health services that focus on continuously improving patient services and developing staff. I have worked in Queensland Health as an experienced Executive and understand the dynamics of the organisation, its culture, politics and ways of doing business. Throughout my career, I have continuously challenged how things are done, identified activities that needed improvement, provided creative and cost effective solutions on complex matters and pursued opportunities with great vigour.

I retired three years ago and have continued to work for my community through a range of board positions. This has enabled me to give back to this community and to use the knowledge that I have gained during my working life.

QUALIFICATIONS

2011	Company Directors Course Diploma
2003	Graduate Certificate in Interprofessional Leadership University of Queensland, Ipswich Campus
1996	Masters of Health Administration University of New South Wales
1992	AHCS-UNSW Certificate in Quality Management Sydney
1989 to 1992	Bachelor of Administration (Nursing) University of New England, Armidale
1981 to 1982	Diploma of Applied Science Nursing and Unit Management Course Queensland Institute of Technology, Brisbane
1979 to 1980	Senior Certificate Board of Secondary School Studies
1970 to 1971	Midwifery Training King Edward Memorial Hospital for Women, Perth
1966 to 1969	General Nurse Training Toowoomba Base Hospital

BOARD AND COMMUNITY INVOLVEMENT

2012 to present	Director West Moreton Oxley Medicare Local FARM sub committee
2010 to 2013 2013 to present	Director of Ipswich Club President, Ipswich Club
2007 to 2014	Bremer TAFE Council member
2005 to 2012	University of Queensland Ipswich Campus Community Advisory Committee
2005 to present	Lady Mayoress Committee
1999 to present	Member of the Ipswich Hospital Foundation
1999 to present 2012 to present	Board Member of Ipswich Hospice Care Secretary Management Committee Safety & Quality Sub Committee
1997 to present	Member of West Moreton Zonta, Past President, Fundraising Chairperson for eight years

RECENT CAREER SUMMARY

July 2011 to 2012	District Chief Executive Officer West Moreton Health Service District
November 2008 to 30 June 2011	District Chief Executive Officer Darling Downs – West Moreton Health Service District
January 2007 to November 2008	District Manager West Moreton South Burnett Health Service District
February 2000 to January 2007	District Manager West Moreton Health Service District
August 1999 to February 2000	Acting District Manager West Moreton Health Service District
October 1993 to August 1999	Director of Nursing Ipswich Hospital
December 1992 to October 1993	Acting Director of Nursing Redcliffe Hospital

REFEREES

Mr Peter McMahon
Chairperson
Ipswich Hospice Care

Mr Peter Johnston
Previous President
Ipswich Club

Janet Pisasale
Mayoress
Mayoress Committee

Dr Tony Fitzgerald
Chairperson
West Moreton Oxley Medicare Local

Queensland Government
Queensland Health

Darling Downs – West Moreton Health Service District

Job ad reference:	**H08EA0969**
Role title:	District Chief Executive Officer
Status:	Contract position
Unit/Branch:	Darling Downs – West Moreton Health Service District
Division/District:	
Location:	Darling Downs – West Moreton
Classification level:	Remuneration will be negotiated
Salary level:	Remuneration will be negotiated
Closing date:	Monday, 6 October 2008
Contact:	Russ Wilde
Telephone:	
Online applications:	www.health.qld.gov.au/workforus or www.smartjobs.qld.gov.au
Fax application:	
Post application:	Recruitment Services, PO Box 2221, Mansfield BC, Qld, 4122

About our organisation

Queensland Health's mission is 'creating dependable health care and better health for all Queenslanders'. Within the context of this organisation, there are **four core values** that guide our behaviour:

- **Caring for People:** Demonstrating commitment and consideration for people in the way we work.
- **Leadership:** We all have a role to play in leadership by communicating a vision, taking responsibility and building trust among colleagues.
- **Respect:** Showing due regard for the feelings and rights of others.
- **Integrity:** Using official positions and power properly.

Purpose of role

- To manage the operations of Queensland Health in a district within agreed budget parameters to ensure optimal levels of patient care are delivered and current and future local health service needs are met.

Staffing and budget responsibilities

- The role of District CEO manages a workforce of 5333 full time equivalent staff and has responsibility for an annual budget of $629,692,133.

Key accountabilities

- Fulfil the accountabilities of this role in accordance with Queensland Health's core values, as outlined above.
- Fulfil the accountabilities of this position in accordance with Queensland Health's core values.
- Ensure optimal levels of employee commitment, performance and service delivery through the establishment of a clear sense of direction and provision of effective leadership and management throughout the district.
- Ensure the current and future health service needs of the district are addressed through the development and implementation of appropriate strategic, operational plans and health service plans which reflect Government priorities.
- Prepare an annual budget which accurately reflects the health service needs of the district and manage actual expenditure within agreed budget parameters.

- Ensure plans and strategies are in place to attract and retain the skills and workforce necessary to meet current and future health service needs.
- Manage and maintain the physical assets (buildings, equipment etc) of the district to enure the delivery of optimal health services.
- Ensure that appropriate procedures and systems are in place to meet governance and patient safety requirements.
- Ensure effective community engagement strategies are in place, either directly or through the District Health Community Council and other stakeholders including local GP's and relevant NGO's, so the district can address, local health service needs and expectations.
- Ensure the management and operation of all activities within the district comply with Queensland Health's policies and delegations and with relevant legislation.
- Ensure the district's perspective is represented in the development and implementation of Queensland Health plans and strategies.
- Ensure equitable access to health services across all sections of the local community.
- Ensure cross district collaboration occurs, utilising clinical services networks as appropriate, in the planning and delivery of integrated health services.
- Research best practice health service models and ensure local health services practices reflect latest developments and innovations.

Qualifications/Professional registration/Other requirements

- An appropriate and relevant tertiary qualification is desirable.

Key skill requirements/competencies

The position requires an understanding of the NHS leadership qualities and the capacity to apply them in discharging leadership and management responsibilities.

- **Technical Knowledge**
  Extensive knowledge of the operations of large and complex service delivery organisations.
- **Strategic Capability**
  Demonstrated capacity to analyse and understand local future service delivery needs for incorporation into strategic plans at a local and corporate level.
- **Client Focus**
  Detailed understanding of all the elements of service (people, facilities and equipment), and the interrelationships between those elements, necessary to deliver quality outcomes.
- **Leadership and Management**
  - Demonstrated ability to apply contemporary leadership principles to develop and maintain an effective workforce.
  - Highly developed skills, including high level ability in the areas of planning, managing resources, budget preparation and management, project management, objective setting and monitoring, coaching and performance feedback and management.
- **Problem Solving**
  - Demonstrated ability to identify and resolve issues.
  - Highly developed analytical skills.
  - Demonstrated capacity to identify opportunities for continuous improvement.
- **Communication and Interpersonal Skills**
  - Highly developed oral communication skills to enable effective interaction in individual and group situations (eg with team members, patients, employees, stakeholders etc).
  - Demonstrated ability to build and maintain appropriate relationships with team members, employees, stakeholders and the broader community.
  - Demonstrated capacity to represent Queensland Health appropriately with stakeholders, government agencies and the broader community.
  - Highly developed written communication skills to enable the development of quality business cases and management reports.
  - Demonstrated ability to make presentations at the highest levels within organisations.

- **Business Acumen**

  - Highly developed understanding of the financial pressures and constraints that impact service delivery and the capacity to make management decisions which achieve optimal outcomes within those constraints.

- **Teamwork**
  - Demonstrated ability to work effectively as a member of a management team to achieve organisational goals.
  - Demonstrated ability to build and lead a cohesive management team committed to common goals.
- **Organisational Commitment and Awareness**
  - Awareness of and commitment to compliance with Queensland Health policies and delegations relating to human resources, workplace health and safety, finance etc.

How to apply

Please provide the following information for the panel to assess your suitability:

- **A short response** (maximum 1–2 pages) on how your experience, abilities, knowledge and personal qualities would enable you to achieve the key accountabilities and meet the key skill requirements.
- **Your current CV or resume, including referees**. Referees should have a thorough knowledge of your work performance and conduct, and it is preferable to include your current/immediate past supervisor. Referees will only be contacted with your consent.
- **Application form** (only required if not applying online).

About the Health Service District

The Darling Downs – West Moreton District incorporates the prior Toowoomba and Darling Downs and West Moreton Health Service Districts and encompasses the Dalby, Goondiwindi, Toowoomba, Southern Downs, Lockyer Valley, Ipswich and South Burnett Regional Shire Councils. The District covers an area of approximately 99 415 square kilometres with an estimated resident population of 463 526 in 2006. The estimated population projection of the District is 581 184 by 2016 with a significant proportion of the population being over the age of 65 years.

There is a range of population dispersion throughout the District ranging from the highly accessible areas such as Ipswich and Toowoomba to the less accessible rural towns classified as remote such as Taroom and Tara.

Hospital and health service facilities are located at Boonah (30 beds), Cherbourg (16 beds), Chinchilla (37 beds), Dalby (41 beds), Esk (26 beds), Gatton (22 beds), Goondiwindi (45 beds), Inglewood (10 beds and 12 residential aged care beds), Ipswich (363 beds), Jandowae (12 beds), Kingaroy (41 beds), Laidley (15 beds), Miles (13 beds and a 14 bed Milton House Residential Aged Care Facility), Millmerran (16 beds), Murgon (15 beds), Nanango (10 beds), Oakey (9 beds plus Dr E A F Nursing Home 71 beds), Stanthorpe (42 beds), Tara (15 beds), Taroom (13 beds), Texas (10 beds and 12 residential aged care beds), Toowoomba (322 beds), Wandoan (2 beds and a Primary Care Clinic) Warwick (and Wondai (5 beds) plus Forest View Residential Aged Care Facility (36 beds). The District also manages the Mt Lofty Heights Nursing Home (40 beds), The Oaks Residential Aged Care Facility (40 beds), Farr Home Nursing Care Unit (26 beds), Karingal Residential Aged Care Facility (80 beds), The Park Centre for Mental Health (192 beds) and outpatient clinics at Glenmorgan, Moonie and Meandarra.

Allied Health Services throughout the District include Nutrition and Dietetics, Occupational Therapy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology. The Darling Downs Population Health Unit Located in Toowoomba provides health promotion, public health nursing, public health nutrition and environmental health services to the District areas.

Community Health Centres are located at Crows Nest, Ipswich, Gatton, Goodna, Oakey, South Burnett and Toowoomba. Services throughout the District include Adult Health, Aged Care Assessment Team, Alcohol, Tobacco and Other Drugs Service, Child Health Services, Dental Services, Family Support Services, Health Information Service, Home and Community Care

Service, Sexual Health Service, Therapy and Support Services for Children, Mobile BreastScreen Clinic, Young Peoples' Health, Aboriginal and Torres Strait Islander Health, Multicultural Health, Integrated Mental Health Services, Child and Youth Mental Health Services, Older Person's Mental Health and Child, Youth and Family Services.

The Baillie Henderson Hospital (204 beds) provides non-acute mental health services and extended mental health and intellectual disability services to the region. The Park- Centre for Mental Health Treatment, Research and Education is also a tertiary metal health extended care facility within the District providing inpatient care, mental health research and education.

Chronic health conditions such as coronary heart disease, respiratory disease, diabetes and renal disease also present the major focus for primary health care and ambulatory services. The relative shortage of allied health and specialist clinical workforce requires the development of service models that maximise the ability to enable early diagnosis and intervention in the at risk population.

Pre-Employment screening

Pre-employment screening, including a criminal history check, may be undertaken on persons recommended for employment. Please refer to the Information Package for Applicants for details of employment screening and other employment requirements.

From: Michelle Mckay
Sent: 11 Sep 2008 12:40:01 +1000
To: TDDHSD District
Cc: Pam Lane
Subject: Darling Downs - West Moreton Health Service District Update

Good afternoon

As indicated in our last email, we intend to keep you informed about activity that is occurring in the creation of the new Darling Downs - West Moreton Health Service District. The position of CEO for this district, and for 9 others, will be advertised across Australia and New Zealand from this weekend. Applications will close on 6 October.

A number of the Executive and other staff across both the West Moreton South Burnett and the Toowoomba and Darling Downs HSDs have started meeting with their counterparts. At this time, the purpose of those meetings is to gain an understanding of the different processes and priorities in each of the areas. The Executive staff of both districts will meet again on 19 September in Toowoomba. As highlighted in our last email, at this point, it is **business as usual**.

Remember, if you have any questions you can email them to or call the Reform hotline and log a question or contact either of us.

Pam Lane and Michelle McKay

Michelle McKay
District Manager
Toowoomba and Darling Downs Health Service District

Minister's Foreword

Mental Health is an area within the health sector that has suffered from considerable neglect. Proposals to improve the extent and quality of mental health services have tended, in the past, to be long on rhetoric and short on substance.

The Queensland Government has therefore determined it will address the historic problems in this state's mental health system. Recent budget initiatives have begun to expand community-based services and increase the number of hospital beds for people with mental illness. However, a long term, comprehensive strategy, over 10 years, is now released to ensure the planning and implementation of reform is sustained.

A Ten Year Mental Health Strategy for Queensland covering the period to 2006 has been developed. It is the result of a collaborative and cooperative planning process involving key stakeholders throughout the state and builds on Australia's National Mental Health Strategy. It provides a much brighter future for mentally ill people in our state.

The Strategy outlines the key directions and framework for the implementation of reforms which will make quality mental health care more accessible and less stigmatised. The detail provided in this document primarily relates to the development of mental health services. Other important initiatives, such as the development of the new Mental Health Act, Project 300, and nongovernment and other interagency initiatives have been announced separately.

I look forward to working with those in the mental health sector and the wider health community in implementing this 10 year strategy.

Mike Horan
Minister for Health

Contents

ISBN 0 7242 7691 2

Executive Summary

Numerous state and national reports and inquiries have documented the lack of services for mentally ill people in Australia. The most prominent of these has been the *1993 Human Rights and Equal Opportunities Commission Report on the Rights of People with Mental Illness.* This Report highlighted the fact that reforms, which have brought improvements in the quality of life and service provision for people with other illnesses and disabilities, largely bypassed people with mental illness and psychiatric disability.

In recognition of this, a National Mental Health Strategy was endorsed in 1992 by all Commonwealth, state and territory Health Ministers, and set the framework for the reform of mental health services in Australia.

Throughout Australia generally, and Queensland in particular, community-based services have been very underdeveloped, despite most people having their care delivered outside hospital. In addition, fragmentation of the community, acute and long-term hospital components has characterised mental health service delivery.

The Ten Year Mental Health Strategy for Queensland advances the directions identified in the Queensland Mental Health Policy (1993) and the Queensland Mental Health Plan (1994). It progresses the key directions and strategic framework for the implementation of service reform throughout the State and identifies the structural and service system reforms.

In Queensland, mental health treatment and rehabilitation services are provided by primary health care providers and specialised mental health services. Specialised mental health services are secondary and tertiary services, which are delivered by specialist mental health personnel. Under the National Mental Health Strategy and State policy directions these services are targeted particularly at those people with mental illness and serious mental health problems.

At the District level, services are delivered through community and hospital services and, in four Districts, extended inpatient services are provided on a supra-district basis from the psychiatric hospital facilities. Private psychiatric services are also key providers of secondary and tertiary mental health services.

The key directions for reform of mental health services in Queensland include significant enhancement of community mental health services, the reorganisation of the service delivery system, especially the psychiatric hospitals, the review of mental health legislation, and the improvement of intersectoral links particularly with housing and disability support agencies. The immediate priorities for Queensland include:

- establishing mainstreamed integrated services to promote continuity of care across service components
- providing locally available care through the more equitable distribution of mental health resources
- involving consumers and carers in the planning, operation and evaluation of services
- prioritising services to those most in need and ensuring services respond appropriately to the needs of priority groups
- progressing the reform of psychiatric hospitals
- establishing and maintaining links with the primary health care services
- implementing quality management systems, including the National Services Standards
- improving intersectoral links, particularly with housing and disability support agencies

The central principle for planning and delivering mental health services is that they must target the needs of consumers and demonstrate the effective use of resources in meeting

these needs. Formal consumer advisory processes and procedures for handling complaints are being established. The implementation of new mental health legislation will be consumer focused and provide for the special needs of people with mental illness by facilitating access to high quality treatment and care while, at the same time, ensuring the rights of individual patients and the community are protected.

An increased emphasis on intersectoral collaboration will occur to take account of the many factors which influence health status in terms of access to social and disability services, such as housing, employment, education and training, income security, transport, community support and recreation. The mental health service system will be responsible for ensuring continuity of care by providing coordination and linkage mechanisms across providers and agencies.

A number of groups have been identified by the National Mental Health Strategy and state policy directions as requiring specific strategies to ensure equitable access to appropriate mental health services. These include Aboriginal and Torres Strait Islander communities, people from non-English speaking backgrounds, older people, people from rural and remote communities, children and young people and mentally ill offenders.

Detailed mental health services planning for Queensland has been completed using population based planning guidelines. These guidelines have been based on existing service provision within Australia and overseas, and the population projections for 2006. The planning has concentrated on developing core mental health services to achieve a balance between hospital and community treatment based on the principles of integration of inpatient and community components and self sufficiency in service delivery for populations within geographically defined catchment areas.

The following service components and priorities for development have been identified for networks of District Health Services:

- referral, intake and assessment, including extended hours capacity
- continuing treatment, using a case management approach, including
  - community treatment services
  - outreach services
  - acute inpatient services, with provision for short to medium term treatment including acute inpatient secure treatment
  - psychiatric crisis response and treatment
  - specialist intensive treatment and support for identified “at risk” individuals (mobile intensive treatment)
  - extended inpatient treatment and rehabilitation services divided into five specialised clinical programs

For catchment area services whose population is not sufficient to support the full range of service components locally, formal arrangements for visiting from or access to District Health Services in major centres will be established.

The national and state directions for mental health services require significant reform in the structure and function of psychiatric hospitals. In Queensland, extended inpatient services are provided by Baillie Henderson Hospital, Wolston Park Hospital Complex, Mosman Hall Hospital, and Kirwan Rehabilitation Unit. These facilities will be restructured to provide services targeting five clinically identified programs.

To enable people to receive extended inpatient services as close to their homes as possible, new facilities are being planned for development in north Queensland, Sunshine Coast, Gold Coast, The Prince Charles Hospital and Bayside Districts. This will enable the decentralisation of extended inpatient services from the existing psychiatric hospitals. This process will be coordinated over the required time frame to allow human resource management and industrial relations issues to be dealt with. The rehabilitation and treatment focus of extended inpatient

services will be strengthened and transfer criteria will be used for people moving between District mental health services and supra-district extended inpatient services.

Resource implications for the implementation of the Ten Year Mental Health Strategy have been identified in terms of financial, human, and physical resources. They have been determined using indicative staffing profiles for each of the service components of mental health services and are based on the recurrent labour and non-labour costs to operate services. The financial implications for the implementation of the Ten Year Strategy will be considered within the context of a combination of Queensland Health growth funds and the allocation of new funds through the annual State Budget process.

A number of the statewide capital works required for the implementation of mental health reform are included in the general hospital redevelopment and expansion program of the Queensland Health's 10 year Hospital and Health Services Building Plan.

The reform of mental health service delivery involves significant changes to the size, location and skill mix of the mental health workforce. A Mental Health Workforce Steering Committee, comprising representatives from the major unions, three District Health Services, and the relevant Corporate Office areas, has identified a program of statewide workforce issues to be addressed.

To achieve the service outcomes identified in the National Mental Health Strategy, significant changes are needed in the delivery of mental health services in Queensland. The planning and service development necessary to achieve these changes is already in progress at both statewide and district levels. The Ten Year Mental Health Strategy for Queensland will ensure a coordinated and consistent approach to the implementation of mental health reform and that resources are allocated efficiently and effectively to best meet the needs of the population.

1 Introduction

1.1 Queensland Health System

Queensland Health is currently moving to a new structure. It is refocussing to concentrate on delivering high quality and accessible health services through self-management. The new structure of Queensland Health has two major divisions; the Planning and Systems Division and the Health Service Division.

The primary function of the Planning and Systems Division is to set statewide broad health priorities, and identify and develop services which improve health status and achieve identified health outcomes, and provide corporate infrastructure support.

The Health Services Division is responsible for direct health service delivery issues in the 39 District Health Services, which are responsible for the delivery of health services to their communities. Health Councils have been established for each District to facilitate community input into the planning, monitoring and evaluation of hospital and community health services.

This structure aims to give greater autonomy and responsibility to Managers of health services and keep decisions or service delivery as close as possible to the local level. This is especially important given the size of Queensland and the different characteristics of each District.

1.2 The Queensland Mental Health System

Mental Health, Corporate Office is responsible for progressing the development of mental health services in Queensland. This includes coordinating the statewide policy directions and strategic framework for service development, review of mental health legislation, supporting the development of the non-government sector, and the administration of the Mental Health Act and Regulations.

Public mental health services will be delivered by District Health Services. These will include services provided by primary health care providers as well as specialised mental health services. Specialised services are secondary and tertiary services delivered by specialist mental health personnel.

Under National and State directions for mental health reform, these services are particularly targeted to those people with mental disorders and serious mental health problems. This is to ensure that the people most at risk receive the treatment they need. This does not exclude access to treatment for people with a range of mental health problems which are serious in terms of their impact on quality of life or have adverse social consequences.

Consultation and liaison services are provided by the specialist mental health services to other health and welfare services dealing with people who have mental health problems. Early intervention for people developing mental disorder and adequate mental health promotion and prevention activities are important components of the mental health service system.

Primary health care services

This level of service is provided through locally available services such as general practitioners, community health services, pharmacists, and domiciliary nursing. Queensland Health's Primary Health Care Policy seeks to strengthen the role of these services in the health system. The aim is to develop a coordinated network of health services and other social and disability support services in both the government and non-government sectors to provide comprehensive support for people with mental disorders and their carers.

Primary health care providers will usually be the first point of contact for people with mental

disorder and will also play an important role in ongoing clinical care. The Third National Mental Health Report (1996) identified that 33 per cent of people with serious mental disorder receiving any form of treatment are being managed by general practitioners. In rural and remote Queensland, primary health care workers are the key providers of mental health services, supported by limited specialised mental health services.

Public and private mental health services provide a consultation and liaison service to primary health care providers which enhances and supports their work.

Secondary and tertiary mental health services

Secondary and tertiary mental health services are delivered by mental health professionals to a geographically defined population of a District and/or network of Districts. Services are provided to address the needs of children, young people, adults and older people with serious mental illness.

Comprehensive services are provided which encompass integrated processes of referral, intake and assessment, and continuing treatment using a case management approach.

These services should be provided in a way that makes them accessible to people with special needs. Mental health non-government community organisations provide a range of complementary specialised support services. Private psychiatric services provide a significant proportion of the specialised mental health services.

The Ten Year Mental Health Strategy for Queensland focuses on the provision of mental health services through the public system while acknowledging the need to link these with private sector services. The development of a strong partnership between public mental health services, private sector services and non-government community sector services is an integral component of providing better mental health services in Queensland.

1.3 Program Management

Within the new Queensland Health program structure a discrete Mental Health Program has been identified as the framework for the provision of mental health services by Queensland Health.

The goal of the Program is *'to improve the quality of life of people with mental disorders and serious mental health problems through the provision of consumer focussed services'* .

The scope of the Mental Health Program includes:

- services funded by Queensland Health for the specific purpose of providing intake and assessment, continuing treatment, and community support services to people with mental disorders, serious mental health problems and associated disabilities
- services normally delivered from a service or facility which is readily identifiable as both specialised and mental health in focus
- services provided by dedicated personnel employed or contracted by state-funded services

The Program is accountable for:

- services being delivered in accordance with social justice principles
- services targeting the core business of the Program
- services being delivered efficiently
- services being consumer focussed and delivered effectively

Services are organised around catchment area populations within networks of District Health Services. Within each network there will be an identified principal service centre. This will be generally defined as one with a minimum size catchment population of 100,000 with an acute mental health inpatient unit located in the general hospital. Using the role delineation model for adult catchment area mental health services this will be a Level 4 service. In many cases the principal service centre will provide direct service delivery and clinical and

professional support services to surrounding Districts which may or may not have a satellite mental health service staffed by locally-based mental health professionals.

In some instances the Mental Health Program budget may be provided to one District to manage and provide mental health services in a surrounding District/s within the network. This arrangement will be clearly articulated in the Service Agreement between Corporate Office and relevant Districts.

Mental health services provided within the Mental Health Program include:

- community mental health services for children, youth and adults, including specialist outpatient services in general and psychiatric hospitals, and day centre, community outreach and other ambulatory mental health services
- dedicated acute inpatient services for children, youth and adults
- consultation and liaison mental health services
- extended inpatient services for the five specialised clinical programs
- any of the above services provided by a private or non-government sector specialist mental health service provider as part of a contractual arrangement with a state funded service
- services provided by community organisations funded under the Community Organisations Funding Program, currently administered by the Mental Health Branch, Queensland Health

These are described in more detail in Section 3 — Service Framework.

1.4 Evaluation

Evaluation of the Ten Year Strategy will occur within the context of Program Management in accordance with Public Finance Standard 310. Performance standards and indicators relevant for mental health are included in the 1996/2001 Corporate Plan. These will be further refined in subsequent Corporate Plans. Mental Health will continue to work on the development of performance standards and indicators for all mental health activities within the Program to form the basis for regular evaluation and review.

2 Policy and Planning Context

A National Mental Health Strategy was endorsed by all Commonwealth, State and Territory Health Ministers in 1992 and set the framework for the reform of mental health services in Australia.

The National Strategy reflects national and international recognition that the majority of mental health care can be delivered by community-based services, that acute inpatient care should be delivered in general hospitals, along with other acute health care, and that a small proportion of people with very severe mental illness do need care for extended periods in psychiatric hospitals.

The agenda for mental health reform in Queensland has been set by a number of international, national and state initiatives. These include:

- United Nations Resolution 98B on the Protection of Rights of People with Mental Disorders and the Improvement of Mental Health Care endorsed by Australia in December 1991.
- The Mental Health Statement of Rights and Responsibilities accepted by all Australian Health Ministers in March 1991.
- The National Mental Health Policy, adopted by all Australian Health Ministers in April 1992, which clearly outlines the need and priorities for the reform of mental health service delivery in Australia.
- The National Mental Health Plan, supported by all Australian Health Ministers in April 1992, which sets the time frame and priorities for the implementation of the National Policy.
- The Medicare Agreement (1993 - 1998), signed by the Commonwealth and Queensland in February 1993, which provides additional Commonwealth funding to support the initiatives outlined in the National Plan.
- The National Health Strategy Issues Paper, "*Help Where Help is Needed: Continuity of Care for People with Chronic Mental Illness*" (February 1993), which proposes directions for the reform of mental health services to ensure continuity of care and recommends change at many levels of service delivery for people with long-term mental disorders and disability.
- The annual National Mental Health Report, which compares Queensland's progress toward the implementation of the National Mental Health Policy and Plan with the other States and Territories.
- The National Health Goals and Targets, which identifies mental health as a priority area in the process to improve the health of all Australians.
- The Queensland Disability Services Act (1992) and the Queensland Anti-Discrimination Act (1991), which assists people with mental disorders to gain access to disability services in a non-discriminatory manner.
- The Report of the National Inquiry into the Human Rights of People with Mental Illness (Human Rights and Equal Opportunity Commission 1993), which highlighted the vulnerability and poor quality of life of people with serious mental illness and provided recommendations for the improvement of services.

2.1 Priorities for Action

The current planning context provided by the National Mental Health Strategy and the policy directions for Queensland set the directions to reshape the mental health service system to be more appropriate and responsive to the needs of the population. This Ten Year Mental Health Strategy for Queensland provides the framework for progressing mental health services reform in Queensland. The reform process has a long-term focus, and it is anticipated that subsequent strategies will address new and emerging issues and include innovative service reforms as they evolve over the next 10 years.

Based on the agreed national approach, the key directions and priorities for mental health service reform in Queensland include:

- The planning and delivery of high quality mental health services targeting those mentally ill people most in need and demonstrating the effective use of resources in meeting these needs.
- The mainstreaming of mental health services as part of the total network of general health system, rather than as an organisationally separate system. This involves the delivery of mental health services as part of the total health service network.
- The integration of inpatient and community specialised mental health services as a single service to promote continuity of care for a defined catchment population.
- The provision of mental health services as close as possible to where people live.
- The establishment of links between mental health services and other sectors to ensure access to the range of support services by people with mental illness.
- Progressing the reform of the psychiatric hospitals in Queensland by improving local mental health and disability support services to provide alternative systems of extended treatment and care, supporting current residents of these facilities to return to live in the community or more appropriate settings, and improving and decentralising the extended treatment and rehabilitation focus of these facilities for those people who do need to be admitted.
- The development of new mental health legislation for Queensland. The *Mental Health Act 1974* is being reviewed as an essential part of the reform of mental health services. A major review is continuing and will result in new legislation which will take account of new policies in mental health, the broader context of established Government policies, and other legislative reform.

2.2 Policy Directions

2.2.1 Consumer focussed service approach

The central principle for planning and delivering mental health services is that they must target the needs of consumers and demonstrate the effective use of resources in meeting these needs.

The strategies to achieve this include:

- establishing adequately resourced and effective, formal consumer advisory processes at state, district, or facility levels to ensure the participation of consumers and carers in mental health service development, planning and review
- establishing consistent methods of service evaluation for Queensland which focus on consumer outcomes
- fully linking mental health services to each District's Quality Assurance Program
- implementing service standards for Mental Health Services
- establishing clearly outlined and publicly available procedures for handling complaints and grievances for consumers and providers

- having in place a clear structure and mechanisms which ensure there is accountability for mental health services at all levels of the system
- ensuring that mental health legislation meets the international principles contained in United Nations Resolution 98B relating to the rights of people with mental illness and the improvement of mental health care

Formal consumer advisory processes and procedures for handling complaints and grievances for consumers and providers are being established. Amendments to mental health legislation to better protect the rights of people with mental illness will further assist in the adoption of a consumer focussed service program.

2.2.2 Organisation of services

Specialised mental health services will be delivered at a District and/or network of Districts level based on the principles established in the National Mental Health Strategy and State policy directions of mainstreaming, integration and self sufficiency.

Mainstreaming

Mental health services will be delivered and administered as part of the mainstream District health system to provide better access to a wider range of quality services for people with mental disorder, and to improve coordination with other health services.

The strategies to functionally mainstream Queensland's acute inpatient and community mental health services include:

- locating all acute inpatient services in general hospitals by 1999. This will involve the transfer of acute beds from Barrett Psychiatry Centre, Wolston Park Hospital, and Baillie Henderson Hospital, Toowoomba, to the appropriate District services.
- ensuring that specialised community mental health services have defined links with other community health services including, where appropriate, the co-location of community mental health services with other community health services.

Integration

Inpatient and community components of specialised mental health services will function as a single service for a defined catchment population.

The development of organisational structures and funding arrangements to support this and improve continuity of care for consumers is a priority. Strategies adopted include establishing a single point of accountability and an identified program budget covering all service components. The re-organisation into integrated mental health services does not require additional resources. Industrial relations issues are being addressed to enable greater flexibility in deployment of mental health staff between the community and inpatient components.

Systems of service coordination will be implemented to ensure continuity of care across all components of the services. These will focus on ensuring:

- a single process of entry into each district mental health service which can be activated from a number of entry points
- a case management approach for the coordination of clinical and support services for an individual
- implementation of information systems that support continuity of care across service sites
- day-to-day coordination between different components of the mental health service
- "barrier free" access to the necessary range of services according to individual needs

The reform of mental health services involves a reorientation of the way mental health services are delivered and includes mental health staff working in new ways. It is important that this is acknowledged and that appropriate training and support is provided for all staff.

Self sufficiency

Consistent with Queensland Health's corporate direction, the key planning principle under this policy direction is that mental health services will be provided as close as possible to where people live.

Districts and/or networks of Districts will be self-sufficient for specialised mental health services, including both acute inpatient and community components, at a level and mix determined by the specific needs of their defined catchment populations. Services will be provided in the least restrictive, most facilitative setting. The majority of treatment will be provided in the community with inpatient services only being used when necessary. Provision of locally available care ensures improved access and better outcomes for people with mental illness, limiting the dislocation from family and support networks.

This involves planning around catchment area populations, at a level and mix determined by the specific needs of the defined population. It also involves the development of appropriate services for rural and remote communities and establishing consultation and liaison services to link with general hospital, private and other health service providers.

2.2.3 Intersectoral links

An increased emphasis on intersectoral collaboration will occur to take account of the many factors which influence health status such as housing, employment, education and training, income security, transport, community support and recreation. These services fall outside the responsibility of health departments and links must be made with responsible agencies to ensure the needs of consumers are met. Effective planning can facilitate good health and, therefore, forging intersectoral links is a fundamental principle in the National Mental Health Strategy.

Many of the services needed by people with mental disorder are available in the private sector. For individuals who cannot or do not want to access these services, three key public sector service components will be available. Clinical treatment and rehabilitation will be provided by mental health services. Public housing and accommodation and disability and social support will be provided through the relevant government agencies or non-government organisations. The mental health service will be responsible to ensure that continuity of care is provided by facilitating access to the necessary range of health, housing and support services.

2.3 Priority Groups

A number of groups have been identified by the National Mental Health Strategy and state policy directions as requiring specific strategies to ensure equitable access to appropriate mental health services and to improve that standard of treatment provided.

Specific mental health policy statements and directions for service delivery for a number of groups have recently been finalised and the strategic framework for their implementation have been incorporated in the Ten Year Mental Health Strategy for Queensland.

2.3.1 Future directions for child and youth mental health services

The policy statement recognises that children and youth present different patterns and types of mental health problems and disorders, and require special consideration of their developmental context and legal status. Contemporary treatment for children and youth needs to be individualised and drawn from a range of therapeutic approaches which are appropriate for different ages, developmental stages, conditions and situations. The policy also recognises the importance of developing close links with other agencies such as education, paediatric, juvenile justice and child protection services in meeting the needs of children and young people with mental health problems.

The following key directions for services are specific to children and youth mental health

services. Services will:

- target those with severe, complex problems which require specialised mental health intervention
- provide assessments, brief, clinically appropriate interventions and crisis response
- improve service responsiveness to youth
- develop and maintain intersectoral links in service planning and, where appropriate, collaborative case management

2.3.2 Aboriginal and Torres Strait Islander people mental health policy statement

The policy statement outlines clear directions for change in the planning and delivery of health services to better meet the mental health needs of Aboriginal and Torres Strait Islander people. The service model promoted under this policy statement requires strengthening the response provided by primary health care services and by specialist mental health services. This is to ensure that access to a culturally appropriate service is available at all levels for people with mental health problems or mental disorders, family and friends. This policy directions require specialist mental health services to become more responsive to the specific cultural needs of Aboriginal and Torres Strait Islander people.

The key directions to improve the capacity to meet the needs of Aboriginal and Torres Strait Islander people include:

- the provision of services based on need
- the creation of Aboriginal and Torres Strait Islander mental health worker positions in specialist mental health services and at the primary health care level
- action to ensure that Aboriginal and Torres Strait Islander people have opportunities to obtain qualifications at all levels
- cross-cultural awareness training of mental health and other health professionals
- the development of culturally appropriate assessment, diagnosis and treatment tools

Primary health care services and specialist mental health services will work in partnership to ensure that assessment, diagnosis, treatment and rehabilitation is available; to facilitate access to more intensive levels of care such as hospital based acute and extended treatment and rehabilitation services; to be involved in discharge planning and follow up care to ensure continuity of care for the individual across hospital and community settings.

2.3.3 Non-English speaking background mental health policy statement

The policy statement sets the directions for change in the planning and operation of mental health services to improve their quality, accessibility and appropriateness to people from non-English speaking background. Strategies to improve outcomes for this particular group are not complex and rest primarily on recognition of the impact of cultural differences and language needs.

The key directions of the policy statement include:

- ensuring cultural differences are acknowledged and addressed at all stages of diagnosis, assessment and treatment
- pro-active recruiting bilingual mental health professionals, where appropriate
- using accredited, trained and gender appropriate interpreters in mental health care settings
- developing information about mental health, mental illness, mental health services and the *Mental Health Act* available in the major community languages

- involving people from non-English speaking backgrounds in community education strategies
- involving consumers and carers from non-English speaking backgrounds in the development, monitoring and evaluation of services
- improving the quality of data available on the use of mental health services by people from non-English speaking backgrounds
- establishing a community-based torture and trauma service in Queensland

2.3.4 Mental health services for older people

The policy statement addresses the needs of all older people with mental illness within a range of service settings, from community-based services to acute inpatient and extended inpatient services.

While many older people will continue to access adult mental health and mainstream services, special expertise is required in the assessment of people with mental illness when it is complicated by problems and illnesses related to ageing. For this group of people, psychogeriatric services are necessary.

The key directions of the policy statement include:

- targeting people aged over 65 who suffer from a mental disorder complicating an underlying disorder related to ageing or a disorder related to ageing complicating a pre-existing mental disorder
- providing psychogeriatric services as an integral component of mental health services across hospital and community settings
- strengthening linkages and developing collaborative approaches to service planning and delivery between primary health, aged care and mental health services
- specific training or supervised experience for mental health professionals in both dedicated psychogeriatric services and mainstream mental health services

2.3.5 Mental health services for rural and remote communities

Mental health services which cover rural and remote communities will develop services to ensure access to specialised services for people living outside the large rural towns and provide appropriate support to the mental health service providers.

The key directions for service development include:

- provision of outreach services from principal service centres to key rural centres in same or neighbouring Districts on a visiting basis
- establishment of satellite services in key rural centres through the employment of locally based mental health professionals. The satellite services will be linked to and supported by visiting outreach services from a principal mental health service centre located in a neighbouring major District Health Service
- establishing collaborative networks with other local health services for the provision of ongoing management and support, between visits by specialised mental health professionals
- access to acute inpatient services located in the principal service centre of a District network
- development of special care suites in a number of rural general hospital settings to provide short term specialised treatment for people experiencing an acute episode of mental illness
- developing strategies to improve the capacity for recruitment and retention, including training, professional development, and clinical supervision for the rural and remote mental health workforce

- improving the availability of communication technology to support the delivery of mental health services to rural and remote areas, including telemedicine technology to assist in the delivery of mental health services, and the provision of professional support, and training
- supporting the primary health sector in addressing mental health issues in rural and remote areas including training, and the development of mental health referral and support networks within this sector

2.3.6 Mental health services for people involved in the criminal justice system

A policy is being developed to ensure that mental health services are available to people with mental illness who are involved in the criminal justice system. These will encompass services to children, young people and adults. Services to children who are before the court on care and protection applications will also be included.

People with mental illness are disproportionately represented in prisons, with prevalence rates of seven to 10 per cent reported. This includes people who develop mental disorders while in prison, and those who have a mental illness at the time of entering the criminal justice system. These people may also be discriminated against when accessing treatment and support services in the community.

The forensic mental health services policy statement is being developed by Queensland Health, in conjunction with Queensland Corrective Services Commission, Queensland Police Services, Department of Justice and Department of Families, Youth and Community Care.

Proposed policy principles state that the majority of mental health services to people who are involved in the criminal justice system will be provided by District mental health services. Queensland Health forensic mental health services will be responsible for providing services to those people who are assessed as requiring more specialised forensic intervention, and will provide consultation and liaison services to support District mental health services.

The Mental Health Act provides a mechanism for people with a mental illness who are subject to a custodial order to be treated within an inpatient mental health service. The policy will facilitate this process through ensuring that the clinical needs of the person are considered in determining the most appropriate setting for treatment to occur. Further discussion of this area is in Section 5 — Service Planning and Development.

The provision of forensic mental health services to other Government facilities and Departments (eg. the Courts; Queensland Corrective Services Commission) will be considered within the development of the policy.

The planning guidelines for the acute and extended inpatient service requirements for this target group have been included within the statewide detailed planning.

3 Service Framework

Under national and state mental health directions, specialised mental health services are particularly targeted to those people with mental disorders and serious mental health problems. This includes people suffering from psychoses, both acute and persistent, mood, anxiety, or eating disorders, and those with situational crises which may lead to self-harm or inappropriate behaviour directed towards others. People with personality disorder whose behaviour places themselves or others at risk of harm are included in the target group.

Service components are planned and organised around age groups — children, youth and adults including older people. However, they will not be segmented within the rigid age criteria. The delivery of mental health services will focus on providing a continuum of care based on individual needs and will take account of the specific needs of priority groups. The continuum of care begins at the point of entry into a mental health service and proceeds through all phases of assessment and continuing treatment, and across hospital and community service settings.

A range of service components are provided as part of a District and/or network of Districts mental health services. To enable a continuum of care for the individual the following service components and priorities for development have been identified:

- referral, intake and assessment, including an extended hours capacity
- continuing treatment using a case management approach. This includes the following components:
  - community treatment services
  - outreach services
  - acute inpatient services, with provision for short to medium-term treatment, including secure treatment
  - psychiatric crisis response and treatment
  - specialist intensive treatment and support for identified “at risk” individuals (mobile intensive treatment)
  - extended inpatient services for treatment and rehabilitation, with services organised around the five specialised clinical programs.

The framework for the development of mental health services will be established for children, youth and adult mental health services taking into account the special needs of priority groups ie. older people, Aboriginal and Torres Strait Islander people, people from non-English speaking background, and people involved in the criminal justice system.

The following section defines the scope of specialised mental health service delivery and describes the service components of a core District and/or network of Districts, mental health service.

3.1 Intake and Assessment

Intake and assessment is the process which occurs during initial contact by a clinical staff member with a person referred to a mental health service. It includes the collection of information to assess the appropriateness of the referral and enables the person to be directed to the most appropriate service, within or outside the mental health service. Where intervention from the mental health service is indicated it enables appropriate and timely specialised assessment and identifies the type and level of service response required.

Intake and assessment will form the single process of entry into a mental health service and will ensure a person receives appropriate and timely assessment and treatment. It will also provide the process for triaging/gatekeeping for admission to the acute inpatient service component.

Where entry to the service operates from more than one service point within a specific catchment area of the mental health service it is essential that:

- common processes be established for standardised collection of information
- intake and assessment be available at least during normal working hours, Monday to Friday, and include the capacity for a mobile response within a specific catchment area of the mental health service
- formal mechanisms be established for all referrals, intake and assessments to be reviewed on a daily basis for the purpose of determining plans of action or validation of action taken
- a mental health professional is nominated at the time a person enters a service delivery stage and has the responsibility for ensuring continuity of care
- the nominated mental health professional (case manager or principal contact) ensures the relevant action is taken and initiates the development of an individual management plan.
- formal mechanisms be established for referrals from the Court or for people in custody, and liaison with police

Extended hours intake and assessment

As increasing resources are made available to the mental health service, intake and assessment will be expanded, or developed, with the capacity for extended working hours. In major centres this will be the extension of the normal working hours within a specific catchment area of the mental health service to a minimum of 12 hours per day, (Monday to Friday), and at times appropriate to the needs of the catchment population on Saturdays and Sundays. This includes an after-hours on-call mobile response capacity, beyond the extended hours, to provide intake and assessment, and limited case management.

In a number of Districts, child and youth mental health services will establish processes for an extended hours capacity in arrangements with the adult mental health services.

In rural centres where there are local mental health professionals, mechanisms will be developed to provide extended hours for intake and assessment, and may include on-call beyond normal working hours, and general practitioner and local general hospital liaison.

Consultation and liaison intake and assessment

Consultation and liaison within a general hospital is also included within this service component and is another point of entry to the mental health service. It includes the provision of specialised and expert psychiatric assessment and advice for management, or collaborative management, of a patient to accident and emergency and other inpatient areas of the hospital. In large general hospitals this service component may be an identified group of mental health professionals. Referral and assessments conducted within this component of intake and assessment will be included in the common process for standardised collection of information, and the review of all intake and referrals on a daily basis. This will enable the capacity to determine plans of action or to validate the action taken and where appropriate nominate a case manager or principal contact.

3.2 Continuing Treatment and Case Management Services

Mental illness is often episodic in nature and associated with varying degrees of ongoing disability. Continuity of care is a critical component of effective service provision for many people with mental illness. It requires that the provision of the range of services to a person

with mental illness is coordinated across service settings, whether hospital or community based, and across a range of clinical and support services.

The range of service components provided by specialised mental health professionals includes an individualised and multidisciplinary focus for the provision and coordination of clinical treatment, rehabilitation, and assistance in accessing housing, disability support, income support and vocational training for a person with a mental illness. Linking and networking with relevant government and nongovernment agencies is essential to ensure coordination and appropriate service responses occur.

The role of the mental health professional is to provide a comprehensive assessment of the individual's clinical and social needs, specialised intervention when required, and the formulation and documentation of a management plan developed with the consumer and focused on that person's requirements and needs.

Continuing treatment and case management is the establishment of formal processes, which follow the intake and assessment process, to ensure continuity of care for people with a mental disorder or serious mental health problem requiring acute and ongoing treatment. It comprises a number of mental health service components and these are described in more detail below.

Case management is well established as an effective way of ensuring continuity of care for people with mental illness. It does not refer to the management of the person with the mental illness but to the management of the provision of services. A person with a mental disorder or serious mental health problem will be assigned a case manager or principal contact at entry to the service delivery stage of the mental health service.

Case management is a clinical service response which draws on the case manager's professional skills in engaging with a person with a mental illness and responding to his or her clinical and support needs. The case manager or principal contact is responsible for coordinating the range of services to meet the individual needs of a person with a mental illness and will include:

- the development of an individual management plan in collaboration with the person with the mental illness
- the provision of education and support for illness, treatment and medication management
- the provision of direct clinical and treatment services where appropriate, including individual, group and/or family treatment
- the provision of support and education for families and carers
- the coordination and facilitation of access to interventions from the range of specialist mental health disciplines within the mental health service
- the facilitation of access to the range of support services where appropriate. Integral to this role is the linking with disability support key workers in centres where these positions exist, or the individual community support agencies, to facilitate access to these services to meet the needs of the person with mental illness
- the provision of consultation and liaison with primary health care providers, and private sector service providers with a focus on specialised assessment and a collaborative approach to individual management
- the regular monitoring and review of individual management plans

3.2.1 Community treatment services

Community treatment is the provision of multidisciplinary, specialised treatment and support services, in a variety of community settings, to people with mental disorders and serious mental health problems. These include clinic based services, outpatient services, domiciliary and other visiting services, and consultation and liaison services to general practitioners,

primary health care and private sector providers.

Child and youth mental health services

In addition to the above, child and youth mental health services will establish their own specific service responses within the community treatment component, to meet the specific needs of children and young people accessing mental health services. These include:

- outreach to children and youth within the context of their everyday environment eg. schools, youth services, day programs
- specialist individualised programs for specific disorders
- interagency liaison and joint case management
- input into interagency program planning and delivery, and community development activities.

Service responses specific to the needs of children and young people will be further developed as part of the implementation of the policy statement *"Future Directions for Child and Youth Mental Health Services"*. These will include specialised programs for young people with early onset psychosis, or severe functional impairments from mental illness, and their families.

The existing forensic community mental health service for young people will maintain its current role as a supra-district service. The further development of this service component will be considered within the development of the forensic mental health service policy statement.

Psychogeriatric mental health service

Older people with a mental disorder who are otherwise fit and well should remain the concern of adult mental health services. Psychogeriatric services are primarily aimed at people over 65 years of age who suffer from:

- a mental disorder complicating an underlying disorder related to ageing; or
- a disorder related to ageing complicating a pre-existing mental disorder.

In a District mental health service with sufficient catchment population it will be possible to create a significant focus of expertise in this area. This will allow a discrete psychogeriatric assessment and treatment (PAT) service component to be developed. The psychogeriatric service component, whether provided by a discrete PAT or as part of the general mental health service, will provide assessment and continuing treatment using a case management approach. In addition, the psychogeriatric service component will have a key role in providing advice and support to carers, other primary health and aged care services.

3.2.2 Outreach services

A mental health outreach service provides visiting specialised mental health services to people who are unable to access these services close to their own community. This service includes regular visits to rural and remote areas by a multidisciplinary team of a mental health service based in a provincial or metropolitan centre. It also includes establishing formal mechanisms for the provision of a point of contact for advice, support and education between visits.

This component is provided to rural and remote areas where there are no mental health services or where there is a satellite mental health service.

Outreach services also include the development of mechanisms in conjunction with local primary health care and/or local mental health service providers to provide intake and assessment, and continuing treatment and case management.

3.2.3 Acute inpatient services

Acute treatment refers to mental health service responses that provide psychiatric treatment and intervention for people who are in an acute phase of their illness with the aim of reducing symptoms and promoting recovery. This service component involves the provision of short-

term intensive treatment with medical management and includes clinical staff on duty 24 hours per day. Acute inpatient services may be provided in a variety of facilities and/or settings, these are described below.

General hospital acute inpatient unit

Hospital-based acute inpatient units will be located in and be an integral part of the public general hospital system. These units will provide assessment and treatment for people suffering acute episodes of mental illness who cannot be treated more appropriately in a community setting, and is seen as only one of many treatment options. To ensure continuity of care across hospital and community settings, management and discharge planning must be in collaboration with case managers, other service providers and carers.

General hospital acute inpatient units in major centres will have the capacity to provide:

- flexible high dependency or acute inpatient secure options
- special purpose rooms which can be used for special needs patients (including mothers with babies; older people with severe cognitive impairment; Aboriginal and Torres Strait Islander people)
- domestic-style open ward accommodation

Child and youth mental health inpatient services

Acute treatment services for children and youth will be established in general inpatient settings as discrete units where bed numbers are of a sufficient size or special purpose areas within adult mental health inpatient units for youth, or as day treatment services attached to community mental health services. Acute treatment services will be developed to provide specialised clinical interventions using best practice models for children and youth with mental disorders, eg. major depression, suicidal behaviour, severe obsessive compulsive disorders, eating disorders.

Special care suites

A special care suite is a small dedicated self-contained facility, about two to four beds, located within a rural general hospital setting. It provides short-term medical management and treatment for people experiencing acute episodes of mental illness. The suite must have the capacity for high dependency options if necessary.

The special care suite is staffed by mental health professionals drawn from the local mental health service as required. In the smaller rural areas, a pool of nurses from the general medical wards who are interested in mental health may be used as a back-up to the mental health professionals. Extra training will be provided to this pool of staff. The service must have access to consultation with a psychiatrist on a regular basis.

When the suite is not occupied by anyone who requires acute inpatient services it is closed, or used for other purposes, eg. accommodation for families or carers of inpatients.

Non-hospital based acute inpatient units

It is proposed to pilot this service model, which will substitute for general hospital acute inpatient beds in some Districts. These facilities will be sited in the community, generally provide the same services as a hospital-based acute inpatient unit (clinical staff on duty 24 hours per day), and be seen as an equivalent treatment facility by public sector mental health services.

The non-hospital based inpatient facility will be developed as a large house consistent with local residential configuration, accommodating eight to 10 people in single and twin room accommodation, and be near to a community-based component of the mental service.

This type of facility will generally provide inpatient treatment services for most people suffering from acute mental disorders, including involuntary patients, within an open environment. It may include an intensive care area for observation of people at risk of self harm. Admission to this facility would be based on clinical assessment and judgement.

Clinical staffing for these facilities are considered to have the same profile as for a hospital

based acute inpatient unit.

3.2.4 Psychiatric crisis response and treatment services

This is a mobile acute treatment response that is available 24 hours per day, seven days per week. The service provides ongoing assessment, short-term clinical treatment and interventions for psychiatric crisis resolution, and the management of people experiencing an acute episode of illness. The mental health service will have the capacity to provide varying levels of intensive treatment, and/or back-up support for carers, families and service providers involved in the management of the person. It ensures access to treatment options in a variety of community-based settings to prevent admission to an acute inpatient unit.

These settings will be considered within the context of alternatives to admission and may include the person's home, host family programs, respite facilities, and supervised accommodation facilities. Alternatives to admission represent a range of options which reduce the need for admission to a general hospital or non-hospital based acute inpatient unit. It is proposed that mental health services in Queensland continue to collaborate with other government and non-government agencies to progress the development of a range of options that reduce the need for admission to general hospital and non-hospital acute inpatient units, and which are not necessarily health-owned facilities.

As resources are made available for the development of this component within the mental health service, formal mechanisms within intake and assessment need to be established. This will ensure that all persons considered for hospital admission are assessed and a decision made as to whether the person can be treated in a less restrictive environment. Once the person no longer requires the short-term acute treatment, ongoing management within the continuing treatment service component and the provision of consultation to other service providers is essential.

3.2.5 Mobile Intensive Treatment services

The Mobile Intensive Treatment (MIT) capacity is a component of continuing treatment and case management services. The target group is the small number of very vulnerable and disabled people with severe mental illness and enduring disability, who are the most difficult to maintain in the community. Without the MIT service this group of people have frequent admissions to an acute inpatient facility or are at risk of future multiple admissions. The service is mobile and focuses on providing assertive and intensive community-based treatment, rehabilitation and support services, using a case management approach to ensure continuity of care. Input is continued until the person is functioning at a level where she or he can be provided ongoing treatment within the less intensive community treatment component of the mental health service.

3.2.6 Extended inpatient services

Adult mental health services

Extended inpatient services are a component of a District mental health service and will be developed to enable people to receive long-term treatment and rehabilitation as close to their homes as possible. In some districts these services are provided on a supra-district basis as economies of scale require a population of sufficient size to sustain the level of clinical expertise necessary for the provision of high quality care.

Significant reform is called for at both a state and national level in the structure and function of the psychiatric hospitals which presently provide these services. Queensland's psychiatric hospitals currently use almost 50 per cent of the State's mental health budget. This is discussed in more detail in Section 4.

Extended inpatient services are organised into five specialised clinical programs for:

- people who are sufficiently ill or disabled by their mental disorder to be unable to be

cared for adequately by their local community and acute inpatient services

- people who cannot function in more independent settings
- people who may pose a serious and/or long term danger to themselves or to the community

Extended inpatient services will provide ongoing assessment, long-term treatment and rehabilitation with the goal for the person to return to management by District mental health services. It includes service provision which extends into the community to facilitate movement of the person back to the referring mental health service when this is clinically indicated.

The focus of services is inclusion in the local community and individual planning to enable enhancement of community living skills, independence and maximising the quality of life. Individual service plans will be collaboratively developed with consumers which recognise people's needs, goals and strengths to ensure that services are appropriate and flexible and that people have access to a range of services and resources in the community. The continuing treatment and case management services of the referring district mental health service will be involved in ongoing case management where appropriate.

3.2.6.1 Criteria for admission/discharge to extended inpatient mental health services

The following principles and criteria for transfer of people from a District mental health service to supra-district extended inpatient services have been developed by Mental Health in consultation with the supra-district facilities and the mental health services.

Principles

- Supra-district facilities will provide services to patients referred by District mental health services based on clinical need.
- District mental health services will give priority to patients transferring back to their District from the supra-district extended inpatient services.
- Procedures for discharge from the extended inpatient facility will be developed at the time of admission in consultation with the referring District mental health service, and including families and carers.
- All referrals must include full documentation from a multidisciplinary team.
- Patients will be referred to extended inpatient services from District mental health services only after all appropriate management options within the referring District have been tried.
- People will only be referred if a length of hospital stay greater than three months is anticipated.
- People to be admitted will be 16 years of age or over.
- Departures from these principles will only occur in exceptional circumstances.

Clinical programs and admission criteria

1. ***Services for people with severe mental disorder and associated severe disability requiring extended treatment and rehabilitation.***

   This service targets people with a chronic mental disorder, usually schizophrenia or affective disorder, who have been unable to maintain themselves in the community with the support of existing local services. It includes those who are vulnerable to exploitation and/or who exhibit behaviours which are unacceptable to the local community to a point where repeated admissions to acute inpatient units have been required.

2. ***Services for people with a mental disorder and concomitant intellectual disability.***

   This service targets those people with a mental disorder who are also intellectually disabled

and who exhibit aggressive or violent behaviour, which makes them unmanageable in an integrated mental health service.

The program offers specialist assessment, treatment and rehabilitation on a medium to long-term basis in an environment where these behaviours can be more appropriately managed. The referring service retains responsibility for ongoing care subsequent to successful treatment and rehabilitation. Those people who are assessed as having an intellectual disability and an associated behaviour problem but no mental disorder will not be eligible for this program.

3. ***Services for people with acquired brain damage and associated mental disorder and/ or severe behaviour problems.***

   This service targets those people with a serious loss of impulse control due to acquired brain damage, including alcohol and drug-related causes, who cannot be managed in other residential or community settings.

4. ***Services for people who suffer a mental disorder and require treatment in a specialised secure facility.***

   This service targets people who have a mental disorder characterised by persistent assaultative behaviour or self harm which has failed to respond to treatment to a point where continued treatment in an acute inpatient unit is no longer clinically desirable. It includes forensic patients, who are not required to be in a Security Patients' Hospital, and non-forensic patients.

   All people referred to this program will be regulated under the Mental Health Act at the time of referral. Mechanisms for transfer of people into and out of Security Patients Hospitals is provided by the Mental Health Act. Treatment aims to discharge or transfer of these patients back to district mental health services when this level of security is no longer required based, on clinical assessment of ongoing needs.

5. ***Psychogeriatric services for people with associated marked behaviour problems.***

   This service targets those people primarily aged over 65 years who suffer from: a mental disorder complicating an underlying disorder related to ageing; or a disorder related to ageing complicating a pre-existing mental disorder; and who, because of the nature of their behaviour, which make their management in an acute inpatient unit or in a nursing home inappropriate. Access to such a facility will only be through the continuing treatment service components of the mental health service.

   The program offers residential, specialist assessment, treatment and rehabilitation services over an extended period of time to people meeting the criteria for psychogeriatric services who cannot be managed in any other setting due to their behaviour requiring both psychiatric and aged care. These facilities will be collocated with aged care facilities wherever possible to enable access to generic aged care services when required.

Hospital based extended inpatient unit

A number of extended inpatient units will be provided within a hospital-based facility and be an integral part of the public sector mental health services. These facilities will provide inpatient services for the five clinical programs. To ensure continuity of care across extended inpatient and District mental health service settings, management and discharge planning must be in collaboration with the referring District mental health services. Extended inpatient services will be better distributed in Queensland as discussed in Section 4, Reform of Psychiatric Hospitals.

Non-hospital based extended inpatient unit

It is proposed to develop facilities in some Districts which substitute for hospital extended inpatient units for the dual diagnosis and extended treatment and rehabilitation clinical programs, and the collocation of psychogeriatric units with aged care residential facilities.

These will be considered within the context of non-hospital based extended inpatient units. These facilities will be sited in the community, generally provide the same services as a hospital-based dual diagnosis, and extended treatment and rehabilitation inpatient units (clinical staff on duty 24 hours per day), and be seen as an equivalent treatment facility by public sector mental health services.

The non-hospital based inpatient unit will be developed as cluster housing and consistent with a local residential configuration. It will be able to accommodate up to 20 people in single and twin room accommodation, and be near proximity to a community-based component of the district mental service.

This type of facility will generally be able to provide extended inpatient treatment and rehabilitation for people with a chronic mental disorder and associated disability requiring extended treatment and rehabilitation, and people with dual diagnosis who have been unable to maintain themselves in the community with the support of existing services. Admission to this facility would be based on clinical assessment and judgement. Clinical staffing for these facilities will have the same profile as for an extended treatment and rehabilitation, and dual diagnosis inpatient units.

4 *Reform of Psychiatric Hospitals*

The national and state directions for mental health services require significant reform in the structure and function of psychiatric hospitals. Strategies to implement reform include:

- the development of specific programs in each of the supra-district extended inpatient services targeting clinically identified groups
- the reduction of the size of the facilities by mainstreaming existing acute beds from psychiatric hospital facilities to general hospitals
- the transfer of services for older people, people with alcohol and drug problems, and those with intellectual disability who do not have a mental disorder to more appropriate service settings
- the relocation to the community of those people who are able to live more independently given adequate treatment and support services

In Queensland, extended inpatient services are provided by Baillie Henderson Hospital, Toowoomba District; Wolston Park Hospital Complex, West Moreton District; Mosman Hall Hospital, Charters Towers District; and Kirwan Rehabilitation Unit, Townsville District. These facilities will be restructured to provide services for the five clinical programs, outlined in Section 3.

Historically, due to a lack of community-based mental health and disability support services, there has been a tendency for people to spend many years in psychiatric hospitals with little or no contact maintained with the referring District after admission. Current reforms will strengthen the rehabilitation focus of the extended inpatient facilities and establish a two-way transfer process. Close links will be developed between supra-district and district services to enable admission and discharge planning. Rehabilitation programs will be extended into the community to facilitate movement of the person back to the referring integrated mental health service when this is clinically indicated.

The specialised services needed for this group of people are often provided on a supra-district basis because economies of scale require a service of sufficient size to sustain the level of clinical expertise necessary for the provision of high quality care.

It is critical that the decentralisation of extended inpatient services is coordinated over the required time frame to allow the human resource management and industrial relations issues to be dealt with.

The planning for adult extended inpatient services has been undertaken for 2001 and 2006 within three geographical zones which relate in part to the historical catchment areas of the psychiatric hospitals. These zones are:

- the northern zone (Torres, Cape York, Tablelands, Innisfail, Cairns, Townsville, Charters Towers, Mount Isa, Bowen, Mackay and Moranbah Districts);
- the south-east zone (Gympie, Sunshine Coast, Redcliffe/Caboolture, The Prince Charles Hospital, Royal Brisbane Hospital, Princess Alexandra Hospital, Mater Hospital, Queen Elizabeth II Hospital, West Moreton, Bayside, Logan/Beaudesert, Gold Coast Districts); and
- the central-downs zone (Rockhampton, Banana, Central Highlands, Gladstone, North Burnett, South Burnett, Bundaberg, Hervey Bay/Maryborough, Central West, Toowoomba, Northern Downs, Southern Downs, Roma, and Charleville Districts).

Consultations were held with key stakeholders in each of these Districts, principally to determine the viability of achieving self-sufficiency. Limiting factors included a perceived inability to recruit senior specialist staff, the lack of existence of core mental health service

components, which were seen as an important prerequisite to the development of extended inpatient services, and most obviously the loss of economies of scale associated with the development of very small inpatient units. It became evident that it is difficult to justify extended inpatient service development for populations of fewer than 500,000 people.

There are approximately 1100 inpatient beds in the psychiatric hospitals. Of these, approximately 600 beds are currently dedicated to providing extended inpatient services for the five specialised clinical programs.

In addition, it is estimated that there are currently 250 beds being used for the provision of geriatric and nursing home type residential care services. The remaining beds are currently being used to provide adult acute inpatient and medium term youth inpatient services, and services for people with drug and alcohol problems or intellectual disability. It is anticipated that these services will be relocated within the next five years.

As a component of the reform of psychiatric hospitals, Queensland Health is working with the Department of Public Works and Housing and the community sector in a joint project to assist people currently living in hospital to return to live in the community. Project 300 will provide packages of support, including mental health services, disability support services and housing to 300 people over the next three years and specifically targets those people who no longer require 24-hour clinical care in a hospital environment. This strategy will assist in achieving the reorientation of psychiatric hospitals from custodial to rehabilitative care, improve the quality of life for those people participating, and increase the infrastructure in the community for the provision of disability support for people with psychiatric disability.

By 2001 it is envisaged that the total number of beds required for extended inpatient services for the five clinical programs will be 824 (this includes 107 beds which may be required for geriatric services continued to be provided in an extended inpatient setting). This number will decrease to 717 beds by 2006 as the use of beds in extended inpatient settings for geriatric services reduces to zero.

The development of extended inpatient services in north Queensland, and The Prince Charles Hospital, Sunshine Coast, Bayside and Gold Coast Districts over the next three to five years will enable the downsizing and decentralisation of Wolston Park Hospital, West Moreton District. Table 1 outlines the planned location of extended inpatient beds by district.

As new extended inpatient services are established, services at the existing psychiatric hospitals will be decreased. By 2001, Mosman Hall Hospital will reduce from 111 beds to 27 beds, Wolston Park Hospital will reduce from 586 beds to 275 beds, and Baillie Henderson Hospital will reduce from 401 beds to 154 beds. Subsequent to this, by 2006 Wolston Park Hospital will further reduce to 177 beds, and Baillie Henderson Hospital to 122 beds.

Table 1 *Location of extended inpatient beds by District, 2006*

District Health Service	**Clinical Programs**

Table 1 *Location of extended inpatient beds by District, 2006*

District Health Service	Clinical Programs						
	Extended treatment and rehabilitation	Dual diagnosis	Acquired brain injury	Extended secure	High security	Psycho-geriatrics	TOTAL
Northern Zone						*19	19
Townsville	24	-	10	21	10	-	65
Charters Towers	8	19	-	-	-	-	27
Central-Downs Zone							
Toowoomba	38	23	13	25	-	16	115
Rockhampton	-	-	-	-	-	7	7
South-east Zone							
West Moreton	51	31	-	34	61	-	177
Gold Coast	27	16	-	19	-	16	78
Bayside	-	-	23	-	-	31	54
For Prince Charles Hospital/Sunshine Coast/ Redcliffe-Caboolture	55	33	16	38	-	33	**175
TOTAL	**203**	**122**	**62**	**137**	**71**	**122**	**717**

* *The site/s for the psychogeriatric places are yet to be finalised — proposed sites are Townsville and/or Charters Towers.*

** *This is the total extended inpatient bed requirements to meet the population catchment areas of The Prince Charles Hospital and District, Redcliffe/Caboolture, Sunshine Coast and Gympie Districts. The sites for the inpatient facilities has yet to be determined.*

The downsizing of the psychiatric hospitals and decentralisation of extended inpatient services, as described in this section, will be coordinated over the required time frame, within the context of the overall implementation of the Ten Year Strategy. This will include a significant number of human resource management and industrial relations issues to be dealt with which will principally involve the redeployment, retraining and redundancy of some staff.

5 Service Planning and Development

5.1 Objectives for Service Planning

To achieve the development of the identified core mental health services detailed mental health services planning has been undertaken. This has been aimed at:

- establishing planning guidelines using per capita estimates of resource needs
- identifying the skill mix required for the provision of services
- developing detailed plans for the development of core District mental health services which aim to achieve identified planning guidelines and priorities by 2006
- developing detailed plans which aim to achieve self-sufficiency for mental health extended inpatient services by 2006

5.2 Planning Principles

The planning to achieve these priorities for action in the delivery of mental health services in Queensland is guided by the following principles.

1. ***Services should be equitably distributed across the State and developed in the context of networks of health services.***
2. ***The community should have access to the full range of services required across both service and program areas.***
3. ***Communities' special needs, such as those of rural communities, will be recognised.***
4. ***The primary health care approach should be accommodated, and primary health care services should be strengthened.***
5. ***New models for service delivery will be assessed and pursued where appropriate.***
6. ***Regional self-sufficiency will be promoted as far as practical to optimise local access to services.***
7. ***Ensuring quality of care in provision of highly specialist services will require cooperation between Districts.***

Ten Year Health Services Plan for Queensland, 1994 - 2003, Queensland Health

As previously stated mental health services have been planned for development around three target groups of children, youth and adults (including services for older people).

In undertaking the planning for mental health services for these groups the following additional factors have been taken into account:

- population projections for 2006 have been used, which may change depending on future population censuses
- the excess morbidity experienced in some catchment areas such as the inner northern areas of Brisbane
- the need for formal arrangement where significant cross-district flows occur
- the particular needs of Aboriginal and Torres Strait Islander people
- the particular needs of people from non-English speaking backgrounds
- the particular needs of rural and remote areas

- the cost effectiveness of the provision of adult extended inpatient services for populations of fewer than 500,000 people balanced against the need for self sufficiency
- the use of existing services by people who live in northern New South Wales
- the development of appropriate and adequately resourced adult acute inpatient and community services as an important pre-requisite to the development of adult extended inpatient services
- the consideration that planning guidelines for adult extended inpatient services need to remain flexible at this time. The impact of community service development, effectiveness of particular service models and other advances in clinical practice (eg. Clozapine) need to be assessed over time

5.3 Planning Guidelines

Based on the emerging consensus from the National Mental Health Strategy, model services in Australia and overseas, and findings of national and international research Queensland has adopted population based planning guidelines for the provision of the specific mental health service components. Table 2 identifies the adopted planning guidelines for Queensland mental health services.

Table 2 *Adopted planning guidelines for Queensland mental health services*

Target Group	**Service Component**	**Type**	**Allocation per 100,000 population**	
			Target population	***Proposed***
Children (age to 13)	Inpatient	Beds	(population 0-13 yrs)	7
	Community	FTEs	(population 0-13 years)	25
Youth (age 14-18)	Inpatient	Beds	(population 14-18 yrs)	15
	Community	FTEs	(population 14-18 yrs)	25
Adult	Acute inpatient	Beds	(population 15-64 yrs)	15-20
			(population 65yrs +)	45
	Community	FTEs	(total population)	30
			(population 65yrs +)	10
	Extended inpatients:	Beds	(total population)	17.7
	Five clinical programs			
	- Acquired brain injury	Beds	(total population)	1.5
	- Psychogeriatric	Beds	(total population)	3.0
	- Extended treatment and rehabilitation	Beds	(total population)	5.0
	- Dual Diagnosis	Beds	(total population)	3.0
	- Secure:			
	extended secure	Beds	(population > 15 yrs)	4.3
	high security	Beds	(population > 15 yrs)	2.2

The planning guidelines adopted for Aboriginal and Torres Strait Islander mental health services, based on the higher level of need, has been set at twice the level for the general adult and children and youth services. These are outlined in Table 3.

Table 3 *Adopted planning guidelines for Queensland indigenous mental health services*

Target group	Service component	Type	Allocation per 10,000 Aboriginal and Torres Strait Islander population
Children and youth	Community	FTEs	5 (population 1-18 yrs)
Adult	Community	FTEs	6 (total population)
Older people	Community	FTEs	2 (population over 55 yrs)

5.4 Child and Youth Mental Health Services

Target group

Children's mental health services will provide services for children under 14 years of age, but mainly target primary school children between five and 13 who are most at risk of severe disturbance.

Youth mental health services will provide services for 14 to 18 year olds, with a specific focus on those within secondary school age groups who are severely disturbed or have a mental disorder.

It is estimated that by the year 2006, Queensland's population of children under 14 will be 830,000, with 500,000 between five and 13 years. The population of youth 14 to 18 years by the same time, is estimated to be 280,000.

Planning guidelines

The acute treatment service component for children's mental health services will require the equivalent of seven beds per 100,000 under 14 population, and youth mental health services will require the equivalent of 15 beds per 100,000 population 14 to 18 years. On this basis Queensland will require the equivalent of 64 beds for children, and the equivalent of 48 beds for youth (including a weighting for specific need areas for children and youth mental health inpatient services). It is proposed that these be established as discrete units where bed numbers are sufficient, or as day treatment services attached to community mental health services.

Currently there are only 10 mental health inpatient beds for children in Queensland, located at the Royal Children's Hospital. In early 1997 the 12 bed youth acute inpatient unit, located at the Royal Brisbane Hospital, will be operational and provide the only dedicated acute mental health inpatient beds for youth in Queensland. The Barrett Adolescent Unit at the Wolston Park Hospital complex has 15 places to accommodate young people with serious mental disorders for medium lengths of stay.

The community service component for child and youth mental health services require 25 full-time equivalent clinical staff per 100,000 population under 19 years. On this basis Queensland will require 213 full-time equivalent clinical staff for children, and 76 full-time equivalent clinical staff for youth mental health services plus administrative support by the year 2006.

An additional 20 full-time equivalent clinical staff are required to enhance community mental health services with mental health staff dedicated to meeting the needs of Aboriginal and Torres Strait Islander children and young people. This has been determined at the level of five clinical full-time equivalent staff per 10,000 indigenous population one to 18 years. This guideline will be reviewed as services are monitored and evaluated.

Service Development

The development of, and access to, acute treatment services for children and young people will be progressed as a priority within the implementation of the *"Future Directions for Child*

and Youth Mental Health Services" policy statement. It is proposed that acute treatment services be established in general hospital settings as discrete units where bed numbers are of a sufficient size, or special purpose areas of adult mental health inpatient units for youth, including partial hospitalisation programs; or as day treatment services attached to community mental health services.

Dedicated mental health inpatient services for children are planned to be provided in the Royal Childrens Hospital, Mater Hospital, Gold Coast, Toowoomba and Cairns Districts. These units will be established in general paediatric inpatient settings either as part of a paediatric unit or, where the bed numbers are sufficient, as a discrete inpatient unit. It is planned that the children's mental health inpatient units will be developed by 2001.

Dedicated mental health inpatient services for young people are planned to be provided in Royal Brisbane Hospital, Logan/Beaudesert, Gold Coast, and Toowoomba Districts. These services will be established as part of the adult inpatient unit or, where the bed numbers are sufficient, as a discrete inpatient unit. It is planned that the youth mental health inpatient units will be developed by 2001.

Formal mechanisms will need to be established between the relevant Districts regarding access to child and youth mental health inpatient services.

In Districts and/or networks of Districts where there are no dedicated inpatient units for children or youth, and where short-term inpatient treatment is required, services can be accessed within a general paediatric unit for children, and special purpose areas within the adult mental health inpatient unit for young people. Child and youth mental health services will be resourced to provide the necessary specialist mental health treatment and management for this service response as a component of the district child and youth mental health service.

Staffing establishment of child and youth community mental health services will be expanded to consolidate service provision to these target groups. Additional clinical staff will be required to provide services for children and youth from northern New South Wales. Based upon the current use of existing services, it is estimated mental health services will require an additional six full-time equivalent clinical staff for mental health services for children and an additional 2.5 full-time equivalent for youth by 2006.

5.5 Adult Mental Health Services

Target group

Adult mental health services will provide services for people aged 15 and over with a mental disorder or serious mental health problem.

It is estimated that by the year 2006, Queensland's population aged 15 and over will be 3.2 million, with 11.7 percent of the total population over the age of 65 years.

Planning Guidelines

The acute inpatient service component for adult mental health services will require: 15 to 20 dedicated beds per 100,000 population aged between 15 and 65 years; and 45 dedicated beds per 100,000 population aged 65 years and over. Where the catchment population is of sufficient size, a separate unit or part of a unit could be dedicated for acute psychogeriatric inpatient services. However, in Queensland the majority of acute units are, and will continue to be, too small for this degree of specialisation.

On this basis, Queensland will require between 622 and 758 acute inpatient beds. The higher figure of 758 takes into account recognised excess morbidity of mental illness in the inner city of the Brisbane north area. Currently there are 643 adult acute mental health inpatient beds in Queensland. Of these 643 adult acute beds, 104 acute beds are located at psychiatric hospitals.

The community service component for adult mental health services will require 30 full-time equivalent clinical staff per 100,000 total population. On this basis Queensland will require

1114 full-time equivalent clinical staff for community mental health services plus administrative support.

An additional 46 full-time equivalent clinical staff is required to enhance the capacity of community mental health services to provide psychogeriatric services. This has been determined at the level of one per 10,000 population aged 65 and over. The established mental health planning guideline for adult community mental health services (30 clinical FTE per 100,000 total population) includes the capacity to provide intake, assessment, continuing treatment and case management services to all adults including older people (at the level of at least one worker per 10,000 population 65 and over). This guideline will be reviewed as services are monitored and evaluated.

An additional 49 full-time equivalent clinical staff are required to enhance community mental health services with mental health staff dedicated to meeting the needs of Aboriginal and Torres Strait Islander people. This has been determined at the level of six clinical full-time equivalent staff per 10,000 total indigenous population for adults up to 55 years, and two clinical full-time equivalent staff per 10,000 indigenous population over 55 years. These guidelines will be reviewed as services are monitored and evaluated.

Service development

Most of the planned redevelopment of the adult acute inpatient units and some special care suites in general hospitals will be completed by 2001. This will provide 16 beds per 100,000 of the population aged 15 years and over. Acute beds in special care suites and non-hospital based acute inpatient units will provide the additional beds for population growth, by 2006, up to 20 beds per 100,000 of the population aged 15 years and over.

The planning for adult acute inpatient units redistributes the existing resources more equitably. For example, in some instances resources will need to be transferred from one District to another to provide inpatient services closer to where people live. This process may require additional funding to establish new services before existing services are reduced or closed.

It is envisaged adult community mental health service development across Queensland will achieve 20 clinical staff per 100,000 total population by 2001. This will have the capacity to provide core mental health service components of routine referral, intake, assessment on an extended hours basis, and some continuing treatment and case management service components (including outreach to rural and remote areas). These service components are the priority for service development.

Additional clinical staffing is required for psychiatric crisis response and treatment, and mobile intensive treatment service components, and will need to be developed when the service components identified above are functioning.

The additional clinical staffing required to enhance the capacity of mental health services to address the specific needs of the priority groups will be incorporated in the development of all service components.

Additional clinical staff will be required to provide services for people from northern New South Wales. Based upon the current use of existing services, it is estimated an additional 32.5 full-time equivalent clinical staff are required by 2006.

5.5.1 Extended inpatient services

Target group

Adult extended inpatient services are planned for the identified five specialised clinical programs for people who are sufficiently ill or disabled by their mental disorder to be unable

to be cared for adequately by local community based and acute inpatient services.

Planning guidelines

The extended inpatient service component for adult mental health services will require the following bed allocations per 100,000 of the specified population.

Acquired brain injury	1.5 (total population)
Psychogeriatric	3.0 (total population)
Extended treatment & rehabilitation	5.0 (total population)
Dual diagnosis	3.0 (total population)
Secure — Extended secure	4.3 (population > 15 yrs)
— High security	2.2 (population > 15 yrs)

Currently these services in Queensland are provided in four facilities: Mosman Hall Hospital, Charters Towers District; Kirwan Rehabilitation Complex, Townsville District; Baillie Henderson Hospital, Toowoomba District; and Wolston Park Hospital, West Moreton District.

Service development

The adult extended inpatient services within Queensland have been planned in three zones based around the five clinical programs, and will be provided on a supra-district basis. As previously stated these zones are:

- the northern zone (Torres, Cape York, Tablelands, Innisfail, Cairns, Townsville, Charters Towers, Mount Isa, Bowen, Mackay and Moranbah Districts);
- the south-east zone (Gympie, Sunshine Coast, Redcliffe/Caboolture, The Prince Charles Hospital, Royal Brisbane Hospital, Princess Alexandra Hospital, Mater Hospital, Queen Elizabeth II Hospital, West Moreton, Bayside, Logan/Beaudesert, Gold Coast Districts); and
- the central-downs zone (Rockhampton, Banana, Central Highlands, Gladstone, North Burnett, South Burnett, Bundaberg, Hervey Bay/Maryborough, Central West, Toowoomba, Northern Downs, Southern Downs, Roma, and Charleville Districts).

Services for the component of the extended secure clinical program for high security inpatient treatment will only be developed in the northern and south-east zones.

Development of extended inpatient services within these zones will occur in the context of the reform of the psychiatric hospitals, as outlined in Section 4 — Reform of Psychiatric Hospitals.

6 Resource Implications

Resource implications for the implementation of the Ten Year Mental Health Strategy have been identified, and are significant in terms of financial, human, and physical resources. They have been determined using indicative staffing profiles for each of the service components of mental health services and are based on the recurrent labour and non-labour costs to operate services.

6.1 Financial implications

In 1995/96, Queensland Health spent an estimated $170 million on mental health services. To provide mental health services to the level described in the Ten Year Mental Health Strategy for Queensland, the annual mental health budget will need to be increased. A strategic framework for mental health service development in each District Health Service has been completed and determines when the financial resources are required.

The directions of the National Mental Health Strategy and the Queensland mental health policy directions require fundamental changes to the way in which mental health resources are used. These changes will involve a number of key strategies:

- identify and monitor statewide and district mental health expenditure
- identify the Mental Health Program budget in the service agreements between Corporate Office of Queensland Health and District Health Services
- increasing the Mental Health Program budget to ensure that service effort is enhanced
- appropriate cost centre accounting and reporting through a specific schedule of the Queensland Government Financial Management System (QGFMS) established to allow monitoring of mental health expenditure
- allocation of resources to priority areas and the transfer of resources from one District Health Service to another
- establish district organisational structures to support mental health reform, this includes the deployment of a single accountable officer for the integrated mental health services within all relevant District Health Services
- inclusion of mental health capital implications within Queensland Health's 10 year Hospital and Health Services Building Plan.

Approximately 68 per cent of the additional funds are required to provide mental health services to the level determined in the detailed mental health service planning. The remaining 32 per cent represents resources required to meet the population growth to 2006. On this basis the financial implications for the implementation of the Ten Year Strategy will be considered within the context of a combination of Queensland Health funds and the allocation of new funds through the annual State Budget process.

6.2 Capital implications

A proposed framework for the statewide capital works required for the implementation of mental health reform in Queensland has been completed. A number of the required capital implications for adult, youth and children's acute inpatient services are included in the general hospital redevelopment and expansion program of the Queensland Health's 10 year Hospital and Health Services Building Plan.

In addition, this program includes the provision of approximately $100 million for mental health capital works as a component of the Ten Year Strategy. In the first instance this will primarily

focus on the decentralisation of existing inpatient services in the psychiatric hospitals. This is discussed in the previous section, Reform of psychiatric hospitals.

The identified priorities within the Building Plan will enable the decentralisation of acute and extended inpatient services closer to where people live and improve progress towards self-sufficiency for catchment area populations. Table 4 outlines the indicative mental health capital works program.

Table 4 *Indicative mental health capital works program*
- Bed numbers and sites for acute and extended inpatient services have been planned on the basis of population projections for 2006, based on 1994 census data.
- Development will need to take into account functional unit sizes and optimum location of facilities.

District	**Service Type**	**Year** *Indicative only*
Cairns	- Acute inpatient (39 adult and youth, 6 child)	1997/98
Townsville	- Acquired brain injury (10) - Extended secure (21) - High security (10) - Psychogeriatric (19)[1] - Extended treatment and rehabilitation (refurbishment — Kirwan, 24)	1998/99
Mackay	- Acute inpatient — Mackay Hospital (refurbishment) - Special care suite — Proserpine Hospital	1997/98 1998/99
Sunshine Coast	- Adult acute — Nambour Hospital (refurbishment 24) - Extended treatment and rehabilitation (24)[2] - Psychogeriatric (17) [2]	1996/97 2000 1999/2000
Redcliffe/Caboolture	- Adult acute — Caboolture Hospital (24)	1999/2000
The Prince Charles Hospital and District	- Adult Acute — The Prince Charles Hospital (60) - Extended treatment and rehabilitation (31)[3] - Acquired brain injury (16) - Dual diagnosis (33)[3] - Extended secure (40) - Psychogeriatric (16)	1998/99 1999 1999 1999 1999
Bayside	- Adult acute — Redlands Hospital (24) - Acquired brain injury (23) - Psychogeriatric (31)	1999/2000 2000/01 2000/01
Princess Alexandra Hospital	- Clinical Studies Unit (refurbishment, 10)	1998
Logan/Beaudesert	- Adult acute — Logan Hospital (17) - Youth acute — Logan Hospital (10)	1999 1999
Gold Coast	- Adult acute (35) [4] - Extended treatment and rehabilitation (27)[4] - Extended secure (19)[4] - Dual diagnosis (16)[4] - Psychogeriatric (16)[4]	1998/99 1998/99 1998/99 1998/99 1998/99
Toowoomba	- Adult acute — Toowoomba Hospital (20, relocate from Baillie Henderson Hospital)	1998/99
West Moreton	- Adult acute — Ipswich Hospital (32) - Extended inpatient — Wolston Park Hospital: - Extended treatment and rehabilitation (51) - Dual diagnosis (28) - Extended secure (28) - High security (64)	1997/98 2000/01 2000/01 2000/01 2000/01

1. The location of these beds is still to be determined. Options include Townsville and/or Charters Towers Districts.
2. The location and number of these beds is still to be determined in collaboration with The Prince Charles Hospital and District.
3. The location and number of these beds is still to be determined in collaboration with the Sunshine Coast District.
4. The location of these beds is still to be determined.

The remaining identified capital works required for the reform are primarily the community health capital development, and the development of additional acute inpatient services required to meet population growth by 2006. The recurrent costs for leasing premises for community mental health services has been included in the overall financial strategy for the reform, rather than delay the establishment of key community services.

The additional acute inpatient services required are the development of two to three bed dedicated mental health inpatient suites in rural general hospitals and the proposed model of non-hospital based inpatient services. It is envisaged that the capital costs for a number of these projects could be met from within minor capital works allocations.

The capital works implications to support mental health reform in Queensland will be coordinated within the framework for overall implementation of the Ten Year Strategy.

6.3 Workforce implications

Queensland mental health services currently employ 3094 full-time equivalent staff, with nurses representing 49 per cent, allied health 12 per cent, medical practitioners 8 per cent, and operational support and administrative staff 31 per cent. Significant increases in staffing are required to implement mental health reform in Queensland. Using the planning guidelines, a total of 4064 clinical and 372 administrative support staff are required by 2006.

The reform of mental health service delivery involves significant changes to the size, location and skill mix of the mental health workforce. An essential component of the implementation of the Ten Year Strategy is ensuring there is a coordinated strategy to achieve a consistent statewide approach to changes in work practice and organisational structure, and a framework for resolving industrial relations and other human resource management issues arising from the reform process.

A Mental Health Workforce Steering Committee, comprising representatives from the major unions, three District Health Services, and the relevant Corporate Office areas, has identified a program of statewide workforce issues to be addressed.

7 Glossary

Acute: recent onset of severe clinical symptoms of mental illness, with potential for prolonged dysfunction or risk to self or others. Treatment efforts are focussed upon symptom reduction, with an expectation of substantial improvement.

Acute inpatient service: provides assessment and short- term intensive treatment, as a part of the continuum of care, for people experiencing acute episodes of mental illness who cannot be treated more appropriately in other community settings.

***Case management*:** the mechanism for ensuring continuity of care, across inpatient and community settings, for access to and coordination of the range of services necessary to meet the individual and identified needs of a person within and outside the mental health service. People with mental disorders and severe mental health problems have ongoing needs necessitating access to health and other relevant community services. This will vary in intensity according to the person's needs and also involve some delivery of clinical services.

Community treatment: is the provision of routine treatment and support services, in a variety of community settings, to people with mental disorders and serious mental health problems. These include clinic-based services, outpatient services, domiciliary and other visiting services, and consultation and liaison services to general practitioners, primary health care and private sector providers.

Continuing treatment and case management: formal processes which follow the intake and assessment process, to ensure continuity of care for a person with a mental disorder or serious mental health problem requiring acute and ongoing treatment. It comprises a number of specialised mental health service components which include the provision of community treatment, outreach services, acute inpatient services in a variety of settings, psychiatric crisis response and treatment, mobile intensive treatment, and extended inpatient services in a variety of settings.

Continuity of care: is the provision of barrier-free access to the necessary range of health care services, across hospital, community and other support agencies, over any given period of time with the level of support and care varying according to individual needs.

Disability Support Services: are a range of service responses which enable the individual to live as independently as possible and be included in the ordinary life of their community.

District Mental Health Service: provides a range of specialised mental health service components, delivered by specialist mental health professionals, to a geographically defined population. Service components provide integrated and coordinated treatment options for people with mental disorders or severe mental health problems, are mainstreamed with general health services, and have well developed relationships with other government and non-government sector service providers. A district (or network) mental health service includes the core service responses required for the treatment of a person with serious mental illness, which comprise the entry into the mental health service delivery system (intake and assessment) and continuing treatment using a case management approach.

Extended hours: is an extension of the normal working hours of the mental health service to a minimum of 12 hours per day (Monday to Friday), and at times appropriate to the needs of catchment populations on Saturdays and Sundays. This includes

an after-hours on-call mobile response capacity (when resources permit), beyond the extended hours, to provide the intake and assessment service component, and limited case management.

Extended inpatient services: provides ongoing assessment, longer-term treatment and rehabilitation, on an inpatient basis, where a severe level of impairment exists. Treatment is focussed on prevention of deterioration and reduction in impairment. The expectation is for improvement over a longer period than in an acute setting and returning to community living in an area of the person's choice. Extended inpatient services are organised into five specialised clinical programs for people who are sufficiently ill or disabled by their mental disorder to be unable to be cared for adequately by community-based and acute inpatient services. The five clinical programs are acquired brain injury, psychogeriatric, dual diagnosis, extended treatment and rehabilitation, and secure services.

Intake: is the initial contact by clinical staff for a person referred to a mental health service. It involves the collection of information to assess the appropriateness of a referral, and enables a person to be directed to the most appropriate service response within or outside the mental health service.

Integration: refers to the process whereby a mental health service becomes coordinated as a single specialist network, and includes mechanisms which link intake and assessment, and continuing treatment and case management to ensure continuity of care. One single accountable officer has management and budgetary responsibilities for all service components within a District and/or network mental health service.

Mental Health Program: is the framework for the provision of mental health services by Queensland Health and its scope is defined by the following:

- services funded by Queensland Health for the specific purpose of providing intake and assessment, continuing treatment, community support services to people with mental disorders, serious mental health problems and associated disabilities
- services normally delivered from a service or facility which is readily identifiable as both specialised and mental health in focus
- services provided by dedicated personnel employed or contracted by state funded services

Mobile intensive treatment services: provides long-term case management and assertive outreach to very vulnerable and disabled people, living in the community, with severe mental illness, enduring disability and complex needs. Without the provision of this service response the person would be likely to have recurring admissions to acute inpatient services.

Network: mental health networks are groups of district health services based on geographic catchment areas to ensure access to a more comprehensive range of service components within the Mental Health Program. A network has an identified principal service centre.

Non-hospital based acute inpatient unit: provides acute inpatient services in a facility that is located on a non-hospital campus. Non-hospital based acute inpatient units can have approximately eight to 10 beds, are sited in the community, and provide the same service with equivalent clinical staffing profile as a hospital-based acute inpatient unit. Criteria for admission are the same as those for admission to a hospital-based acute inpatient unit.

Non-hospital based extended inpatient unit: provides extended inpatient services in a facility that is located on a non-hospital campus. Non-hospital based extended inpatient units can have about

20 beds, are sited in the community, and provide the same services with equivalent clinical staffing profile as hospital-based extended inpatient units for dual diagnosis and extended treatment and rehabilitation inpatient services. Criteria for admission are the same as those for admission to hospital-based dual diagnosis, and extended treatment and rehabilitation inpatient units.

Outreach services: provides visiting specialised mental health services to people who are unable to access such services close to their own community. It includes regular visits from a mental health service, located in a major population area, to rural and remote areas, and the establishment of formal mechanisms for clinical consultation and support between visits. This is generally provided to rural and remote areas where there are no local mental health services or those areas with satellite mental health services.

Principal service centre: is within a mental health network of districts and is defined as one with a minimum size catchment population of 100,000 with a mental health acute inpatient unit located in the general hospital. A principal service centre is responsible for providing acute inpatient services, community treatment, outreach and clinical and professional support services to satellite services within its own and other districts in the network. Using the role delineation for adult catchment area mental health services this will be Level 4 services.

Psychiatric crisis response and treatment: provides ongoing assessment, short-term interventions and treatment in the community for psychiatric crisis resolution. It includes the management of a person in an acute episode of mental illness with access to treatment options in a variety of settings to prevent admission to an acute inpatient unit.

Psychogeriatric services: is a component of the mental health service which targets older people with mental illness who require both specialised mental health and aged care expertise.

Rehabilitation: is focussed on the disability dimension and the promotion of personal recovery, across inpatient and community settings, with an expectation of substantial improvement over short to mid term. The key requirement is reduction of functional impairments that limit independence. There is a relatively stable pattern of clinical symptoms and an emphasis on prevention of illness relapse.

Satellite mental health service: provides intake and assessment, continuing treatment and case management, and consultation and liaison from a small number of mental health professionals based in rural or non-provincial centres. These services are supported clinically and professionally by outreach mental health services from provincial and metropolitan mental health services (from within the district or from another district).

Secure treatment service: provides services for people with mental disorders or serious mental health problems who, based on clinical assessment, require treatment in a closed setting to ensure the safety of the person, the staff and the community. Three levels of inpatient secure treatment are provided: acute inpatient secure treatment, extended secure treatment and high security treatment.

Single point accountability: within the program management structure, the Mental Health Program necessitates that one accountable officer be able to link all service components both administratively and operationally.

Special care suite: provides short-term specialised treatment for a person experiencing an acute episode of mental illness. It is a small dedicated self-contained facility, about two to four beds, located within a rural general hospital setting.

Specialised mental health service: are specifically designed health services for individualised assessment, continuing treatment and rehabilitation for people with mental disorders and

serious mental health problems. They also provide specialised consultation and liaison services to other agencies and include a component offering expert advice to facilitate rehabilitation and promotion programs.

QUEENSLAND GOVERNMENT

QUEENSLAND HEALTH

FUTURE DIRECTIONS FOR CHILD AND YOUTH MENTAL HEALTH SERVICES

QUEENSLAND MENTAL HEALTH POLICY STATEMENT

FOREWORD

Children and youth were identified in the National Mental Health Policy and Plan as a priority group with special mental health service needs. Key issues requiring consideration included future directions for service planning, the need for significant new service models and the need for appropriately trained staff.

This policy statement, *Future Directions for Child and Youth Mental Health Services* is Queensland Health's first policy on mental health service provision for children and youth. It was developed following extensive consultation with service providers, consumers and families, government and non-government agencies and other key stakeholders. It also takes into account recommendations from a formal review of existing community mental health services provided for children and youth, conducted in 1994 and the recommendations from the Consumer Consultation Project. Cabinet recently endorsed the Ten Year Mental Health Strategy which incorporates the strategic framework for the implementation of this policy statement.

In developing the policy statement it is recognised that children and youth present different patterns and types of mental health problems and disorders and require special consideration of their developmental context and legal status. Contemporary treatment for children and youth needs to be individualised and to draw from a range of therapeutic approaches which are appropriate for different ages, developmental stages, conditions and situations. The policy also recognises the importance of developing close links with other agencies such as education, paediatrics, juvenile justice and child protection services in meeting the needs of children and young people with mental health problems.

A statewide Professional Development Strategy has commenced for child and youth mental health services. This strategy will determine training and professional development requirements to build upon the existing expertise of individual professional disciplines in child and youth mental health services.

Delivering high quality services to young people and their families is a priority for the government. I welcome this opportunity for new directions in the delivery of child and youth mental health services. I am confident that this policy statement will guide us to achieve the vision "to promote, maintain and improve the mental health of the children and youth of Queensland."

Mike Horan
MINISTER FOR HEALTH

EXHIBIT 75

CONTENTS

Future Directions for Child and Youth Mental Health Services

Vision

To promote, maintain and improve the mental health of the children and youth of Queensland.

Introduction

This statement aims to set specific and clear directions to guide the development of specialised mental health services provided by Queensland Health, within a wider system of services which impact on mental health for children and youth. These include government agencies in child health, adult mental health, public health, education and juvenile justice, as well as private sector health service providers and non-government community based organisations.

The development of this policy and planning statement was informed by extensive consultation with service providers, consumers and families, government and non-government agencies and other key stakeholders. It also takes into account recommendations from a formal review of existing community mental health services provided for children and youth, conducted in late 1994 and a consumer consultation project.

Major reform of mental health services is occurring throughout Australia. Guiding the development of this Policy and Planning Statement are policy directions articulated in

- the National Mental Health Policy (1992) and Plan (1992)
- the Queensland Mental Health Policy (1993) and Plan (1994)
- National Goals, Targets and Strategies for improving Mental Health (1994)
- the Health of Young Australians (1995)
- the Ten Year Mental Health Strategy for Queensland (1996).

This is Queensland Health's first specific policy on mental health service provision for children and youth. A separate policy is needed for children and youth to ensure that services are tailored to meet their specific needs.

BACKGROUND

Mental health problems and mental disorders in children, youth and young adults are usually expressed through emotional disturbance, behavioural problems, and problems with coping and relating to people.

These are often accompanied by cognitive difficulties, speech and language problems and disorders, and psychomotor difficulties. Certain developmental life transitions, physical and intellectual disabilities, and a range of medical disorders are known to be associated with mental health problems.

Children and young people often cannot communicate their experience or distress, relying on an adult to recognise their need and seek help for them. Because the child is in the process of development, including transitions between primary and secondary school and between adolescence and adulthood, the overall presentation may be diffuse and difficult to define in terms of a diagnosable psychiatric condition.

Information about the prevalence of mental illness in childhood and adolescence is limited. Review of current national and international figures suggest that between 10-18 per cent of those under 19 years of age have mental health problems or disorders that warrant recognition and treatment. Many of these problems are of a less severe nature and can be helped successfully by primary health care services and supportive social systems which can promote better adjustment, without the need to access specialist mental health services.

It is estimated that three to five per cent of children and young people under 19 years of age suffer severe disturbance and functional impairment. It is this group, a proportion of whom are likely to be involved in other service systems, whose clinical needs require the intervention of a specialist mental health service.

Recent data from Western Australia indicates that the proportion of the population under 19 years of age with severe levels of disturbance could be as high as eight to 10 per cent. An accurate prevalence level will be determined by the national epidemiological survey, which is being conducted as a key initiative of the National Mental Health Strategy.

Prevention and early intervention strategies are important in interrupting the development of severe mental health problems and disorders. Early and adequate intervention with mental disorders in childhood and adolescence allows many young people to resume a normal developmental pathway and reduces the longer-term impact of social rejection, educational failure, and inappropriate coping methods such as substance abuse. While it may often be difficult to diagnose mental health problems in the early stages, it is possible to target intervention because of known risk factors.

Service delivery for children and youth differs from service delivery for the adult population. Children and youth present different patterns and types of mental health problems and disorders and require consideration of their developmental context and specific legal status. Services are different with respect to their structure, staffing profiles, clinical practice and models of service delivery.

A spectrum of intervention strategies for the under-19 population is needed to maximise the effectiveness of mental health promotion and the prevention, early intervention and specialist treatment of mental disorders. (Illustrated in Figure 1, over)

At one end of the spectrum, mental health promotion and prevention programs targeting general population groups aim to promote health and well-being and prevent illness. Another level of intervention is detecting and intervening with mental health problems as they are developing. Child health services, primary health services, education, protective services, juvenile justice and other support systems for children and youth are the most appropriate vehicles for these strategies.

The mental health service's primary focus is on those whose level of need requires intervention by a specialist service and on developing targeted detection and early intervention strategies in collaboration with other agencies, for children and young people at higher risk of developing serious mental health problems. Further detail regarding the role and future directions for these services is provided in this policy statement.

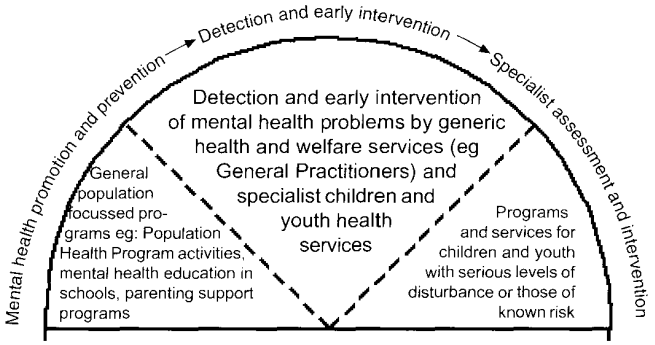

Figure 1: Spectrum of interventions needed to promote, maintain and improve mental health of children and youth.

PRINCIPLES

The following principles guide the delivery of mental health services for children and youth:

- Each child or young person with serious levels of disturbance, or at risk, should have timely access to high quality mental health services, which take account of family and social circumstances, and cultural and language differences.
- Service provision should include the development of strategies for identification and early intervention targeting those with known risk factors.
- Mental health services for children and youth must be flexible and individually tailored, taking into account developmental and social contexts as well as clinical need.
- Children and young people need to be able to make informed decisions and be involved in the processes affecting them.
- Services should be developed, delivered and evaluated with the involvement of consumers and carers.
- Mental health services for children and youth will be coordinated between adult mental health, general health, welfare and education services in ways that ensure children and youth have access to the particular mix of services they require.
- The service approach will maximise the support given to the child's caring network, including parents, and build on existing strengths and opportunities within their environment.

PLANNING CONSIDERATIONS

National and state policies require that all specialised mental health components are integrated on a catchment specific basis. The organisational structure of CYMHS within the integrated mental health service will vary depending on size of the catchment, demographics and service delivery networks.

Service location and development of treatment teams need to recognise the importance of developing close planning and operational links with other essential services. The nature of such links will vary depending on the age range of the target population. For children and younger adolescents the development of links to other child services, including paediatric services, juvenile justice, educational services and child protection services are a priority.

Some children and youth need special consideration in service planning and delivery. These include:

- those from an Aboriginal or Torres Strait Islander background
- those with cultural and communication needs, eg. those from a non-English speaking background, or with profound hearing impairment
- those from rural and remote areas
- those who are homeless

Future planning and resource allocation will aim to provide an equitable distribution of services throughout Queensland. Role delineation guidelines will be developed to identify the range of expected services in rural and remote areas, provincial centres, major cities and in the metropolitan regions and future planning requirements.

Planning for rural and remote communities will include the use of teleconferencing and other technologies to provide rapid assessment and guidelines for treatment of children, youth and their families distant from CYMHS services. It will also include providing a range of service options for families, such as expanding local services, supported by visiting mental health services.

SERVICE DIRECTIONS

Service title

The statewide title of the service is *Child and Youth Mental Health Service*. The service can be known by the acronym CYMHS.

Specialised services targeting those most in need

Mental health services for children and youth are a component of Queensland Health's Mental Health Program, providing early diagnosis and intervention, treatment and rehabilitation for the target group. As specialist services they will target direct service delivery to that portion of the population whose disorders are severe and complex, or at risk of becoming so, and whose needs cannot be met by other services.

They also provide a lead role in addressing mental health issues across the spectrum of interventions, through the input of specialist knowledge and assisting other service systems in the areas of detection, prevention and early intervention.

Access to a specialist service will be determined by a clinical decision, taking into account the psychiatric nature of the disorder, the severity of disturbance, the complexity of the condition (including comorbidity), the extent of functional impairment and the level of child, young person's and/or family distress.

In most cases it is preferable that clients access the service through a referring agent such as a general practitioner, guidance officer or youth worker. However, in situations of acute need, service responsiveness requires that families or individual youth can directly access the service. Suicidal, psychotic, severely disturbed and traumatised children and young people whose behaviour is causing risk of harm to themselves or others will be given urgent priority.

Services will target children and youth known to be at higher risk of developing serious mental health problems and disorders. Targeted detection and early intervention strategies appropriate to local need will be developed by CYMHS services, in collaboration with other relevant agencies.

Examples of **high risk groups** include:

- children and youth living with family members who have mental illness
- children and youth in care or in contact with the law
- those with early onset mental disorders (eg. conduct disorder, psychosis)
- those suffering abuse, neglect or other traumas
- children and youth with chronic illness or disability
- youth engaging in substance abuse

Those at risk of developing mental health problems which are of a severe, complex or life-threatening nature are identified through a number of service systems which have established ongoing links with children, young people and their families. These include child health services, schools, general practitioners and community youth agencies. The role of CYMHS is to link with these agencies in providing advice, consultation and development of expertise in ensuring that a timely and appropriate response is provided. Such collaborative relationships will facilitate referral and access for those in need of specialist mental health assessment, intervention and ongoing case coordination.

Mental health services for children and youth are planned to address the age bands 0-13 years and 14-18 years, adopted to reflect current service delivery in schools, community health services and hospitals. Hospitalisation of children in children's wards tends to cut off at age 14 and children transfer from primary to secondary schools between the ages of 12 and 13 years. For larger catchment populations, services for these age groups may be organised separately and collocated with other age-appropriate services as best suited to local need. The needs of young adults over 18 years require specific planning consideration in the adult mental health service.

- **Children (primary focus 0-13 years)**
  Mental health services targeting children will focus on 0-13 year olds and their families, with flexibility in the older ages depending on developmental stage and family supports. Early detection and intervention strategies are necessary in this age band for those young children who are exhibiting severe disturbance or known to be at risk.

- **Youth mental health service (primary focus 14-18 years)**
  This service will focus on services to youth between 14 and 18 years with flexibility at both ends of the age spectrum, to respond to developmental, clinical and family needs. Early detection and treatment services for those with low incidence disorders which have a high risk of death or impairment, such as schizophrenia or eating disorders, are to be given priority. Historically, services oriented to children and youth have seen relatively few people in the older youth age group. To overcome this service gap, the development of service delivery models will need to prioritise improved access to services by this group.

  To promote continuity of care for seriously disturbed youth, access to consultant psychiatrists, inpatient services and 24-hour mental health crisis response services necessitates establishing close links with adult mental health services.

- **Young adult mental health services (over 18 years)**
  Services to young adults over 18 years need to be identified and provided from within the adult mental health program, with close links to CYMHS. Such links will facilitate continuity of care and take into account the developmental focus.

SERVICE DELIVERY APPROACH

Contemporary treatment for children and youth is individualised, using a range of therapeutic approaches, appropriate for different ages, developmental stages, conditions and situations. Treatment approaches need to be open to review, as new evidence becomes available on effective interventions.

Professionals working in specialist children and youth mental health services need to possess a knowledge of childhood and adolescent development and temperament, disorders in children and youth and the course of these disorders, disorders in parents, resilience and protective factors, and patterns of interactions within families.

Services are delivered by a multidisciplinary workforce which needs to possess a core body of knowledge and skills which builds on the expertise of individual disciplines. Collaboration in treatment planning between and among multi disciplinary team members ensures consideration of the interactions between relevant biological, psychological and social factors.

In many situations, effective and efficient treatment may be quite brief. Timely and early intervention is desirable to minimise family disruption, reduce the length of intervention needed and produce better outcomes in the longer term. Children and young people with disabling, severe and complex disorders require longer-term case management and support, with some needing ongoing interventions over a period of years.

Since the social context of young people has a powerful influence on the onset, expression and remission of psychiatric disorder, working with families, schools and communities is a central part of treatment approaches. Effective case management practices will ensure that carers and other service providers are appropriately involved in treatment planning and service delivery.

In the delivery of services to individuals and their families, research has shown that better health outcomes are achieved by building on strengths and opportunities in the child and young person and their support networks.

The focus of the clinical approach of CYMHS will be on:

- identification and early intervention to treat and reduce the development of additional problems, especially in known high risk groups
- targeted, clinically appropriate, outcome oriented and effective interventions
- maximising the support given to the client's caring network, and working in a specialist advisory and support role with other agencies, where clinically appropriate

SERVICE PROFILES

A range of service responses are to be provided as part of a single mental health service for a defined catchment population. Services will be designed to facilitate continuity of care within CYMHS. The following service components and priorities for service development have been identified.

Children's mental health services

Referral, intake and assessment services:

- referrals are generally from another service provider. In situations of acute need, families or individuals can directly access the service
- appropriate and timely specialised mental health assessment and consultation, including the capacity for emergency assessment
- extended hours capacity in arrangement with the intergrated mental health service

Continuing treatment and case management services

Community treatment services providing a combination of:

- clinic-based services, outpatient services, domiciliary and other visiting services
- outreach to children in schools and in day programs
- specialist individualised programs for children with specific disorders
- outreach services to smaller communities, including rural and remote communities

Consultation and liaison services, including:

- hospital and GP consultation and liaison services
- interagency liaison and joint case management
- input to interagency program planning and delivery and community development activities
- CYMHS services linked with child and family support services e.g. respite, therapeutic fostering and day-relief services
- education and training of community workers in mental health issues

Acute treatment services providing intensive responses which may include:

- Day Treatment Services. Structured day - only treatment program which provides intensive treatment for brief or extended periods
- acute inpatient services provided on a 24 hour basis. Periods of hospitalisation to be kept to a minimum. Age - appropriate environment, either in a dedicated children's mental health inpatient unit or access to general paediatric beds
- Partial Hospitalisation. Step down service for ongoing stabilisation after acute inpatient treatment, before receiving ongoing treatment in the less intensive continuing treatment component

Youth mental health services

Referral, intake and assessment services:

- referrals are generally from another service provider. In situations of acute need, families or individuals can directly access the service
- appropriate and timely specialised mental health assessment and consultation, including the capacity for emergency assessment
- extended hours capacity developed in arrangement with the intergrated mental health service

Continuing treatment and case management

Community treatment services providing a combination of:

- clinic-based services, outpatient services, domiciliary and other visiting services
- a range of outcome-focussed interventions
- outreach provided within the context of the young person's everyday life, eg. outreach to schools, youth services
- intensive treatment and support using case management approach for young people with severe disturbance and mental disorders
- outreach services to smaller communities, including rural and remote communities

Consultation and liaison services, including:

- consultation and liaison services provided to hospitals, general practitioners, Young People at Risk program, and youth services
- CYMHS services linked with respite, supported accommodation options, and therapeutic fostering services
- interagency liaison and joint case management
- input to interagency program planning and delivery and community development activities
- education and training of community workers in understanding mental illness, detection and referral

Acute treatment services providing intensive responses which may include:

- Day Treatment Services. Structured day - only treatment program which provides intensive treatment for brief or extended periods
- acute inpatient services provided on a 24 hour basis. Periods of hospitalisation to be kept to a minimum. Age-appropriate environment, either in a dedicated youth mental health unit or allocated mental health beds in adult wards. Capacity to provide care and treatment for those at higher risk of harm to self or others according to the requirements of the Mental Health Act for involuntary treatment
- Partial Hospitalisation. Step down service for ongoing stabilisation after acute inpatient treatment, before receiving ongoing treatment in the less intensive continuing treatment component

Specialist day programs to assist young people with early onset psychosis or severe functional impairments from mental illness:

- to be developed in collaboration and consultation with adult mental health services to enable continuity of care

ENSURING QUALITY SERVICES

Components of quality care include:

- providing clear directions about what CYMHS can provide and how and when to refer
- using assessment, management and intervention methods, which are selected on the basis of empirical evidence to provide the most appropriate clinical response
- providing training, leadership and continuous support to CYMHS staff to ensure specialist skills and services
- supporting other agencies to understand, detect and refer
- making the service easy to access by closing gaps for high risk children, youth and their families and carers
- having clear accountability for the quality of care provided and appropriate targeting of available resources
- providing adequate resources to meet the need

Strategies for a number of these have been discussed earlier.

Training

A statewide professional development strategy is being developed, with input from all clinical disciplines. The first stage will identify the training requirements for the specialist skill areas to build on the existing expertise of individual professional disciplines. In the second stage, options for delivering a training program and identification of strategies for supervision, professional development, retention and career progression for the current CYMHS workforce, the incoming workforce and the adult mental health workforce will be developed. In the third stage a curriculum will be developed.

The identification of educational and support needs will be an integral part of this process, and strategies will be developed to assist staff working with rural and remote communities.

To provide academic and clinical leadership in this field, a Chair in Child and Adolescent Psychiatry has been established at the University of Queensland.

Queensland Health has also developed and enhanced the statewide training program for senior trainees in Child and Adolescent Psychiatry following negotiations with the Royal Australian and New Zealand College of Psychiatrists, Faculty of Child Psychiatrists, University of Queensland, and service providers.

Ongoing support and supervision

Geographical and professional isolation, and lack of a critical mass of specialists must be addressed in service planning. The second stage of the professional development strategy will examine strategies to ensure that support and supervision arrangements are in place. This might include the negotiation of agreements between services.

Quality of service provision

Information systems will be established in all CYMHS services to collate and evaluate process output and outcome data.

Services will seek to continue to be updated on developments in knowledge and skills and will actively participate in extending the boundaries of that knowledge.

The National Standards for Mental Health Services will be released in 1997 and services will be assisted to comply with these standards.

Families, children and youth will be involved in planning, delivery and evaluation of services to effectively orient services to meet local needs and focus on quality outcomes for clients.

Accountability

An officer will be appointed in each CYMHS with responsibility for service standards.

The Mental Health Services Program Manager is responsible for identifying and maintaining the CYMHS budget, and reporting on CYMHS expenditure and performance targets.

CLOSING THE GAPS

The responsibility for the mental health of children and youth cuts across departmental boundaries. To adequately address service gaps, the development of a system of care that integrates the service delivery of multiple sectors and agencies is required. Coordination of a number of service systems is important in providing effective prevention and promotion programs.

The mental health services will work closely with other sectors to:

- achieve greater coordination of services for children and youth with severe emotional disturbance and their families (who are clients of several systems)
- provide consultation, education, training and liaison services to systems providing services to less severely disturbed children and youth
- provide specialist knowledge and input into the development of population health programs and early intervention strategies

Queensland Health will facilitate the development of service systems, based on interagency protocols to clarify mutual expectations of services and to standardise referral channels.

Strategies will include:

* development of frameworks for interagency collaboration on service provision
* establish or support existing local community networks
* identify local area high risk needs
* establish joint protocols for case management, shared care, confidentiality and joint programming
* establish local agreements about service responsibilities

The links with other services are outlined as follows:

- **Agencies involved in mental health promotion and prevention activities**

  Health promotion and prevention programs aim to address broad social, economic, and physical environments which impact on the mental health of children, young people and their families. Programs are targeted for delivery through schools, in the primary health sector with child health nurses, school health nurses and general practitioners, and youth agencies. The role of specialised mental health services in prevention and promotion is to provide input into the development of these programs and enable appropriate referral for identified high risk children and young people.

- **Private psychiatrist and allied health professionals**

  About 50 per cent of severely disturbed children under the age of 14 years are seen by private psychiatrists. Private psychiatrists also provide a valuable rural mental health service ranging from fortnightly to quarterly visits, in collaboration with local primary health and mental health allied health professionals. The opportunity to refer to the public sector for intensive multidisciplinary interventions is particularly valued by the private sector.

  Private psychologists, counsellors, and their allied health professionals provide a significant role in the treatment of children and young people with serious levels of disturbance.

- **General Practitioners**

  The strengthening of linkages between children and youth mental health services and general practitioners is essential as general practitioners hold a pivotal position in health care and are often the first point of contact for parents of troubled children. General Practitioners provide the long-term management, with consultation and liaison support from the Child and Youth Mental Health Service. Shared care arrangements between mental health services and general practitioners are particularly useful in the support of families.

  Innovative strategies to encourage links between the private and public sectors will be promoted and explored in the implementation of this policy, in keeping with Queensland Health's policy on private sector involvement in health services.

- **Education**

  Schools play a major part of the lives of all children and young people. Schools provide a valuable vehicle for education programs aimed at promoting mental health and enabling the early prevention and treatment of mental health problems. A significant part of the work of CYMHS is to provide consultation and liaison services to schools, and to support teachers and guidance officers to assist with implementing intervention programs in the school setting. Where appropriate, CYMHS takes referrals for assessment and intervention. Teachers and guidance officers are well placed to participate in interagency case management arrangements, and to detect and refer children and young people with problems.

- **Public sector family and community support services**

  Workers in systems, such as protective services and the juvenile justice system, have the potential to identify emotional distress or behaviour problems and assist through providing advice and emotional support. The specialised service should aim to assist workers in these service sectors to recognise severe difficulties and high risk situations and ensure appropriate referral.

  Case management involving interagency collaboration is a key strategy for children and youth with serious disturbance and their families.

- **Non government community based youth and family counselling and parent support services**

  These services provide a range of counselling and support services to children, youth and their families. Workers in youth specific services frequently deal with mental health issues and

require support to enable them to detect and appropriately refer people experiencing mental health problems. Family and youth counselling services, by providing information and support, have a significant preventive role, and may refer people experiencing more serious problems for specialist help.

- **Acute child and youth health services**

  Child and youth health services are major health care providers for children and youth considered at risk of developing mental illness and disturbance. A range of specialist private and public developmental paediatric assessment and treatment services are involved in the effective detection and treatment of mental disorders at the earliest time after they begin. They assist families to manage behavioural and adjustment difficulties. When specialist mental health skills are necessary, referral will be made to a Child and Youth Mental Health Service for treatment or consultation and liaison.

- **Adult mental health services**

  Coordination and collaborative service planning is required with adult mental health services. They provide services to the families of adults with severe mental illness, including information and support for relatives and children. Services for young adults from 18 years need to be identified and provided within the adult mental health program, with close links to the mental health services for children and youth. The adult service needs to give due regard to developmental and contextual issues in assessing young adults over 18 years.

- **General health**

  General health services may need specialised input to assist them to meet the needs of children and youth with psychological responses to illness and disability. Child and Youth Mental Health Services need to develop close links with alcohol and drug programs which provide treatment, counselling and support to adults and youth who may also be parents.

glossary

Acute: recent onset of severe clinical symptoms of mental illness, with potential for prolonged dysfunction or risk to self or others. Treatment efforts are focussed upon symptom reduction, with an expectation of substantial improvement.

Acute inpatient service: provides assessment and short-term intensive treatment, as a part of the continuum of care, for people experiencing acute episodes of mental illness who cannot be treated more appropriately in other community settings.

Case management: the mechanism for ensuring continuity of care, across inpatient and community settings, for access to and coordination of the range of services necessary to meet the individual and identified needs of a person within and outside the mental health service. People with mental disorders and severe mental health problems have ongoing needs necessitating access to health and other relevant community services. This will vary in intensity according to the person's needs and also involve some delivery of clinical services.

Community treatment: is the provision of routine treatment and support services, in a variety of community settings, to people with mental disorders and serious mental health problems. These include clinic-based services, outpatient services, domiciliary and other visiting services, and consultation and liaison services to general practitioners, primary health care and private sector providers.

Continuing treatment and case management: formal process which follows the intake and assessment process, to ensure continuity of care for a person with a mental disorder or serious mental health problem requiring acute and ongoing treatment. It comprises a number of specialised

mental health service components, which include the provision of community treatment, outreach services, acute inpatient services in a variety of settings, psychiatric crisis response and treatment, mobile intensive treatment, and extended inpatient services in a variety of settings.

Continuity of care: is the provision of barrier-free access to the necessary range of health care services, across hospital, community and other support agencies, over any given period of time with the level of support and care varying according to individual needs.

Extended hours: is an extension of the normal working hours of the mental health service to a minimum of 12 hours per day (Monday to Friday), and at times appropriate to the needs of catchment populations on Saturdays and Sundays. This includes an after-hours on-call mobile response capacity (when resources permit), beyond the extended hours, to provide the intake and assessment service component, and limited case management.

Intake: is the initial contact by clinical staff for a person referred to a mental health service. It involves the collection of information to assess the appropriateness of a referral, and enables a person to be directed to the most appropriate service response within or outside the mental health service.

Integration: refers to the process whereby a mental health service becomes coordinated as a single specialist network, and includes mechanisms which link intake and assessment, and continuing treatment and case management to ensure continuity of care. A single accountable officer has management and budgetary responsibilities for all service components within a District and/or network mental health service.

Mental Health Program: is the framework for the provision of mental health services by Queensland Health and its scope is defined by the following:

- services funded by Queensland Health for the specific purpose of providing intake and assessment, continuing treatment, community support services to people with mental disorders, serious mental health problems and associated disabilities
- services normally delivered from a service or facility which is readily identifiable as both specialised and mental health in focus
- services provided by dedicated personnel employed or contracted by state funded services.

Rehabilitation: is focussed on the disability dimension and the promotion of personal recovery, across inpatient and community settings, with an expectation of substantial improvement over short to mid term. The key requirement is reduction of functional impairments that limit independence. There is a relatively stable pattern of clinical symptoms and an emphasis on prevention of illness relapse.

Specialised mental health services: are specifically-designed health services for individualised assessment, continuing treatment and rehabilitation for people with mental disorders and serious mental health problems. They also provide specialised consultation and liaison services to other agencies and include a component offering expert advice to facilitate rehabilitation and promotion programs.

EXECUTIVE SUMMARY

1.0 INTRODUCTION

The Wolston Park Hospital Transition Team and the Hospital Redevelopment Project Team propose the implementation of three project phases critical to the decentralisation of Wolston Park Hospital and the redevelopment of associated mental health services. The three phases and associated significant actions are depicted in the attached gantt charts. Details, rationales and implications of the phases and significant actions are summarised in the following sections.

2.0 BACKGROUND

The Wolston Park Hospital Transition Team and the Hospital Redevelopment Project Team conjointly conducted two planning days on 25 and 26 February 1998. The aim of these planning days was to establish critical pathways for the project areas of the two teams, primarily in relation to the decentralisation of Wolston Park Hospital. The establishment of critical pathways centred on three main phases of the decentralisation and redevelopment process. The three proposed phases are: 1) planning/initiation; 2) the establishment of transitional wards at Wolston Park Hospital; and 3) the new mental health services coming on-line.

3.0 PLANNING FRAMEWORK

The successful decentralisation and redevelopment of mental health services is largely pivotal on timely collaboration between the four project areas: 1) Human Resource Management; 2) Patient Relocation; 3) Financial; and 4) Capital Works. To facilitate a smooth transition it is proposed the first three project areas dictate to a significant extent, the Capital Works project area. Consequently the time lines for these three project areas are identified separately on the first page of the attached gantt chart and the Capital Works on the second page. The gantt charts are based on the principle of flexibility

allowing the significant actions and associated time lines to be adapted as required (see Section 6 : page 9 “Monitoring”).

4.0 THE THREE PROPOSED PHASES

4.1 Planning/Initiation Phase

This phase identifies significant actions and time lines for the three project areas: Human Resource Management, Patient Relocation and Financial. These are briefly outlined below. The significant actions specified for each project area have several detailed components critical for the successful completion of each area. Further definition and more specific time lines for these components will be undertaken upon endorsement of the significant actions and time lines specified in the gantt charts.

4.1.1 Human Resource Management

4.1.1.1 Communication Strategy

- Stakeholders and the method and frequency of communication and consultation are specified in the Communication and Consultation Plans for the two Teams.

4.1.1.2 Corporate Human Resource Policy and Plan finalised and endorsed

- A Corporate Human Resource Policy and Plan in relation to the decentralisation of the three State psychiatric hospitals and the redevelopment of the new/redevelopment mental health services is being developed in consultation with stakeholders including the Single Bargaining Unit. The Policy and Plan will focus on areas related to: the provision of trained staff in the new/redeveloped services; maintaining an efficient and effective service during the decentralisation; and allowing planned options for staff. Endorsement will be by the Director-General.

4.1.1.3 Staffing Profiles negotiated with Districts and endorsed by the District Manager

- Staffing profiles require development with Districts through the Service Development Reference groups and then these will be endorsed by each affected District Manager.

4.1.1.4 Personal Profile process for Wolston Park Hospital staff developed and endorsed

- A Personal Profile proforma and process will be developed by the Wolston Park Hospital Transition Team. This process will assist in identifying individual needs in relation to human resource management issues and a current workforce profile for the hospital. It is proposed all permanent employees will participate in this process with temporary employees being optional. Endorsement will be by the Wolston Park Hospital Transition Steering Committee.

4.1.1.5 Relocation Package developed and supplied to staff

- It is proposed Relocation Information Packages be developed to outline the new mental health services, clinical programs and

applicable staffing profiles. This package will be distributed to categories of staff whose positions are identified in the staffing profiles. Information sessions are proposed prior to the release of these packages. The package and process will be endorsed by the Wolston Park Hospital Transition Steering Committee.

4.1.1.6 Wolston Park Hospital Human Resource Plan developed and endorsed

- A Human Resource and Change Management Plan specific to Wolston Park Hospital will be developed and endorsed by the Wolston Park Hospital Transition Steering Committee after the Corporate Human Resource Policy and Plan has been endorsed. The Wolston Park Hospital Human Resource and Change Management Plan will be derived from the Corporate Policy and Plan and focus on the similar objectives and strategies.

4.1.1.7 Wolston Park Hospital Human Resource Plan implemented

- The objectives and strategies identified in the Wolston Park Hospital Human Resource and Change Management Plan will be implemented primarily through the proposed Workforce Working Parties under the guidance of the proposed Workforce Planning and Advisory Steering Committee.

4.1.1.8 Relocation Package completed and returned

- Staff will have approximately six to eight weeks to complete and return the Relocation Packages to the Transition Team.

4.1.1.9 Staff Selection Process and Appointment to all Services

- The details of the selection process will be included in the Corporate and Hospital Human Resource Plans. It is envisaged the selection process for the positions in the new mental health services be completed over a three month time period. Staff will be informed of the outcomes of the selection process by February 1999.

4.1.1.10 Staff to Transitional Wards, Wolston Park Hospital

- When the selection process is complete and staff are informed of their future employment locations it is proposed that staff are reorganised into the transitional wards (see Section 4.2; page 5, “Establishment of Transitional Wards at Wolston Park Hospital”).

4.1.2. Patient Relocation

4.1.2.1 Communication Strategy

- Stakeholders and the method and frequency of communication and consultation are specified in the Communication and Consultation Plans for the two Teams. Additionally, the Patient Relocation plan further elaborates on communication strategies.

4.1.2.2 Service Development Models developed by Service Development Reference groups

- Service Development Models for each clinical program and receiving Districts are proposed to be developed by Service Development Reference groups. These models will guide the development of staffing profiles.

4.1.2.3 Patient Relocation Plan finalised and endorsed

- The Patient Relocation Plan depicts the overarching process for the transfer of patients to new/redeveloped mental health services and identifies different stages and strategies for this transfer. Endorsement of this plan is planned by the end of April 1998 by the Wolston Park Hospital Transition Steering Committee.

4.1.2.4 Potential patients identified for new services

- The Patient Relocation Plan identifies clinicians as the primary stakeholders identifying potential patients for transfer to new services.

4.1.2.5 Districts consulted concerning potential patients for transfer

- The Patient Relocation Plan identifies the process for consulting with receiving Districts in relation to potential patients for transfer.

4.1.2.6 Patients and relatives consulted concerning relocation decision

- The Patient Relocation Plan identifies the method for consultation with patients and relatives concerning the relocation decision.

4.1.2.7 Selection of patients finalised

- Following the identification of potential patients for relocation and the individual consultative processes, patients will be selected to move to the new services.

4.1.2.8 Patient transferred to Transitional Wards, Wolston Park Hospital

- When the patient selection process is finalised it is proposed that patients are reorganised into the transitional wards (see Section 4.2; page 5, "Establishment of Transitional Wards at Wolston Park Hospital").

4.1.3 Financial

4.1.3.1 Current Budget for Wolston Park Hospital identified

- The current 1997/98 budget for Wolston Park Hospital is broken down across clinical program and across wards. Clinical and non-clinical labour costs, non labour and superannuation costs are identified.

4.1.3.2 Optimal Funding required for new/redeveloped services identified

- A summary identifying funding required for new/redeveloped services utilising the optimal staffing and recurrent costing profiles has been developed. The summary identifies clinical and non-clinical costs, non-labour costs, off-sets and superannuation costs.

4.1.3.3 Communication Strategy developed and implemented

- Stakeholders and the method and frequency of communication and consultation are specified in the Financial Communication Strategy for all the financial aspects of the Hospital Redevelopment project.

4.1.3.4 Strategy for the timely transfer of patient trust accounts developed and implemented

- This strategy will include identification of patients deemed capable and incapable and promoting awareness with receiving Districts and other stakeholders.

4.1.3.5 Strategy for patient maintenance charges developed and implemented

- This strategy will include: promoting awareness of patient maintenance charges with stakeholders; identifying the classification of maintenance charges applied at Wolston Park Hospital and receiving districts; and identifying the pertinent requirements under the Mental Health Act and the Health Services Act.

4.1.3.6 Financial Plan developed and endorsed

- A Financial Plan detailing all the financial aspects of the project will be developed. The financial plan will detail the amount of funding required, source, time frames and methodology of financial transfers to new/redeveloped services. The financial plan will also identify non-recurrent funding requirements for initiatives such as training packages and relocation expenses. This Financial Plan will be endorsed firstly by the Wolston Park Hospital Transition Steering Committee and then by the Hospital Redevelopment Project Steering Committee.

4.1.3.7 Financial Plan implemented

- The endorsed Financial Plan will then be implemented in consultation with identified stakeholders.

4.1.3.8 Funding transferred to Transitional Wards, Wolston Park Hospital

- When the patient and staff selection processes are finalised it is proposed that transitional wards be established and funding transferred into separate quarantined cost centres (see Section 4.2; page 5, "Establishment of Transitional Wards at Wolston Park Hospital").

The major purposes of this planning/initiation phase are the collection of information, establishment of overarching policies and plans and the initiation of strategies that lead to the staff, patients and financial resources being prepared to move into the second phase of the decentralisation and redevelopment of the new/redeveloped mental health services.

4.2 The Establishment of Transitional Wards at Wolston Park Hospital

Following the completion of the patient and staff selection processes in the planning/initiation phase, it is proposed that the current Wolston Park Hospital wards be redesignated and assume the role and function of new mental health services.

For example, it is proposed Wacol A will assume the role of the 16 psychogeriatric beds at Robina Hospital. The staff and patients who have been selected to transfer to the psychogeriatric unit at Robina Hospital will be collocated in Wacol A (transitional ward) until this service is commissioned. The appropriate financial funding will also be quarantined for the transitional ward cost centre at this time.

4.2.1 Rationale for the Establishment of Transitional Wards at Wolston Park Hospital

The rationale for the establishment of Transitional wards at Wolston Park Hospital focuses on areas including patients, staff, building utilisation and finances. These areas are summarised below.

4.2.1.1 Patients

The primary purpose of the transitional wards is to allow patients and staff to develop therapeutic relationships prior to a significant change in their environment, thus potentially reducing any relocation trauma.

The draft Patient Relocation Plan cites several authors, including Cochran, 1977; Shugar et al, 1986; and Hill 1987, and their findings in relation to "patient relocation trauma". However, the draft Patient Relocation Plan also notes that the most recent literature shows that it is the **nature** rather than the **act** of relocation that determined the outcome (Morris, 1988). Sensible preparation with an emphasis on patient involvement and continuity of care before and after a transfer greatly alleviated any associated trauma (Jones 1991; Farhall et al 1996). Consequently, the draft Patient Relocation Plan details a proposed model for the relocation of patients which includes four stages: planning; preparation; transfer; and adjustment.

The collocation of patients and staff in transitional wards at Wolston Park Hospital, prior to the relocation to the new/redeveloped mental health services will assist in the implementation of strategies detailed in the patient preparation and transfer stages. Continuity of care will be optimised by organising clinicians and patients prior to the relocation. Strategies such as, patients and clinicians visiting the new/redeveloped mental health services prior to relocation will be facilitated by an environment that organises these consumers in the same 'ward'. The positive expectations of the relocation can also be created and shared within the one ward environment.

The redesignation of Wolston Park Hospital wards into transitional wards will create an additional relocation for the patients. However it is a transitory relocation that enables the patients to adjust to the possible involvement of different clinicians in their care within a hospital environment that is largely familiar to the majority of patients. The risk that

some patients may demonstrate a small decompensation in their health status may be considered to be offset by the advantage of developing a therapeutic relationship with staff and facilitating continuity of care prior to the transfer. Additionally the potential for relocation trauma associated with the transitory relocation can be minimised if the move is carefully planned and consumers are involved and empowered to adjust.

4.2.1.2 Staff

The rationale for the establishment of the transitional wards as described in section 4.2.11 'Patients' can be shared in relation to the movement of staff (primarily clinicians). The primary purpose is again the development of therapeutic relationships with patients prior to a significant change in their working environment and a focus on continuity of care. The ability for staff to move to new mental health services with patients is significantly dependent on the endorsement of the Corporate Human Resource Policy and Plan and the Wolston Park Hospital Human Resource Management and Change Management Plan.

Strategies that will be outlined in these Policies and Plans and strategies that have been detailed in the Resource Package and Educational Package for Line Managers/Supervisors at Wolston Park Hospital can be categorised into four similar stages as the Patient Relocation Plan: planning; preparation; transfer; and adjustment. The ability to successfully implement these strategies can be facilitated by the collocation of patients and staff in transitional wards at Wolston Park Hospital prior to the relocation to new/redeveloped mental health services.

As stated the establishment of these transitional wards will primarily affect patients and clinical staff, however it is anticipated there may be secondary effects on non clinical and support services in the form of work practices and the workforce composition (see Section 4.2.13 "Building Utilisation"). It is proposed that the Workforce Planning and Advisory Steering Committee and associated Workforce Working Parties will plan and manage these issues.

4.2.1.3 Building Utilisation

The gantt chart depicts that 18 wards will be utilised as the transitional wards. The gantt chart reflects that the intended moves of Barrett A to Ipswich Hospital, Barrett G to Barrett A and Noble House to Barrett G and the closure of Ellerton House have occurred. In the majority of instances the current 'primary' role of the ward (for example Clark unit as a secure ward currently and as a transitional ward) will continue. This will allow for the 'building design' to continue to be used for its primary purpose.

The establishment of transitional wards allows for building closures as the applicable new/redeveloped mental health services are commissioned.

The funding associated with this closure and transfer of services as outlined in section 4.2.14 "Funding" will be facilitated. Alternatively, the continuation of the current ward establishments may mean that as new/redeveloped services are commissioned the patients, staff and funding associated with the new service may come from more than one ward resulting in an imbalance in the hospital's economy of scale. Buildings may not be closed, but cater for reduced patient and staffing numbers with a worst case scenario of 18 wards operating at a reduced capacity but requiring building maintenance etc.

4.2.1.4 Funding

When the patient and staff selection processes are finalised it is proposed that transitional wards be established and funding transferred into separate quarantined cost centres. This will allow for the appropriate financial funds to be transferred to the new/redeveloped mental health services, as indicated in the Financial Plan, when these services are relocated. Additionally, the financial quarantining will allow for the release of funding requirements for initiatives such as training packages and relocation expenses.

4.2.2 The Process for the Establishment of Transitional Wards at Wolston Park Hospital

It is proposed that the reorganisation of the hospital into transitional wards will occur over a period of one month (February 1999). Preparation will be undertaken over the next ten months to ensure a planned and systematic approach to this reorganisation.

As it is proposed that specific units of the hospital will progress through the phases of the Patient Relocation Plan at differing times, it may be possible, in the majority of instances, to reorganise the patients identified for specified clinical programs over a longer time period. For example as the patients in the psychogeriatric unit are identified by future clinical program the psychogeriatric unit may commence its reorganisation earlier than February 1999. However, further examination of this issue is required as the Patient Relocation Plan is operationalised.

An appropriate forum for the overall planning and management of the establishment and operationalisation of the transitional wards may be the Workforce Planning and Advisory Steering Committee and associated Workforce Working Parties whose primary objective is related to the management of clinical and non clinical services during the decentralisation of Wolston Park hospital.

4.2.3 The Operation of the Transitional Wards at Wolston Park Hospital

It is proposed that the operation and management of the transitional wards will occur within the current organisational structure of the five Business Units and Corporate Services.

4.3 New Services Come On-Line

As the new mental health services are commissioned and come on-line the patients, staff and finances will be transferred to these new services. A staged scheduling of the Capital Works project area is proposed to enable services from Wolston Park Hospital to be transferred over a period of three years. Consequently, the size of Wolston Park Hospital will gradually, but consistently, reduce over this time period, until the current Wolston Park Hospital is vacated and all the new mental health services (planned by the year 2003) are commissioned.

5.0 FURTHER CONSIDERATION REQUIRED

5.1 The Role of Medical Centre and Other Activity Areas

Further advice is required for the activity areas, the General Practice Service and the functions of the Medical Centre acute medical beds. The Service Delivery Model for the new mental health services to be located on the Wolston Park Hospital site may provide guidance on these services in the interim.

5.2 An Interim Ward

An interim ward may be established for some psychogeriatric patients who may not be relocating to new services. This ward may be functional until the year 2003.

5.3 The Adolescent Unit

The Adolescent Unit is planned for continuation at the new mental health services to be located on the Wolston Park Hospital site pending further planning.

6.0 MONITORING OF PROJECT AREA ACTIONS

Whilst the significant actions specified for each project area are largely predetermined, the time lines will be reviewed and amended where required on a monthly basis by the Wolston Park Hospital Transition Team and the Hospital Redevelopment Project Team.

Direction and endorsement will be attained from the Wolston Park Hospital Transition Steering Committee and the Hospital Redevelopment Project Steering Committee in relation to amendments to the significant actions and time lines.

Additionally, the actions and any amendments required will be undertaken in a consultative manner and the outcomes communicated to stakeholders as per the Communication and Consultation Plans for the two Teams.

7.0 RECOMMENDATIONS

1. The decentralisation and redevelopment phases and the associated significant actions and time lines as depicted on the gantt chart be endorsed by the Wolston Park Hospital Executive and the Wolston Park Hospital Transition Steering Committee.
2. The Wolston Park hospital Transition Team and the Hospital Redevelopment Project Team further define and progress specific actions and associated time lines for the four project areas 1) Human Resource Management; 2) Patient Relocation; 3) Financial; and 4) Capital Works following endorsement of recommendation 1.

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Queensland Government
Queensland Health

MEMORANDUM

To: Dr Peggy Brown
Director of Mental Health
Queensland Health

Copies to: Pam Lane
District Manager
West Moreton Health District

Ann McMillan
Manager
Mental Health Unit
Queensland Health

Trevor Sadler
Director
Barrett Adolescent Unit

From: Kevin Fjeldsoe
Executive Director and Director of Nursing

Contact No:

Fax No:

Subject: ***REDEVELOPMENT OF BARRETT ADOLESCENT CENTRE***

File Ref: BAU Redevelopment 011101.doc

It has been some time since we discussed the redevelopment of the Barrett Adolescent centre, I understand that funds have been allocated to undertake a study which will, in part, consider the redevelopment of the Barrett Adolescent Centre. You have advised previously that a project officer has been appointed to progress this work. I am not aware of any progress made in relation to this matter.

The need to make a decision of the future of the Barrett Adolescent Centre is becoming critical for the following reasons:

...2/

1. The unit was never designed to provide services for adolescents and has undergone significant structural change over the years to adapt its purpose. Anecdotally the clinical profile of the ward has changed in that new acute units developed in South East Queensland are referring increasing numbers of adolescents with complex clinical problems often characterised by histories of aggression or violence. Although HoNOSCA data has been collected routinely in recent times it has not been collected over a sufficient period to reflect the change. The ward is in urgent need of refurbishment and extension to include, in particular the capacity to provide for the safe treatment of adolescents in a high dependency unit. In recent times there have been a number of serious incidents which have highlighted this need.

2. At the completion of the redevelopment the unit will be located immediately adjacent to the Adult High Security Forensic Unit with direct access to the High Security perimeter fenceline. This is an unsatisfactory arrangement and has the potential to lead to significant problems over time. The Adult High Security Unit is to be commissioned in February next year. This issue and the broader issue of locating this unit with the adult Mental Health service needs to be considered carefully.

3. We have previously discussed the increasing likelihood of redevelopment of the unit on this site in light of the development of the Youth Detention Centre. I am not suggesting that Wolston Park Hospital represents an ideal solution to the challenge of locating this unit. It may in the end become a somewhat pragmatic solution. A comprehensive marketing strategy is about to be undertaken aimed at seeking public expressions of interest to facilitate site disposal. If the unit is to be relocated to this campus it is important that a site be determined and allocated through this process. Expressions of Interest will close at the end of this year and decisions regarding site disposal made shortly thereafter. It would be prudent to identify and allocate a site during this process. I believe that this work should be undertaken by the project officer appointed to progress these matters. Site selection is complicated and requires expert assessment of site infrastructure and associated issues.

Discussions concerning the future of the Barrett Adolescent Centre have been occurring over a number of years. I am concerned that if a decision is not made in the near future we will continue to manage high risk patients in an unsuitable environment and/or commit significant capital funds to refurbish and extend a building with a limited life span. Failure to confirm a site for the Wolston Park Hospital Campus during the expressions of interest process may result in a lost opportunity to secure the best redevelopment site on this campus.

I look forward to your early advice.

Kevin Fjeldsoe
Executive Director and Director of Nursing
01 November 2001

Queensland Government

Queensland Health

HEALTH SYSTEMS STRATEGY BRANCH

Enquiries to: Dr Peggy Brown
Director of Mental Health
Telephone:
Facsimile:
Our Ref: 1120-0010-022 PB:mp

Mr Kevin Fjeldsoe
Executive Director and Director of Nursing
Wolston Park Hospital
WACOL QLD 4076

Dear Mr Fjeldsoe

Redevelopment of Barrett Adolescent Centre

Thank you for your memorandum regarding a number of issues relating to the redevelopment of the Barrett Adolescent Centre (BAC). A Project Officer within the Mental Health Unit has been preparing a scoping report from a statewide perspective on the need for inpatient mental health services for children and young people in detention centres (child and youth forensic beds) and the current distribution and occupancy rates of acute child and youth beds statewide. The draft report is now complete.

In terms of the redevelopment of specific units such as the BAC, I am in agreement that site selection is complicated and requires expert assessment. Ideally such a task would involve the Mental Health Unit in conjunction with a number of other areas of Queensland Health including West Moreton Health Service District and Capital Works. I have asked Ivan Frkovic to place this as an agenda item for the next Hospital Redevelopment Project Steering Committee Meeting in February 2002.

Yours sincerely

Dr Peggy Brown
Director of Mental Health
19 /12 /2001

NOTED.
TO CONSIDER
AGENDA PLEASE.
COPY TO JOHN QUINN
& TREVOR SADDLER.
3/1/02.

2/1/02

Office Queensland Health
Postal GPO Box 48 BRISBANE QLD 4001
Phone **Fax**

REPORT ON THE NEED

FOR

CHILD & ADOLESCENT SECURE INPATIENT SERVICES

AND

THE RE-DEVELOPMENT OF EXTENDED TREATMENT ADOLESCENT IN-PATIENT SERVICES.

Mental Health Unit
Queensland Health
October 2002

Contents

1.0 INTRODUCTION

In 2000, Cabinet endorsed a proposal to undertake a study on the development of secure in-patient mental health services for incarcerated children and youths in youth detention centres and the redevelopment of the extended treatment adolescent in-patient services. Cabinet instructed that this study be considered in the context of the Ten Year Mental Health Strategy for Queensland 1996.

The development of the Queensland Mental Health Policy (1993) and the Queensland Mental Health Plan (1994) provided the framework for the reform of mental health services in Queensland consistent with the objectives of the National Mental Health Strategy (1992) and the National Mental Health Plan (1998). The Ten Year Mental Health Strategy for Queensland (1996) advances the key directions and strategic framework of Queensland's mental health policy and plan for the implementation of structural and service reform.

The Ten Year Mental Health Strategy for Queensland, the Aboriginal and Torres Strait Islander People Queensland Mental Health Policy Statement (1996) and the Future Directions for Child & Youth Mental Health Services (1996) provide a complex, sensitive and interrelated multi-dimensional approach to improve the quality of life and service provision for children, youth and adults with mental disorders or mental health problems.

This multi-dimensional approach incorporates service principles of mainstreaming, integration and self-sufficiency within a consumer focussed and least restrictive framework. Key objectives include:

- significant enhancement of community mental health services;
- the reorganisation of the service delivery system, specifically the role and functions of the existing hospital system;
- the improvement of intersectoral links; and
- the review of mental health legislation and the introduction of updated legislation that supports contemporary mental health service delivery;

The Queensland Forensic Mental Health Policy Statement aims to promote, improve and maintain the mental health of children, young people and adults who have a mental disorder or serious mental health problem, and are involved in the criminal justice system. The policy emphasises the rights of the individual to optimal care, based on clinical need, and provided in the least restrictive setting. This needs to be balanced against the rights of the public to protection from risk of harm. The policy promotes a greater role for district mental health services in the provision of mental health services to the target population.

2.0 SCOPE OF THE STUDY

This study will examine the following:

2.1 the need for secure inpatient beds for young offenders based on data provided by Department of Families (DOF), Youth Justice Branch, Brisbane Child & Youth Forensic Mental Health Service (who have provided a service to the Brisbane Youth Detention Centre since February 2001), and Townsville Child & Youth Mental Health Service (who provide a service on a needs basis to Cleveland Youth Detention Centre);

2.2 service delivery models necessary to meet the mental health needs of children and young people incarcerated in detention centres who have a mental illness or serious mental health problem, and who require assessment and/or treatment in a secure setting to ensure the safety of the person and the community;

2.3 a review of the extended treatment adolescent mental health service that is delivered at the Barrett Adolescent Centre, located within the Wolston Park Hospital complex at Wacol;

2.4 population projections across the state in order to determine future child and adolescent mental health service requirements on an equitable and best practice basis.

3.0 BACKGROUND

The 10 Year *Mental Health Strategy for Queensland* (1996) outlines the provision of community mental health services for children and adolescents, as well as acute inpatient services and day treatment programs. The inpatient services foreshadowed in the Strategy include:

Children

- Royal Children's Hospital,
- Mater Misericordiae Children's Hospital
- Gold Coast District Health Service
- Toowoomba District Health Service
- In regional locations it is recommended that dedicated beds may be constructed in general paediatric in-patient settings either as part of a paediatric unit or, where the bed numbers are sufficient, as a discrete in-patient unit.

Adolescents

- Royal Brisbane Hospital
- Logan- Beaudesert District Health Service
- Gold Coast District Health Service
- Toowoomba District Health Service
- Cairns District Health Service

Using the planning guidelines outlined in the *10 Year Mental Health Strategy for Queensland* (1996), it can be determined that Queensland had the need for 94 beds for children and adolescents in 2001 and will need 117 beds (64 children and 53 adolescent) by 2006.

The number of beds actually established to date has been below the planning guidelines as illustrated by the following table that sets out the current bed capacity for children and adolescents.

	Current Beds	Age Group	Date Opened
Children:			
1. RCH – Child & Family Therapy Unit	10	0 –14 years	July 1983
Young People:			
2. Royal Brisbane Hospital	12	15 – 18 years	July 1996
3. Logan	10	15 – 18 years	July 2000
4. Barrett Adolescent Centre	15	15 – 18 years	June 1984
5. Cairns Base Hospital (Special Care Suite)	4	15 – 18 years	1997 (* not dedicated to child and youth)
Combined Children and Adolescent:			
6. Gold Coast	11	0 – 18 years	Aug 2000
7. Mater	8	0 – 14 years	July 2001
"	4	15 – 18 years	July 2001
8. Toowoomba	6	0 – 18 years	Nov 2001
Total number of inpatient beds in Queensland for Children and Adolescents		**80 BEDS**	

The number of child and adolescent beds has therefore increased from 25 (in 1996) to 80 beds (in 2002). Currently, there are 26 child beds (0-14 years) and 54 adolescent beds (15-18 years) available. With the exception of the special care suite in Cairns (that is not dedicated to use by children and adolescents), all are located in the south-east corner of the state.

4.0 CURRENT UTILISATION OF INPATIENT SERVICES

Analysis of state-wide data for 1999-2000 shows the average level of occupancy for all child and adolescent units running between 50 and 65%. However, the figures for Gold Coast, Logan and Mater units should be viewed with caution since these units were operational for a short period of time only during these years, and were still in the early stages of development. Occupancy rates may also not be entirely reflective of the level of demand as units managing particularly difficult children/adolescents may reduce their admission numbers temporarily in order to boost the staff/patient ratio to facilitate the management of a client.

Bed utilisation data for the Barrett Adolescent Centre indicates that in 2000/01 there has been a reduced demand for adolescent beds but an increased usage of the beds for the assessment and treatment of children. Despite this the bed utilisation rate is well below the 50% rate. The

reasons for this are not clear, and require further investigation, but this was beyond the scope of this study.

The admission of adolescents to the four bed Special Care Suite, operational within the adult acute mental health unit at Cairns Base Hospital, has been limited due in part to the paucity of experienced child/adolescent clinicians, and to the increased demand for psycho-geriatric patients and women with post-natal depression.

In the absence of dedicated child and adolescent mental health inpatient beds beyond the south-east corner, mental health services from regional centres in the Central and Northern Zones advise that significant numbers of young people are consistently admitted to general hospital wards or adult acute in-patient mental health units.

While collectively the numbers are significant in the regional centres, the need for dedicated facilities at all of the identified sites is clearly not supported by the data. Access to a supraregional facility located in a geographically central and accessible site would be the most desirable solution for both Central and Northern Zones In the absence of this, alternative models, such as inpatient facilities in paediatric wards should be further explored as a priority for these sites. Equally, where adolescents are admitted to adult inpatient units, appropriate expertise and treatment options for this age range must be available.

5.0 SERVICES TO INCARCERATED YOUNG OFFENDERS

[1]The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) 1985 state in part 5, sec 26.3 that juveniles *'in institutions shall receive care, protection and all necessary assistance for social, educational, vocational, psychological, medical and physical needs, that they may require because of their age, sex, and personality and in the interests of their wholesome development'.*

Whilst incarcerated young offenders were identified as a priority target group in the 10 Year Mental Health Strategy for Queensland, there has been no establishment of dedicated secure acute inpatient facilities for [2] severely mentally disturbed young offenders under 18 years of age.

A Forensic Community Mental Health Service has operated within the Royal Children's Hospital and District Health Service at Spring Hill for many years, but has focused primarily on the assessment of parental competence for child protection applications, limited psychometric testing and expert witness presentations in court in relation to these matters. Hence, it did little to meet the needs of incarcerated young offenders.

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[1] The United Nations Standard Minimum Rules for the Administration of Juvenile Justice. (The Beijing Rules) 1985

[2] The term 'severely mentally disturbed' applies to those diagnosable psychiatric conditions that adversely affect the psychosocial development of children and adolescents, and contribute to major interactional difficulties in their social environment. These diagnoses are outlined in the international classification systems ICD9-CM and ICD10, and the United States' systems DSM-IIIR and DSM-IV. They are a heterogenous group of conditions with significant differences from those which appear in adulthood. Some are categorical entities (for example, adolescent bipolar disorder) where the disorder is either present or absent. Others (for example, phobic anxiety disorder) are more dimensional, and shade from normal variation into disorder. Where the line is drawn between mild and severe disorder is a clinical decision determined by the extent of the impairment or disability caused.

Prior to February 2001, there had been a series of visiting mental health services to Sir Leslie Wilson, Cleveland and John Oxley Youth Detention Centres. These were variously sourced from Queensland Health and the private sector. Demand for the service depended largely upon the following:

- The practice of the courts in requesting pre-sentence reports, which may include a request for a mental health assessment, and
- Requests from detention centre staff concerned about the mental health of a young incarcerated person.

Overall, the response to these requests by the visiting medical services was often less than satisfactory. This was due, in part, to a lack of congruence between the requests (particularly for pre-sentence reports) and identified service priorities.

In response to recommendation 10 of the Forde Inquiry, Queensland Health committed $1 million recurrently to improving mental health and general health services to youth in detention centres. Following a substantial collaboration between Queensland Health and Department for Families, an overarching service model has been developed. The full implementation of this model is now proceeding following finalisation of the Memorandum of Understanding between the two departments. However prior to the finalisation of the MOU in September 2002, an interim mental health service had been operating at Brisbane Youth Detention Centre (from February 2001), whilst the Cleveland Youth Detention Centre had been serviced on a needs basis by the Townsville Child and Youth Mental Health Service.

Since the commencement of the adolescent units at Royal Brisbane Hospital (1997) and Logan Hospital (2000), young offenders from detention centres in Brisbane who require acute inpatient mental health treatment have been admitted to these units. When this has occurred, the young offenders are generally accompanied for the duration of the admission by staff from the youth detention centre. Admissions tend to be short, with early discharge back to the detention centre and follow up in this setting by a visiting psychiatrist. Whilst this option for inpatient treatment is reported anecdotally to be reasonably satisfactory to the staff involved, and no adverse events have been reported, it is not seen as a desirable process in the longer term for a number of reasons. Firstly, it creates an inconsistency with the adult sector where patients are admitted from courts, watchhouses and prisons, and responsibility for their custody is handed over to health staff. Additionally, there is a significant impact on the overall therapeutic milieu of the inpatient ward by having detention centre staff 'guarding' one patient, and the potential for a significant negative impact on other patients in the ward.

There appear to have been few, if any, admissions of youth from the Cleveland Detention Centre in Townsville to an inpatient facility, hence it is not possible to comment on the practices to date in North Queensland. Townsville does not have an adolescent ward.

Data from the Department for Families, Youth Justice Branch (March, 2002) and the Cleveland Youth Detention Centre provides information with regard to the number of incarcerated young people in these two centres. The daily average number of young people incarcerated during 2001 in the two detention centres was fewer than 100. The average number in the Brisbane Youth Detention Centre was 69, and the Cleveland Youth Detention Centre was 25. 51% of this total includes young people on remand, and 55% of the total are Indigenous young people.

It should be noted that this data does not include those young people aged between 17 and 18 years who have been charged and/or convicted of an offence, and who are subject to the adult *Penalties & Sentencing Act 1992*, with the outcome that they are incarcerated within the adult correctional system.

Equally the data provided does not identify those young people included in the numbers above who are over 18 years of age. (These young people were sentenced as 17 year olds, the age they committed the offence, and there is provision within the *Juvenile Justice Act* for them to serve their sentences in a Youth Detention Centre, rather than transfer to adult corrections.)

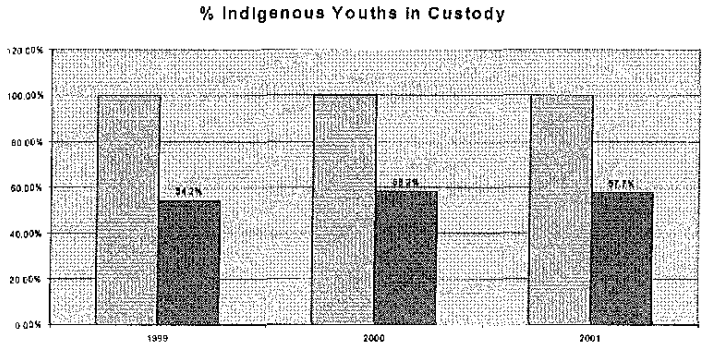
Both of these issues illustrate a lack of consistency that exists between Queensland Health, Department for Families, Youth Justice, Queensland Police and Correctional Services whereby the cut off age for inclusion within a program area shifts between 17 and 18 years.

Data obtained from the interim Brisbane Child and Youth Forensic Mental Health Service to the Brisbane Youth Detention Centre provides a greater understanding of the mental health needs experienced by young people incarcerated during the 2001 calendar year. The total number of referrals received by the interim forensic mental health services over the 12 month period was 117; this number represents 100 males and 17 females. Of the total, there were 45 indigenous young people, comprising 37 males and 8 females.

Females represent approximately 8% of the detention centre population, most of whom are referred for mental health assessment and treatment. This referral rate is consistent with national and international trends for the female offender population, where it is considered there may be a tendency to over-pathologise. Conversely, it is acknowledged internationally that there may be limited recognition of the need to refer male offenders for specialist mental health assistance.

5.1 INDIGENOUS ISSUES

The data in the following table clearly identifies the continuing over-representation of indigenous adolescents within the juvenile justice system. While indigenous children and adolescents comprise 1.41% of the [3]Queensland population between the ages of 0 – 18, they make up 55 - 60% of the [4]detention population. The over representation of indigenous children and adolescents is amplified at each stage in the criminal and juvenile justice systems, from arrest through to detention, indicating they are more likely to be treated in a manner that moves them deeper into the juvenile justice system.



[3] ABS Census data 1996

[4] Department of Families, Youth Justice Branch data 2002

At the same time, indigenous children and adolescents are under served by the mental health system. Many children and adolescents entering the juvenile justice system have either not received any assistance or have been poorly served by the systems in their communities, including the mental health system. For example:

- When they do receive services, indigenous children and adolescents with mental health problems tend to be diagnosed with more severe disorders, including disorders less amenable to treatment. [5]This suggests that prevention, early identification and early intervention services may be less available to indigenous children, adolescents and their families.

- Indigenous adolescents (particularly males) are more likely to be referred to the juvenile justice system rather that the treatment system, and indigenous juvenile offenders are less likely than their white counterparts to have previously received mental health services.

- In the past, indigenous and other immigrant groups have shown low rates of use of mental health services, due in part to the history and policies of past governments and to language differences and lack of locally based services.

5.2 SENTENCING & TREATMENT:

The available data also highlights the challenge for youth justice and mental health in their provision of services for young people incarcerated on remand, and those serving brief sentences. The average time served on remand for the year 2001 was 38 days; and the average time served for sentenced offenders was 112 days. These short periods of incarceration impact upon the type of service delivery that can be offered within the detention centre, and highlight the critical need for strong linkages between mental health services within the detention centre and those in the young person's local community, in order to provide a comprehensive continuum of care that is acceptable and sustainable to the young person, their guardian and family.

There is also a clear need for the development of a protocol between adult and adolescent services, necessary to ensure the provision of the most appropriate mental health treatment within both systems. This is critical, particularly for younger offenders who are more at risk of developing mental health problems which are of a severe, complex or life threatening nature, and which have the potential to accelerate the individual further into both the criminal and mental health systems.

5.3 SERVICES TO YOUTH DETENTION CENTRES:

The service model agreed by Queensland Health and Department of Families provides for a comprehensive mental health service to youth detention centres. This includes assessment, treatment and case management services, and liaison with the mental health service in the young person's local community, in order to facilitate their ongoing treatment upon release. In addition, the child and youth community forensic mental health service will provide a forensic consultancy service to district clinicians. The interim service operating at Brisbane Youth Detention Centre has been operating on this model since February 2001, but the interim service provided to Cleveland Youth Detention Service has only been on an needs basis by the Townsville Child & Youth Mental Health Service.

[5] Mental Health Service Needs of Indigenous Children and Youth in Queensland, June 1999

5.4 SECURE INPATIENT SERVICES:

Security when used in everyday speech encompasses notions of safety from harm and danger. In mental health settings, security refers to those practices, policies and environmental changes that provide safety to consumers with severe disturbances resulting from mental illness. It also implies measures that protect the safety of other consumers, staff, family and the community in general from consumers experiencing mental illness.[6] Common problems that are the focus of security measures include aggressive behaviour, the inability to remain in a treatment setting and severe disorganisation that poses risks to the individual and others.

All mental health services undertake measures that respond to needs associated with these problems using the principle of a least restrictive alternative. Most of these needs can be met by district mental health services within the community, inpatient facilities and high dependence/intensive care options available in some inpatient settings. Where these needs can not be met due to the severity or duration of a consumer's condition, access may be required to facilities that have practices, policies, environmental modifications and staff resources specifically designed to address these needs.

As previously described, there are no secure inpatient facilities dedicated to providing services for children and adolescents in Queensland. Whilst it would be impractical to provide care for a child in one of the existing high secure or medium secure adult units across the state, it is not inconceivable that an adolescent may be admitted to such a unit. However, such a process is seen as highly undesirable for a number of reasons, including the inappropriate peer group within this setting, and the lack of age appropriate services and staff available within these settings. (Reflective of this, admission of a young person under the age of 17 years to a high security unit requires the approval of the Director of Mental Health and triggers a prompt review by the Mental Health Review Tribunal under the *Mental Health Act 2000*).

Requests for secure care for adolescents are relatively infrequent, and it is impossible to accurately track the number of such requests because there is no mechanism in place to do so. However, consideration of the reasons for requesting secure care indicate that the largest percentage of requests are likely to involve adolescents already in a custodial setting such as a youth detention centre.

During a 12 month period in 2001, the interim forensic mental health service at the Brisbane Youth Detention Centre reported that only three young people required inpatient admission. These people were hospitalised at the Logan and Royal Brisbane Hospital inpatient adolescent units during the acute episode, and were returned to the detention centre for completion of their juvenile justice sentence, where they received ongoing care by mental health staff. Secure containment was not required for any of these individuals. No data is available from Cleveland Youth Detention Centre in relation to the number of young people who required inpatient admission.

Based on this data, the potential need for secure beds would appear to be low. However, it needs to be born in mind that this data has been available for one year only while the service was in the development phase. Analysis is required over an extended period to more appropriately estimate the potential need for access to secure facilities for youth in detention.

[6] A Model of Service Delivery for Medium Secure and High Security Treatment Services in Queensland, 2001

6.0 EXTENDED TREATMENT ADOLESCENT INPATIENT SERVICES

The Barrett Adolescent Centre located within the Wolston Park Hospital complex is the only specialised extended treatment in-patient facility in Queensland for adolescents. It is primarily aimed at servicing those between the ages of 14 and 17 years who have mental disorders or serious mental health problems. Currently, it has 15 beds of single room accommodation and the capacity for 5 day patients. Its operating budget in 2001/02 financial year was approximately $1.9 million.

Prior to 1996, the Barrett Adolescent Centre (BAC) and the Royal Children's Hospital, Child & Family Therapy Unit (CAFTU) were the only in-patient units for children and adolescents in the state. With the opening of additional acute adolescent inpatient facilities in the south-east of the state, the BAC has experienced a change in their daily operation, with acute admissions now being appropriately directed to these new units.

The Ten Year Mental Health Strategy for Queensland foreshadowed the ability to meet the extended treatment needs of children and adolescents through enhanced community based services in association with the new acute units and day treatment programs. In line with this, it was foreshadowed that the Barrett Adolescent Centre would be closed and the funds redirected to enhance community-based services. Again, consistent with this, the master plan for the redevelopment of Wolston Park Hospital did not include Barrett Adolescent Centre.

An attempt was made to close Barrett Adolescent Centre in 1997. However, this was unsuccessful due largely to a strong community response that led the then Minister for Health, the Hon M Horan, to reverse the decision articulated in the Ten Year Mental Health Strategy. It should be noted, however, that this attempt to close Barrett Adolescent Centre preceded the opening of any of the additional (acute) adolescent beds that are now available in south-east Queensland.

The Barrett Adolescent Centre was constructed in 1976 and opened in 1984. As currently constructed, it has deficient noise insulation, and inadequate indoor recreational and dining areas, and is unsuitable for its current purpose. In addition, its current location is adjacent to the new High Security Unit at The Park Centre for Mental Health, and this is considered highly undesirable. Therefore, demolition of this sub-standard unit is desirable. There is currently no provision for its re-construction within The Park Centre for Mental Health complex.

6.1 OCCUPANCY RATES – BARRATT ADOLESCENT UNIT

For the period 01 July 1999 to 30 June 2000, 81 young people were admitted to BAC, of whom 35 were 14 years of age or younger. For the period 01 July 2000 to 30 June 2001, 59 young people were admitted to BAC. Of this number, 31 were 14 years of age or younger. This data indicates a change in practice to admitting adolescents younger than the specified target group, although it is acknowledged that this data represents only a two-year window and may not necessarily reflect an ongoing trend. The centre currently operates below 50% capacity, although there may be other factors contributing to this as previously outlined in Section 4.0. Most admissions are from the south east corner of Queensland.

6.2 BEST PRACTICE

At a national and international level, there have been positive changes in the provision of contemporary mental health care treatment for children and young people. This includes a

broader range of treatment options with a move away from institutional style settings to psycho-social models which focus on treatment in the context of the social and family setting, closer to where the young person and their family, carers and support networks live.

Queensland Health has likewise attempted to broaden the range of treatment options available to this target group. As stated above, examination of our admission data reveals that the newly constructed adolescent facilities are increasing their occupancy, resulting in a reduction in the number of referrals of the target group, 15 –18 years, to the BAC. Experience however suggests that acute units remain resistant to offering extended admissions because of the difficulty in providing a program to cover both acute and extended treatment options. Therefore, there is a need to explore options for alternative community based extended treatment programs which are not dependant upon access to inpatient beds.

7.0 DISCUSSION:

On the basis of data presented above, it is readily apparent that the distribution of child and adolescent inpatient beds is inequitable across the state, both for acute care and for extended treatment. All beds (with the exception of the four beds in the special care suite at Cairns Base Hospital that are not dedicated exclusively to providing services to children and adolescents) are located in the south-east corner.

On the basis of this and the admission rates of children and adolescents to either adult mental health facilities and/or paediatric wards in centres in the Northern Zone, there is a need to establish a small number of child and adolescent beds in the Northern Zone.

Likewise, an argument could be made for a small acute unit to also be established in either the northern or central part of the Central Zone, given the distances involved to access the existing Central Zone service located at the Royal Brisbane and Royal Children's Hospitals. The occupancy figures for these facilities would suggest that they can meet the needs of the entire Central Zone. However, it is clear from the admission rates to Bundaberg and Sunshine Coast, that there are significant numbers of families and/or clinicians who prefer to treat locally rather than refer to a Brisbane based unit. This practice reflects a recognition of problems arising for young patient as a result of dislocation from their family, school and support network when admission requires a transfer to Brisbane. A small unit outside of Brisbane, perhaps on the Sunshine Coast, would better meet the needs of these patients.

Southern Zone is relatively well bedded, with acute facilities at Logan, Robina, Mater and Toowoomba, in addition to the Barrett Adolescent Centre.

Whilst acknowledging the data on admissions from the Brisbane Youth Detention Centre is limited by virtue of the fact that it is confined to a twelve month period when only an interim service was operating, the overall number of admissions was extremely small. In addition, as the daily average of residents in both youth detention centres across the state was less than 100 in 2001, there is no data to support the development of stand alone secure beds for adolescents in Queensland.

Whilst it is possible for secure care to be provided for an adolescent within an existing medium secure or high secure unit, this is highly undesirable. The development of a more containing capacity, for example, through the establishment of a high dependency unit that has the capacity to be locked when necessary is seen as a preferable alternative. A high dependency unit could be incorporated into any newly established facility for Northern Zone, and may also

be incorporated into an existing unit or a rebuilt facility in Southern Queensland. This would not be regarded as secure care for the purposes of the *Mental Health Act 2000.* However, since the number is potentially very small, a viable option may be to admit to pre-existing adult secure facilities for stabilisation, with a transfer to the adolescent high dependency units as soon as practicable.

A decision is required as a matter of urgency regarding whether Queensland Health will continue to provide extended treatment inpatient care for children and adolescents. The original intent of closing Barrett Adolescent Centre and replacing it with community based alternatives in conjunction with the acute adolescent units, as outlined in the Ten Year Mental Health Strategy, remains the preferred policy option. If pursued, this option would realise approximately $1.9 million recurrently for reallocation to support the development of alternative services. However, there are significant political risks associated with this proposal, particularly given current community attitudes and the vocal community reaction to the prospect of closure in 1997.

If extended treatment services are to be continued, an urgent decision is needed on whether to refurbish Barrett Adolescent Centre or to decommission it and rebuild a purpose built facility. The latter option would be the preferred approach, since the current building and location of the facility are considered entirely unsuitable.

The following recommendations are put forward for consideration as ways to address the combined issues outlined in the above report:

8.0 RECOMMENDATIONS

High Priority

- **The establishment of an 8-10 bed child/adolescent acute inpatient unit in North Queensland with a four-bed high dependency area for optional use for forensic patients as required.**

- **The creation of an optional four (4) bed high dependency area in the Logan Adolescent Unit or Royal Brisbane Hospital Adolescent Unit.**

- **Conduct a scoping exercise on the development of community based treatment options, such as 'step down' programs as an alternative to extended inpatient treatment.**

- **Undertake a detailed operational review of the Barrett Adolescent Centre, the Child and Family Therapy Unit (CAFTU) and the Mater Child Inpatient Unit in light of the low admission rates, with a view to assessing the capacity of CAFTU & Mater to take up the under 14 population currently serviced by the Barrett Adolescent Centre.**

- **Undertake a detailed operational review of the Royal Brisbane and Logan Adolescent Units in light of the low admission rates, with a view of assessing their capacity to take up the over 14 population currently serviced by the Barrett Adolescent Centre.**

- **Taking into account the findings of the operational reviews and the implementation of a range of 'step down' programs, consider a 50 % reduction in the number of beds at the Barrett Adolescent Centre, and relocation of these funds towards the establishment of the high priority recommendations.**

- **Review the need for an adolescent inpatient extended treatment program 12 months following the closure of 50% of beds at the Barrett Adolescent Centre and the implementation of a range of 'step down' programs.**

- **Taking into account the findings of the review consider the closure of the remainder of the Barrett Adolescent Centre beds following:**

  (a) the opening of the new unit in North Queensland;
  (b) the creation of an optional high dependency area at Logan or Royal Brisbane Hospitals; and
  (c) the implementation of a range of 'step down' community based treatment options.

Medium Priority

- **The development of small six-bed (6) child/adolescent acute inpatient facility linked to the adult acute inpatient unit on the Sunshine Coast to service the Sunshine Coast and Bundaberg regions, for inclusion within the next capital works program.**

- **Continue to monitor the bed utilisation rates in existing child and adolescent acute inpatient units.**

E-MAILED
05·11·02

Queensland Government
Queensland Health

MEMORANDUM

To: Dr Peggy Brown
Director of Mental Health
Queensland Health
GPO Box 48
BRISBANE Q 4001

From: Dr Terry Stedman
Director of Clinical Services
The Park - Centre for Mental Health
Treatment, Research and Education

Contact No:
Fax No:

Subject: ***REPORT ON NEED FOR CHILD AND ADOLESCENT SECURE INPATIENT SERVICES***

File Ref: TS:ss

Thank you for the opportunity to comment on this paper which has significant implications for this organisation.

The Barrett Adolescent Unit Management Committee have also provided a response (attached).

The Barrett Adolescent Unit has experienced significant changes in the nature of consumers referred since the opening of the four or five district adolescent units. The client group appears to be more acutely ill, to demonstrate more disturbed behaviours and to be generally more complex. This has made providing care in the available facilities very demanding. There has been a string of serious incidents that suggest that the facilities and function of the Adolescent Unit need to be seriously considered.

We have concerns about some of the assumptions and conclusions of this paper.

Data:
The bed occupancy data is misleading. Recently, the Adolescent Unit has been operating at near full capacity. This is not reflected in the bed occupancy data due to the non inclusion of day patients, non inclusion of Monday to Friday patients, patients on leave and also to some complex discharge arrangements which need to negotiated with some services and agencies.

The method for determining the need for secure beds does not account for consumers who need security due to the severity of their disturbance. Recent experience in the Adolescent Unit has encountered a need for at least high dependency areas on several occasions in recent times.

Adults in custody can now be managed in any inpatient setting appropriate to their needs with minimum formality. There may be peculiarities in the legislation for Youth that need some escort from the custody service but it would be pity to construct a secure facility for children simply for this need.

Since the issue of the need for a secure service is a major focus of this paper, a more detailed examination of the issues would be required before a decision could be made. The principle of exploring all alternatives to a secure service and enhancing local capacity to provide greater security is supported.

Barrett Special School:
The report does not refer to the collocation of the Adolescent Unit with the Special School operated by Education Queensland. This department and other services and agencies effected by closure of the Adolescent Unit would need to be consulted in a decision to close the service.

Report's conclusions:
The suggestion that closure of half the beds could be undertaken without loss of service is not practical due to the high use. It is also unlikely to result in significant reductions in staffing and hence unlikely to result in savings.

The single option of closure is highly likely to encounter political resistance. The family groups that were effective when closure of the service was previously planned continue to be actively involved in the life of the Unit.

From this organisation's perspective, there is an urgent need for some clear direction for the Adolescent Unit. Some discussion of the options for refurbishment, rebuilding and/or refocussing of the current service need to be included. Overcoming the problems facing the Adolescent Unit requires clear direction and commitments. A decision that has considerable political risk may have the effect of exacerbating the current problems due to the loss of staff or staff morale, and may result in a longer period in unsatisfactory facilities while political concerns and alternative solutions are negotiated.

Dr Terry Stedman
Director of Clinical Services
31 October 2002

att

REPLY TO THE DRAFT REPORT ON THE NEED FOR CHILD & ADOLESCENT SECURE INPATIENT SERVICES AND THE RE-DEVELOPMENT OF EXTENDED TREATMENT ADOLESCENT IN-PATIENT SERVICES BY THE BARRETT ADOLESCENT CENTRE

Thank you for the opportunity to comment on the "*Report on the Need for Child & Adolescent Secure Inpatient Services and the Re-development of Extended Treatment Adolescent Inpatient Services.*"

Our response is primarily to the aspects of the Draft Report which pertain to the Barrett Adolescent Centre. Minor comment will be made in relation to any possible role the Barrett Adolescent Centre may have in relation to the Secure inpatient services.

1. THE BARRETT ADOLESCENT CENTRE IS ONE END OF THE SPECTRUM OF STATE WIDE CYMHS SERVICES

As the Draft Report has not sought any information about the Barrett Adolescent Centre or its programs, this section will provide a perspective on our place in the development of services.

1.1 Historical Overview

The Draft Report correctly notes that the Barrett Adolescent Centre (BAC) at Wolston Park Hospital and the Child and Family Therapy Unit (CAFTU) at the Royal Children's Hospital were the only two inpatient facilities for children and adolescents through the 1980's into the mid 1990's. CAFTU took children up to 12. BAC admitted adolescents from 13 – 17. Unlike the adult mental health system, the child and adolescent mental health services in the 1980's and 1990's was primarily community based.

BAC has always been a short to medium term unit, never an acute unit, although there was a period in the early 1990's when it did attempt to admit less than 10 acute adolescents.

BAC observed first hand the adverse effects on adolescents who were admitted to acute adult inpatient units. It was a strong advocate for the establishment of acute adolescent inpatient. Reports from BAC staff (in varying capacities) were written to the then Director of the Mental Health Branch, Dr. Harvey Whiteford, reports to Ministers and the response to the Solomon report to lobby for the establishment of acute adolescent inpatient units.

We also highlighted the inequitable funding to child and adolescent mental health services, and advocated strongly for the need for more community services throughout Queensland, which had declined from the early 80's into the early 90's.

We have always regarded ourselves as ideally being part of the spectrum of child and youth services throughout Queensland, albeit a small services which addressed the needs of adolescents with the most severe and complex mental disorder..

1.2 Changes in the BAC admission policy

The criteria for admissions to the Barrett Adolescent Centre have certainly changed in the past decade. These changes have been driven by two factors.

- The desire to ensure equitable access to the services for all adolescents with severe and complex mental health problems
- The dynamic recognition of who is, and is not able to be helped by our program. We realise that we are an expensive service. We seek to admit those who may be likely to benefit from our service.

The changes we have introduced are:

- The short lived experiment to admit acute inpatients in the early 1990s out of concern for the impact on adolescents of an acute adult inpatient admission. This was abandoned because of the detrimental impact on longer stay patients.
- Admission of adolescents with severe and complex mental disorder irrespective of their living arrangement from the early 1990s. This provided access to treatment for adolescents living on the streets.
- The introduction of the two week trial admission in 1994. Conduct disorder per se has always been an exclusion criterion to BAC. However, we noted that this was disadvantaging youth with co-morbid emotional disturbance. This policy (which still continues) helps to determine those who will benefit from an extended admission, from those who do not.
- Admission of older adolescents (of 17 years) and retention of a number past their 18th birthday. This is consistent with the later age of leaving school, the *Future Directions for Child & Youth Mental Health Services (1996)* and the concept of specialist child and adolescent services being directed towards the unemancipated adolescent, as enunciated by Werry.
- Admission of adolescents with increased severity and complexity of mental disorder and family dysfunction.

One change not introduced was any lowering of age to maintain our bed numbers, as stated by the Draft Report. The notion that adolescent beds are for those over 14 years is an artefact of the *Future Directions for Child & Youth Mental Health Services (1996)*. This has never been the case in Queensland. Puberty, the transition to high school, significant changes in peers/ family relationships and independence all occur around thirteen. For the last decade, the decision to admit to either a children's or an adolescent unit has been made on what is clinically and developmentally the most appropriate for any particular individual considering the mix of patients on either ward at the time. The age range in *Future Directions for Child & Youth Mental Health Services (1996)* coincided more with WHO data which collects data for children (10 – 14 years) and adolescents (15 – 19 years).

1.3 Changes in the patterns of referrals to BAC

The late 1990's saw the establishment of the Royal Brisbane Adolescent Unit, and community CYMHS became more adolescent orientated. We noted that our referrals were most likely to come from the RBH and those community CYMHS with the most effective adolescent outreach. During this period we had a waiting list.

- Acute inpatient services provided a flexible treatment approach. Consistent with the principles of *Future Directions*, they provided a locally based service to as many as they could. Only those with the most severe disorder, and the greatest level of functional impairment were referred to BAC.

- Our referrals came primarily from both inpatient settings (the Mater and Royal Brisbane) and community CYMHS with the most effective programs to adolescents – a paradox which suggests that as competency increased the identification and recognition of the needs of adolescents with severe disturbance improved, and the full range of treatment options considered.
- There was a marked conceptual change in the treatment of eating disorders, with primary interventions being provided by gastro-enterologists. Re-feeding has primacy. This was contrary to our experience. BAC was always a tertiary admission centre for adolescents with anorexia (with a couple of exceptions) with adolescents having had twelve months or more of outpatient and inpatient treatments. We used a very flexible operant behavioural program together with psychological and developmental interventions. Two years after discharge, 75% of adolescents had stabilised their weight and established regular eating and exercise patterns. Only two were treated in the adult system. However, we are finding less than 40% are responding to our treatments after extensive periods of continuous nasogastric feeding for twelve months or more.
- We are concerned by the perception that there are no effective treatments for those with certain conditions, particularly recurrent self harm. Adult units referred these, simply because they were too difficult in their system. Now some are not being referred, simply because of a they are regarded as untreatable. We are actively seeking to educate clinicians in this area.

1.4 BAC and *Future Directions for Child & Youth Mental Health Services (1996)*

The Draft Report noted the lack of a place for BAC in the development of mental health services for adolescents in Queensland. We have always agreed with *Future Directions* that services need to be community and locally based where possible. Indeed, an adequate trial of community treatment (unless dictated otherwise by absolute clinical necessity was always part of admission criteria. On the other hand we are acutely aware of the extreme pain, distress and regression of adolescents with severe and complex mental health problems. Our observations on this document in the six years since it was produced are:

- It was always paradoxical that a document which sought specifically to address the needs of those with the most severe problems sought to close a facility for adolescents at the most severe end of the spectrum, to provide more services for those with less severe problems. The forecasts that interventions at an earlier point would prevent adolescents from reaching these levels of distress were never fulfilled. These assumptions revealed a lack of understanding of the mental disorders involved, the dynamic interaction with the adolescent's environment, and the limitations of treatment interventions. Our own experience, and anecdotal experience from clinicians from interstate and internationally is that these issues are becoming even more potent. The relevant societal influences are poorly understood.
- The Draft Report notes the strong community response to the intended closure of BAC, but completely fails to understand the passionate dynamics of this response. The Adolescent Unit at the Royal Brisbane Hospital was then operating, and had referred a number of patients to BAC. The community had experience of the efficacy of community, acute hospital and extended hospital treatments. There was incredible anxiety and anger that BAC, which had been most efficacious in treating these adolescents with severe and complex disorder, would be unavailable not only to

themselves but also to similar adolescents in the future. The closure of BAC without proven alternatives will inevitably generate the same response.

- The Draft Report states *"The Ten Year Mental Health Strategy for Queensland foreshadowed the ability to meet the extended treatment needs of children and adolescents through enhanced community based services in association with the new acute units and day treatment programs"*. These premises were based on United States experience, which was in rapid transition from long stay, psycho-analytically orientated units to very short stays dictated my managed care. The premises were theoretical, without research or practical support. BAC had few parallels with the US experience to make any comparisons or predictions meaningful. The continued high levels of referral to BAC from CYMHS acute inpatient, day patient and community clinics are strong evidence that the ability of these facilities to meet the extended treatment needs remain no more than shadows. Indeed they are perhaps even mirages.
- The Draft Report states *"In line with this, it was foreshadowed that the Barrett Adolescent Centre would be closed and the funds redirected to enhance community-based services."* The reality is completely different. Closure of BAC would mean that a proportion of beds in the acute inpatient adolescent units are occupied by longer stay adolescents. These units then cannot be as responsive to the needs of the community CYMHS. (This was evident in north Brisbane in 1997 – 98 when BAC had a waiting list, and could not take some of the longer stay adolescents from RBH. CYMHS clinics reported an excess of resources supporting adolescents in the community who desperately needed hospitalisation.) The evidence is that the community CYMHS can have a disproportionate amount of their time consumed with the ineffective treatment of adolescents who can receive effective help in either acute or extended care settings. Eventually this would be resolved by labelling adolescents with the most severe and complex problems "untreatable". The effective functioning of community clinics depends on the existence of an integrated spectrum of care, which includes effective treatment of those requiring extended care.
- The Draft Report states *"This (best practice) includes a broader range of treatment options with a move away from institutional style settings to psycho-social models which focus on treatment in the context of the social and family setting, closer to where the young person and their family, carers and support networks live."* We agree totally with this sentiment. However, what both the Draft Report and the *Future Directions for Child & Youth Mental Health Services (1996)* fail utterly to comprehend is the devastating and destructive effects on both the adolescent when those very family, social, school and support networks have partially or totally disintegrated, either as a cause or a consequence of the mental disorder. Indeed, leaving adolescents to suffer in these environments is totally contrary to best practice. In this context, BAC has developed best practice with a well developed psychosocial model to treat both the mental disorder and either restore or re-establish appropriate networks.

2. THE BARRETT ADOLESCENT PROGRAM

The Draft Report states *"The Barrett Adolescent Centre located within the Wolston Park Hospital complex is the only specialised extended treatment in-patient facility in Queensland for adolescents"* yet fails to acknowledge the specialist components of the service. An open heart unit has clearly identifiable features that distinguish it from an acute coronary care unit. These differences are not as obvious at BAC. They range from those that may be developed elsewhere, to those that are unique to Barrett.

Unlike orthopaedic procedures eg, a fractured femur, treatment and rehabilitation to do not follow in sequence. They are closely interwoven from soon after admission.

- The BAC program has been developed around clear conceptual principles to address both therapeutic and developmental needs in an integrated manner. We have avoided highly structured programs. The interstate experience from similar long term units is that treatment options for adolescents are limited if they do not fit the program requirements. Instead, our program is flexible to provide a highly individualised program for each adolescent, with clear pathways of therapeutic and rehabilitative intervention for each.
- BAC staff bring an invaluable mix of expertise to the program. This expertise ranges from extensive experience with adolescent inpatient treatment through to varying recognised treatment modalities through to the development of early intervention and mental health promotion projects and activities. The continued improvement in outcomes reflects the enormous experience, maturity, and professionalism of BAC staff. The acute inpatient units will continue to develop staff expertise, but it should not be assumed that reallocating beds means that this resource is readily replicated.
- The Barrett Special School is a unique partnership of Education Queensland and Queensland Health to provide a integrated service which is vital to the whole program.
- The program incorporates both very low stimulus and high stimulus activities according to the need of the individual adolescent.
- The program is flexible, allowing for full hospitalisation, partial hospitalisation, and day patient treatments, according to individual needs.
- The BAC care management plan is developed in conjunction with the community clinic that referred the adolescent or that is likely to be involved in their care on discharge.
- The BAC treatment program involves the community CYMHS in the treatment process wherever possible.
- Discharge planning and transition back to the community is an integral part of the program since 1995, but requires considerable staff time.
- The physical setting of the unit allows developmental and therapeutic needs to be addressed. This is regarded as an absolutely essential part of the program.
- The program is not disrupted by acute adolescents with a variety of behavioural and substance unit problems moving rapidly in and out of the unit.

It is the integration of all these factors, some of which are unique to the BAC program, which provides the specialist element of BAC. Adolescents need time to work through the psychosocial issues in a relatively constant environment with physical space to either be solitary or move with various groups.

Emerging outcome data from the BAC support the anecdotal claims of the efficacy of the BAC program, particularly for those who have required longer term care. Queensland is in the fortunate position of offering a range of treatment options to adolescents with severe and complex mental health problems. This is not so in most other states in Australia.

The conceptual model used by BAC has found wide application to both community and inpatient settings. Up until this year, and again in 2003 it is part of the training program in

child and adolescent psychiatry. It provides a framework for a variety of treatment modalities and interventions with an emphasis on realistic goal directed treatment.

3. MEASURING RESOURCE UTILISATION

The Draft report repeatedly refers to bed occupancy as a measure of activity. This is an extremely crude measure in child and adolescent inpatient units, and does not reflect at all the Best Practice models of the these centres. Nevertheless numbers do fluctuate, and all units operate below capacity at times.

Our data for the month of October, when we had 13 – 15 inpatients and 2 – 3 daypatients (ie close to capacity) shows that the bed occupancy was only 61%. The reasons for this are:

- A number of adolescents went on weekend leave (consistent with best practice).
- A number of adolescents had their week end leaves extended by their parents because it was not convenient to bring them back on the Sunday evening.
- A number of adolescents had extended leave over the holidays (consistent with best practice).
- A number of adolescents were away from the unit on an outdoors program.
- Some adolescents were in the process of discharge, but had beds held should there be a crisis (consistent with best practice).
- Some adolescents were transferred to a partial hospitalisation program (consistent with best practice).
- One had extended leave to her home at a distant location (consistent with best practice).

We believe that there needs to be a uniform data set across the adolescent inpatient units which adequately reflects the resource utilisation activities of those units. Such a data set should measure:

- Bed occupancy rates
- Adolescents on leave
- Day patient activity
- Activity not on the unit
- High dependency needs (eg. those who require one to one special care).
- Indicators of disturbance. Bed numbers are lower when there is an unstable mix of adolescents.
- Community integration programs. The latter are time intensive on a one to one basis.

Referrals to BAC from the other inpatient and community CYMHS units have fluctuated over the past six years. They appear to be stabilising in the last six months. The reasons for this fluctuation are:

- As each inpatient unit opened, there was an initial period of consolidation lasting six months or more. During this period, the unit was in the process of developing its program, determining those who did or who did not benefit from the program. Every attempt was made to treat every adolescent within that facility. Referrals from the client Districts to BAC dropped during this period.

- Perceptions of which adolescents benefited from inpatient treatments varied across the units. In such cases the choice was never community versus inpatient treatment. It was always no treatment vs inpatient treatment. We have worked hard to ensure that those who would benefit from an extended treatment program had access to it, rather than receive no treatment at all.
- The treatment of eating disorders has changed dramatically over the past six years. Although re-feeding programs are short term, a cohort of adolescents face repeat admissions with no progress in treatment. A study by Dr Philippa Bowen showed that the total lengths of inpatient stay over a year for this group ranged from three to six months, mostly in medical units. We have indicated our concerns that such prolonged treatment may be detrimental, and needs to be reviewed.
- The general perceptions of community and acute inpatient CYMHS are that BAC is very difficult to admit adolescents to. We have improved on this perception, but it does affect admission rates, sometimes to the detriment of the adolescent when they are finally admitted, because of the continuing adverse psychosocial effects of their environment.

Finally the Draft Report proposes the solution that resource utilisation be maximised by aggregating function. Each unit needs to have time to consolidate its staff and programs, which are the effective therapeutic tools during quieter periods. Treatment does not occur in a therapeutic vacuum, simply with the administration of medication. Moreover, with Queensland's growing population, it is not realistic to cut beds in the short term.

3. MEASURING OUTCOMES

For the past six years we have sought adequate measures which reflect the distress these adolescents experience, the deterioration in their function, and the difficulties in their home environment. We have:

- Sought measures of family functioning. These include a request to Prof Gavin Andrews to computerise the WHO Parent Interview Schedule for the Psychosocial Axis of the Multiaxial Classification of Child and Adolescent Psychiatric Disorders, referral of NIMH and British surveys of family function to Professor Barry Nurcombe and Dr Len Bickman.
- We are in the process of developing measures of social and emotional functioning. No adequate measures currently exist, yet they are critical to measures of vulnerability.
- Begun a data base that is presently undergoing analysis.
- Using the HoNOSCA as a global measure of distress. Preliminary data is emerging indicating the efficacy of treatments.

4. THE PHYSICAL ENVIRONMENT

We acknowledge that the Barrett Adolescent Centre is ancient in terms of current mental health facilities in Queensland. Specifically there are difficulties with noise levels, security and distance from the city. This latter has become less of a problem with the freeway system and rail transport.

The Draft Report contains some misperceptions of BAC.

- While indoor recreation areas are considered less than optimal, they far exceed those of any adolescent acute inpatient unit.

- The dining facilities are no more or less adequate than the adolescent acute inpatient units
- The proximity to the adult secure forensic facility is overstated. This latter unit is visible in the distance, with green space in between, which will be planted with trees.

However, the current site does offer some advantages.

- The ground level construction reduces chances of suicide by jumping
- The open space around the units which has a positive impact, and creates a feeling that they are in the least restrictive environment.
- The unit is isolated from adult psychiatric inpatients compared to any acute adolescent inpatient facilities
- BAC has access to a range of recreational facilities
- BAC is stimulated in its professional development by a high level of psychiatric care in The Park – Centre for Mental Health.
- A buffer zone for adolescents who attempt to abscond.
- There are fewer reminders of being sick in hospital, and more emphasis on addressing tasks of adolescent development.

We believe that while the building may be antiquated, the effects of the environment need to be acknowledged in any decision on where to rebuild BAC.

5. SERVICES TO ADOLESCENTS IN THE FORENSIC SYSTEM

It is noted that the few adolescents requiring inpatient admission from the Brisbane Youth Detention Centre are acute. The reasons for which BAC might consider it has a role are:

- Its proximity to the Brisbane Youth Detention Centre, allowing ease of access to CYMHS forensic staff visiting both facilities
- That if BAC were redeveloped, it would need to be with a high dependency unit.

6. RECOMMENDATIONS

We believe that there is strong evidence that the Barrett Adolescent Centre is an effective, integrated facility within the State wide CYMHS network of services. Queensland Health can be proud of its record in providing effective treatment to the most adolescents with the most serious and complex disorders, often from extremely adverse environments.

In view of the strategic importance of the Barrett Adolescent Centre within the Child and Youth Mental Health Services, and the lack of any credible alternatives, we propose:

- A two year moratorium on all plans
- Use that period to establish and implement a data base of adequate measures of resource utilisation across all inpatient units
- Use that period to establish and implement measures of severity and complexity, family environment and function across CYMHS services
- Use that period to establish and implement outcome measures, and begin delineation of clinical pathways across CYMHS services.
- Use that period to research whether there are viable and well established alternatives to extended inpatient treatment.
- Include the redevelopment of BAC as an option at the end of this period.

Queensland Government
Queensland Health

MEMORANDUM

To: Jenny Stone, Manager, Project Coordination Unit, Capital Works Branch

Copies to: Pam Lane, District Manager, West Moreton Health Services District
Kevin Fjeldsoe, Executive Officer, The Park – Centre for Mental Health, Treatment, Research and Education
Karen Roach, Zonal Manager, Southern Zone

From: Dr Arnold Waugh, A/Director of Mental Health

Contact No:

Fax No:

Subject: **Structural/Environmental Review of the Barrett Adolescent Centre**

File Ref:

Further to your discussions with Ivan Frkovic, A/Manager, Mental Health Unit, I would like to progress as a matter of urgency a structural/environmental review of the Barrett Adolescent Centre to determine the suitability of the facility to accommodate safely adolescents requiring extended inpatient treatment.

As you may be aware this is not a purpose built facility. It was constructed 1976 and opened as an adolescent unit in 1984. An attempt was made to close the facility in 1997 in line with the *Ten Year Mental Health Strategy for Queensland*, however due to strong community reaction the then Minister of Health reversed this decision.

A recent review of a critical incident at the facility by McDermott, et al, 2003 identified that "the building looked dated and that it would benefit from a process to establish whether it could be improved by significant modifications or a new type of facility required". Additionally a recent Mental Health Unit report into child and youth beds in Queensland in 2003 made a range of recommendations about the Barrett Adolescent Centre but these will not be pursued until advice is received about the building and its ability to safely house this client group.

The Mental Health Unit has the funds to pay for the review and has identified two people with extensive child and youth expertise to assist the Capital Works Branch in the review process. Your assistance in this review is appreciated and please feel free to contact Mr Frkovic on if additional information and support is required.

Dr Arnold Waugh
A/Director of Mental Heath
16 /3 /2004

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Queensland Government
Queensland Health

Options Study
for
Barrett Adolescent Centre
at
The Park Centre for Mental Health

December 2004

Prepared By

Project Services
Queensland Government
Department of Public Works

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SUMMARY AND RECOMMENDATIONS

The question of the future of the Barrett Centre seems to be a very open one. There are a number of possible options, and many stakeholders with various requirements. This report can not give the definitive answer, but it is hoped that it will provide a focus for further investigation.

3 main options have been considered, which may be regarded as samples from the range of possible options.

Option 1. Major refurbishment of the existing building. Gross project cost estimate $1.564 million excluding GST

Option 2. Major refurbishment of the existing building, plus extensive internal alterations and some extensions. Gross project cost estimate $2.318 million excluding GST.

Option 3. A complete new building on a new site. Gross project cost estimate $4.128 million excluding GST

In general terms, each option offers substantial advantages over the previous one, but with corresponding increase in cost. Each of the options therefore can be regarded as providing some value for money spent.

Option 3 has two distinct advantages over the other two:-

- It gives the opportunity to meet all the needs of the Barrett Adolescent Centre, rather than just being a compromise.
- The new building could be constructed while the old one remains in operation, necessitating only one clean move. Options 1 and 2 would require the residents to move into temporary accommodation for the duration of the building work, and then move back again. The availability of suitable temporary accommodation, and associated costs, have not been investigated at this stage. If the cost of temporary relocation were factored in to options 1 and 2, a more accurate comparison could be made.

Of course, refurbishments to a lesser extent than Option 1 are possible, and so are combinations of alteration, extension and refurbishment other than Option 2. The estimate for Option 3 is based on comparable long-term residential facilities constructed for Queensland Health in recent years.

More detail of the scope and cost of each option and its relative merits are included later in this report. It should be noted that there are certain limitations to the cost estimates (for example, they are at today's prices - please refer to the section on cost estimates) and their main function is as a basis of comparison between options.

A preliminary program is attached which suggests future progress leading to completion of construction in the second half of 2006.

We would welcome the opportunity to discuss this report with the various stakeholders, once they have had an opportunity to study it, with a view to arriving at a direction for the next stage.

1. BACKGROUND

The Barrett Adolescent Centre (BAC) is a residential facility for young people from 13 to 18 years old, who are experiencing complex mental or emotional problems, resulting in a wide range of behaviours. It can accommodate up to 18 residents (8 male, 10 female or vice versa) of which a maximum of 5 may be behaving disruptively at any one time. It provides extended treatment and rehabilitation (2 weeks to 12 months) and is the only facility of its kind in the State.

The residents attend school in an adjacent building.

The origin of this report was a memorandum dated 16th March 2004 from Dr Arnold Waugh, then acting Director of Mental Health at Queensland Health, requesting a structural/environmental review of the Barrett Adolescent Centre to determine its suitability to safely accommodate adolescents requiring extended in-patient treatment.

The memorandum pointed out that it was not a purpose-built facility; that it was constructed in 1976; was opened as an adolescent unit in 1984; and was proposed for closure in 1997, but kept open due to strong community pressure.

The memorandum also referred to a report in 2003 following a critical incident at the facility which stated "the building looked dated and ...would benefit from a process to establish whether it could be improved by significant modifications or a new type of facility required".

The memorandum also mentioned a 2003 Mental Health Unit report into child and youth beds in Queensland.

Following this memorandum, a meeting took place on site on 5th April 2004 attended by representatives of Queensland Health and Project Services. Project Services was commissioned in July 2004 to prepare this report.

2. SCOPE OF THIS REPORT

There are two types of problem with the building:-

- lack of suitability for its current purpose
- wear and tear due to its age

The aim of this report is to provide Queensland Health with advice and information, so that informed decisions can be made on the future of the facility. Specifically, it will investigate the cost of bringing the building up to a standard that will extend its useful life, and compare this with the cost of building a completely new purpose–built facility. This will help Queensland Health to make an informed decision on its future.

In compiling this report, information has been obtained from:-

- existing drawings
- maintenance records
- site inspections, and
- consultation with facility staff

Advice has been obtained from building specialists including:-

- architects
- a structural engineer
- a mechanical engineer
- an electrical engineer
- a communications / security engineer
- a hydraulics consultant
- a quantity surveyor, and
- a termite inspector

The report includes:-

- suggestions for two upgrade options with cost estimates
- a cost estimate for a new purpose-built facility, and
- a suggested time frame

The report excludes:-

- block C (the adjacent school building)

3. THE EXISTING FACILITY

3.1 The building.

The building housing the Barrett Adolescent Centre is one of several similar structures constructed in the 1970s as a ward block forming part of the Wacol Admission and Treatment Centre in the Wolston Park Hospital.

It is a single-storey structure, with a concrete floor-slab-on-ground, and a reinforced concrete frame with brick infill walls internally and externally. There is a sloping metal deck roof incorporating raised areas with clerestory windows over internal corridors, and a deep feature fascia. Windows are aluminium framed.

3.2 Floor plan

The floor plan consists of two dormitory wings running east-west, joined by a central area running north-south.

Each of the dormitory wings consists of a central corridor, with single- and four-bed dormitories off it, plus a shower / toilet block. One of the dormitory wings has two of the 4-bed dormitories used for other purposes (art room and conference room) reducing the number of beds available to 8. This is currently the boys' wing. The other dorm wing has two of the single rooms used for "time out" purposes, and a 4-bed dorm used for and office and a 'blue' (teenager's retreat) room. This reduces the number of available beds to 10, and the wing is currently the girls' wing. It is understood that the allocation of wings is sometimes changed over, depending on the relative numbers of boys and girls.

The central area contains the entrance, lounge, dining and activities rooms, staff areas, kitchen, laundry, clinic, storage and small toilets, plus some small verandahs.

The main entrance is through the dining area at the north east corner of the central area. There are other potential entry/exit points around the central area, the main one leading out to a covered walkway to the school building. There is also a pair of double doors at the end of each dormitory corridor.

A floor plan of the existing facility is attached in Appendix A. Comparison of this with the original floor plan indicates that there has been little change to the plan since construction, apart from to the staff areas and the kitchen.

3.3 Use and function

It is understood that the building's main function is residential, ie that it provides long-term accommodation to adolescents with mental health problems. Its secondary function is therapeutic, in that it provides opportunities for observation by staff and supervised activities. Medications are also administered plus other treatments, such as tube-feeding. There are also small areas devoted to offices and a conference room. All residents attend school in the adjacent school building.

Main meals are brought in from a kitchen elsewhere on the campus and served from the facility kitchen. This internal kitchen is also used for preparation of minor meals and drinks under supervision. The facility has a domestic-type laundry for use of residents. It is understood that residents are encouraged to participate in domestic activities, but that there are also professional cleaning and care staff.

Most problem behaviour takes place in the residential wing, not in the school. This behaviour includes:-

- self-harm / substance abuse
- damage to the building
- disturbance of others
- absconding

Toilets are a favourite place for self-harm.

3.4 Siting, access and external areas.

The facility is housed in Block D on the campus of the Park Centre for Mental Health. Access is via the Park's internal road system. The building's main entrance is off a cul-de-sac with parking to the north of the building. The site is in a very quiet, semi-rural parkland setting.

There is substantial open space consisting of lightly treed grassland to the north, east and west, with Wolston Park golf course close by to the east. To the south (rear) of the building, there are some other Barrett Centre buildings, but sufficiently far away that there is an open prospect in this direction.

The open space immediately around the building is landscaped, and contains facilities for resident activities such as trampolining, putt-putt and vegetable growing. There are a couple or storage sheds containing equipment for outdoor activities.

The natural slope of the land is from south to north, but the site of blocks C (school building) and D (Adolescent Centre) have been cut and filled so that they sit on a level plateau above the access cul-de-sac.

The site is not fully fenced.

3.5 Aesthetics

Both internally and externally, the building looks institutional rather than domestic.

The external colours (dark brown brick and dark anodised windows), though serviceable and low-maintenance, reflect the time when the building was constructed (1970s) and contribute to a drab first impression.

Internally, the type of ceilings and lighting, the colours and finishes, confirm the impression that this is an institution rather than a home, although there has been some attempt to improve this aspect as far as the nature of the building allows.

3.6 Condition

Based on a visual inspection by a number of building specialists, and perusal of maintenance reports, the overall condition of the building is good, in terms of wear and tear and maintenance. The cracks in some walls are not considered to be structurally significant.

There are no obvious indications of termite activity, and the form of construction would limit the likelihood and severity of termite attack, however, a termite inspection is to be made early in the new year.

An inspection for asbestos materials has been done by Q-Build. Their report indicates that, although some materials are suspected of containing asbestos, the type, location and condition of these materials does not make their removal urgent.

The initial impression that it is tired and old, is more a function of the age of the building, its style, colours and finishes, than of any major defects in the fabric. Though dated, most visible surfaces appear to have been well maintained. Many materials are low-maintenance ones, which may contribute to the institutional feel.

Of course, with a building of this age, there may be hidden problems, such as deterioration of underground pipework.

3.7 Plans and photographs

Building plans and photographs are attached as appendices to this report.

4. SOME IDENTIFIED PROBLEMS

The following is a list of problems reported by the users of the building, or resulting from site inspection, which have a bearing on the built environment.

4.1 Resident behaviour

- The institutional ambience of the building, and the drab environment, may be less than therapeutic, and even counter-productive to resident mental health.
- Visual supervision by staff is limited by the layout of the building and solid walls. Undesirable behaviour can occur as a result.
- A number of rooms provide easy opportunities for residents to barricade themselves in.
- Self-harm and substance abuse are facilitated by supervision problems, and by the existence of places where contraband can be hidden (eg over accessible ceilings).
- For suicide attempts, there are numerous hanging points, and possible access to electric cabling.
- Toilets are a favourite place for self harm and substance abuse. The toilet and shower cubicles do not enable quick and easy access for staff in an emergency.
- When bad behaviour does occur, there is no part of the facility where residents can be isolated, apart from "seclusion" rooms". The design and location of the seclusion rooms is not ideal, and there is no facility for more long term accommodation of disruptive residents.

4.2 General Environment

Problems with the general environment include:-

- A tired, drab, appearance.
- An institutional, rather than home-like feel.
- Lack of privacy (most residents are in 4-bed rooms, and no separation between living, dining, TV, games and entry areas)
- Noise between rooms and within rooms (a lot of hard surfaces and no separation of living areas, lack of sound proofing between rooms)
- Very hot in summer in main living areas, which apart from discomfort, can contribute to behaviour problems.
- Generally "tired" looking internal finishes, especially ceilings and roof lights.

4.3 Functionality

- Treatment room too small
- Incorrect signage to girls and boys toilets
- There are no bath tubs, only showers. Baths can be useful therapy.
- Facilities for disabled staff or residents are not to current standards.
- Hard surfaces in seclusions rooms which can lead to self-harm and enable disturbance of others with noise.
- Unattractive views out of seclusion rooms.
- The "office" in the girls' wing is not used.
- There is no dedicated visitors' room.
- Privacy when using resident telephones is minimal.
- Some offices, currently located in the school might be better located in the residential wing.
- There is a lack of opportunity for recreational activities. Basically there is one noisy main space plus a TV room and a small gym on a verandah. The art room is not generally accessible, and there are no small rooms for varied quiet (or noisy) activities, such as handicrafts, reading, study, homework, internet, individual music. Neither are there many facilities for energetic sports-type activities.

4.4 Safety / Security

- Absconding - Residents can get out easily without being unobserved. There are a number of uncontrolled exits, and the front entry is not visible from the staff station.
- The front sliding doors are not very secure or easy to operate.
- Bearing in mind that the presence of teenage girls may attract undesirable attention, and other risk factors associated with resident backgrounds, intruder prevention may not be adequate.
- The fire exits appear to be locked at night to prevent absconding. This creates a risk in the event of a fire at night, and puts heavy responsibility on staff. Locks which automatically release on fire alarm are preferable.

- The existing key system may no longer be restricted, due to expiry of patent (ie it now may be easy to have copies made) and the need to use keys is inconvenient and insecure when compared with electronic swipe cards.
- Some floor finishes are slippery when wet, eg in the main entry.
- There is no secure courtyard.
- Much of the glass is breakable.
- The accessible ceilings have allowed residents to break in to rooms in the past.
- Initially, staff complained about inadequate duress and paging, but it is understood that this has since been rectified.

4.5 Building deterioration

Problems identified include:-

- Leaking roofs (replaced in 1990s but still a problem, eg over staff toilet)
- Structural cracking (eg in Director's office)
- Rotten fascias
- Possums in roof and consequent ceiling stains.

5. SUGGESTED REMEDIES

5.1 Generally

There are a number of levels of upgrading possible, depending on priorities, available finance, and the time span being considered.

5.2 Priorities

Staff from the BAC have indicated some priorities, and safety has to be of prime concern. There are also legal obligations which arise, once a major refurbishment is considered, for example the need to provide access for persons with disabilities.

High on the staff list is the provision of a high-dependency unit (HDU) .

5.3 High-Dependency Unit (HDU)

An HDU is understood to be a sub-unit of the facility where residents exhibiting disruptive behaviour could be accommodated on a medium-term basis (a few days) in a safe environment where they could be kept under close observation and away from other residents. This would eliminate the need for such residents to be removed from the BAC to an acute mental health unit.

In built form, the HDU is expected to consist of two bed-sitting rooms, each with its own en-suite bathroom and secure courtyard. Fixtures and finishes would be designed to minimise self-harm and maximise staff supervision. There should be a discreet exit point for those cases where removal to an acute unit became necessary.

It is understood that a HDU would be in addition to, not instead of, seclusion rooms.

5.4 Other user suggestions

A number of suggestions have been documented by the BAC staff. These are attached as in Appendix E.

5.5 The three options

There exists a whole range of possibilities for upgrading the Barrett Adolescent Centre, from a new coat of paint and a few repairs at one end of the spectrum, to a brand new building at the other.

In order to simplify the task, and to help find the appropriate level, three options have been considered.

- **Option 1** consists of a major refurbishment of the existing building to address many of the problems, but without any major alterations or extensions to the building.

- **Option 2** consists of most of the refurbishment work in Option 1, plus major internal alterations to address the most pressing problems, and some extensions to provide a HDU and other additional facilities.

- **Option 3** is a new purpose built facility on a new site, to a standard comparable to other recently-constructed Queensland Health residential facilities, such as the Acquired Brain Injury unit at Sandgate.

More detail of each option follows.

6. OPTION 1

6.1 Scope

Option 1 consists of the following refurbishment work.

Building work

- Replace all ceilings with seamless, impact-resistant type. Thermal / sound insulation over. Perspex panels over dormitory corridors to be eliminated.
- New floor finishes in communal areas.
- Replace doors to bedrooms, bathrooms, and toilets with light weight ones on lift off hinges, to prevent barricading.
- Re-swing laundry door to open outwards to prevent barricading.
- Replace sliding entry doors with heavy duty hinged ones.
- Provide threshold ramps at all external doorways to improve disability access.
- Complete refurbishment of bathrooms, including floor and wall finishes, joinery, personal lockers, new partitions, reduced opportunities for hanging, and improved disability access.
- Re-key all locks.
- Replace remaining breakable glass with safety glass.
- Crimsafe to all windows.
- Glass panel in the east wall of the staff station wall to improve supervision of dining / entry area.
- Glass panel in the kitchen north wall to improve supervision.
- Bigger pantry and oven in kitchen.
- New soft floor and wall finishes to seclusion rooms with double glazing to internal windows with integral blinds.
- Major renovation to roof to eliminate leaks and possums. Clean out roof space.
- Replace rotten fascias.
- Complete internal and external repaint.
- Upgrade signage generally
- Extend paving and upgrade landscaping in courtyard off activities area.

Electrical

- Provide RCD protection to all electrical installations, including lights.
- New vandal-resistant lights throughout with better lighting levels, especially in dormitory corridors.

Electronic

- CCTV surveillance to critical areas (corridors, seclusion rooms, art room, laundry, TV room, terraces, front and back entrances externally)
- Prox card access to front and rear entrances, staff station, kitchen, clinic and seclusion rooms.

Mechanical

- Air-conditioning to all areas not currently air-conditioned.

Fire engineering

- Change all fire sprinkler heads in resident-accessible areas to vandal-resistant / hang-proof type.

Other

- Minor repairs and maintenance items as necessary.

6.2 Cost

The capital cost of Option 1 is estimated as $1,290,000 with a Gross Project Cost of $1,563,509.

6.3 Advantages

Apart from cost, the main advantages of Option 1 are:-

- Improved safety and security
- Increased ability of staff to monitor and modify behaviour
- A more pleasant environment for residents and staff
- Increased working efficiency for staff
- Improved facilities for persons with disabilities
- Prolongation of life of building.

6.4 Disadvantages

Disadvantages of Option 1 include:-

- Some aspects of safety, security and supervision still not addressed.
- The need for the HDU is not met
- 4-bed dormitories continue
- The continuing lack of varied activity spaces and recreational facilities
- Continued inadequate clinic
- Some offices and other rooms remain in the school building.
- It remains a 30-year-old building with its dated and institutional appearance.
- The work is sufficiently major that it would be necessary to vacate the building and move the residents into temporary accommodation.

7. OPTION 2

7.1 Scope

Option 2 consists of major refurbishment plus major internal alterations and some extensions. Specifically:-

- Refurbishment generally as for Option 1
- Internal alterations to provide only 1 and 2 bed dormitories
- Relocation of the staff station to provide better supervision
- Addition of a 2 bed HDU
- Relocation of kitchen, dining room and art room for improved supervision
- Enlarged clinic
- Improved seclusion room
- Better bathroom facilities for wheelchair users, and addition of bath tubs
- Two "blue" rooms (teenage retreats)
- Improved staff facilities.

A plan showing Option 2 is attached as Appendix C

7.2 Cost

The capital cost of Option 2 is estimated as $1,935,000, with a Gross Project Cost of $2,317,909.

7.3 Advantages

The main advantages of Option 2 are:-

- All the advantages of Option 1
- Improved privacy and environment for residents due to smaller bed rooms etc.
- Greatly improved supervision
- Improved behaviour management due to the HDU
- A safe and efficient clinic
- A greater range of bathroom amenities
- Improved recreational facilities for residents

7.4 Disadvantages

Disadvantages of Option 2 include:-

- Some aspects of safety, security and supervision still less than ideal.
- Only one seclusion room
- Not all resident recreational needs are met
- Some offices and other rooms remain in the school building.
- There inevitably has to be some compromise due to the nature of an existing building
- After considerable expenditure, there remain substantial parts of the building that are 30 years old, and hence still will look dated, lack a home-like ambience, and have limited life span with potential maintenance problems.
- The work is sufficiently major that it would be necessary to vacate the building and move the residents into temporary accommodation for a prolonged period.

8. OPTION 3

8.1 Scope

Option 3 consists of a new built facility to replace the existing one, constructed on a different site, either at The Park Centre for Mental Health, or at another location in the greater Brisbane area. It would be purpose-designed to meet the current and foreseeable needs of Queensland Health.

8.2 Cost

The capital cost of Option 3 is estimated as $3,570,000, with a Gross Project Cost of $4,128,409.

8.3 Advantages

The main advantages of Option 3 are:-

- The opportunity to achieve a purpose-designed facility without the compromise of altering an existing building.
- A new building with a fresh look and home-like environment.
- Longer building life and reduced maintenance
- Less disruption to staff and residents because only one move would be necessary.

8.4 Disadvantages

The only disadvantage of Option 3 compared with the others is cost.

9. COST ESTIMATES

9.1 Capital Costs

The estimate for Option 3 is based on the cost of building similar residential facilities for Queensland Health in recent years.

Due to the limitations of cost estimating at this stage, with limited information, these estimates should only be used for the purpose of comparing the three options. A full Project Definition Plan would need to be done before project budgets could be arrived at.

9.2 Gross project costs

Gross project cost estimates include capital cost of building works, plus statutory fees and charges and professional fees.

9.3 Exclusions

Estimates exclude:-

- Escalation from today's prices
- Temporary accommodation and re-location
- GST
- Demolition of existing building (option 3)
- Abnormal site conditions
- Site works (eg roads, footpaths, landscape) or external services for Options 1 or 2.

- Loose furniture and equipment
- Information technology

9.4 Limitations

Due to the limitations of cost estimating at this stage, with limited information, these estimates should only be used for the purpose of comparing the three options. A full Project Definition Plan would need to be done before project budgets could be arrived at.

9.5 Recurrent Costs

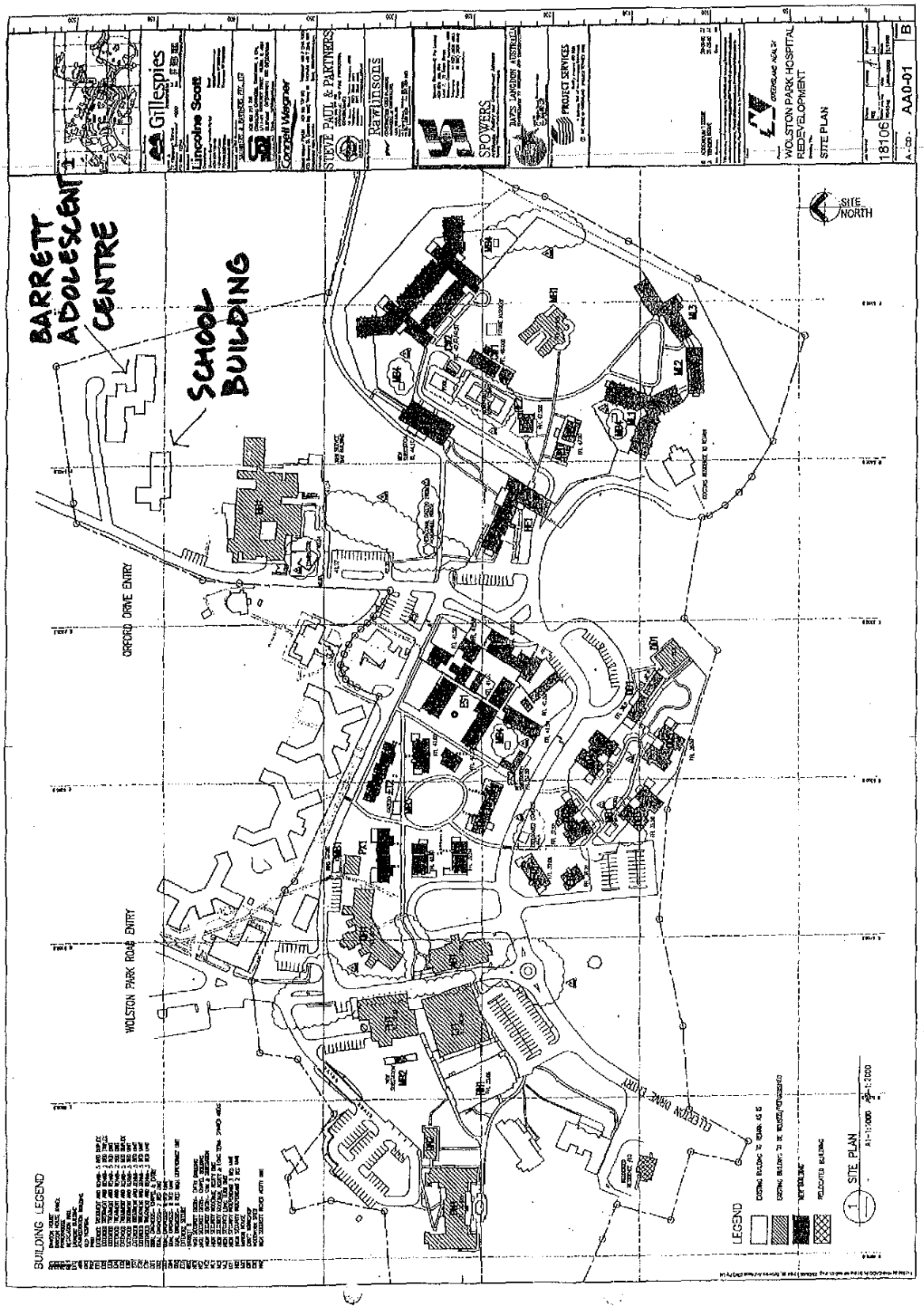
Recurrent costs have not been considered at this stage.

10. PROGRAM

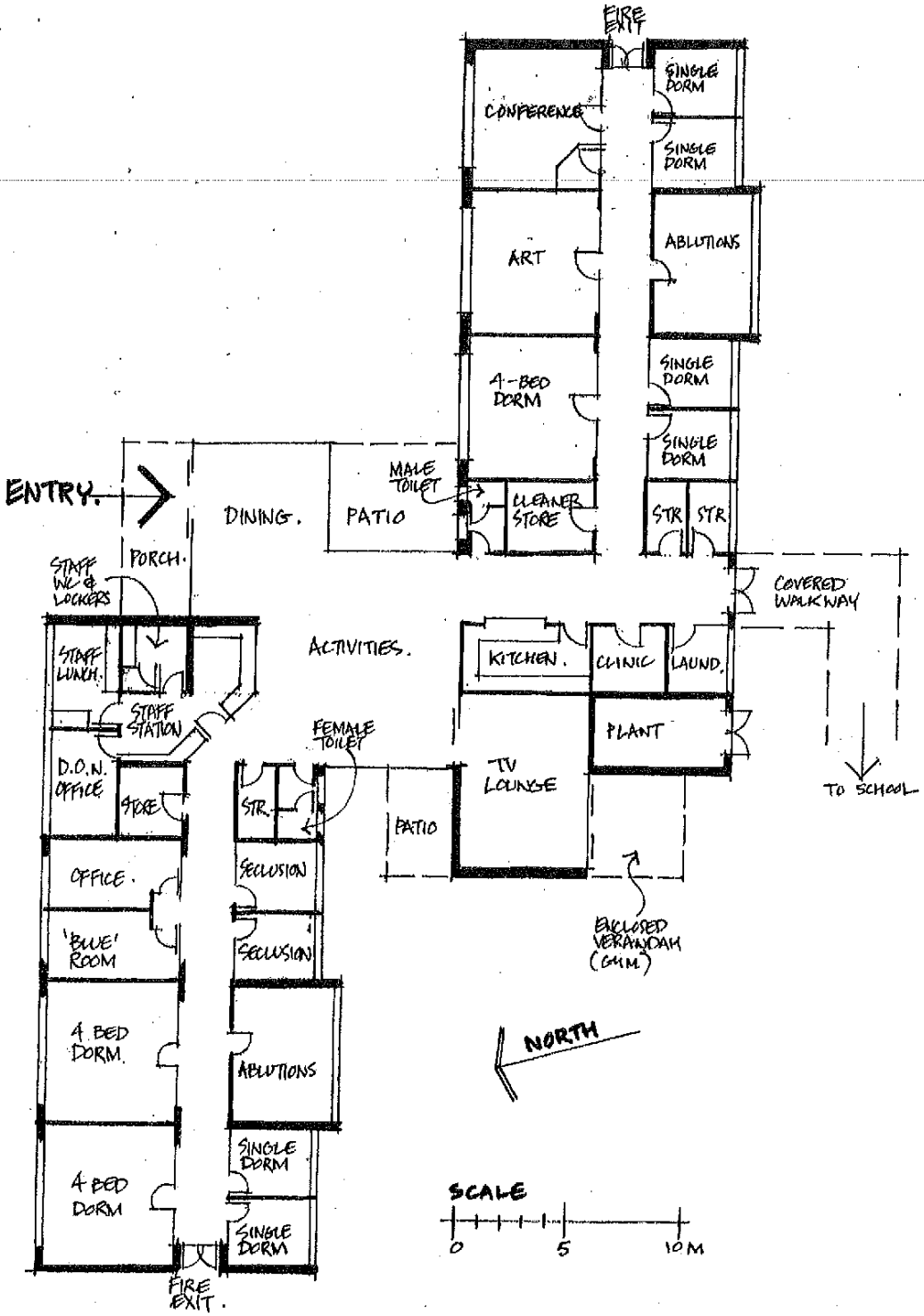
The Project Program is contained in Appendix D, which shows that completion of construction could be achieved by late August 2006.

APPENDICES

Appendix A – Plans of existing facility


BARRETT ADOLESCENT CENTRE
SCHOOL BUILDING
SITE NORTH
WOLSTON PARK HOSPITAL REDEVELOPMENT
SITE PLAN
ORFORD DRIVE ENTRY
WOLSTON PARK ROAD ENTRY
BUILDING LEGEND
LEGEND
SITE PLAN

SITE PLAN



BARRETT ADOLESCENT CENTRE
FLOOR PLAN AS EXISTING.
DECEMBER 2004

Appendix B - Photographs