Agenda Item	Action/Person
• Recommendation for model to include multi disciplinary complex case panel process for admission to AITRC or for extension of treatment beyond initial 6 months. • **Treatment**: o How therapies work in a continuum of care? o How does the school operate in the model of care? o Is it evidenced based treatment modalities or is it re parenting? o Clear care pathways to be established. • Concerns around eating disorder clients. Felt that ED clients should not be at AITRC in a model that currently caters for admissions of over 6 months. Concern that there is not the level of expertise needed at Barrett to cater for ED clients as this is a specialised field. It was acknowledged that some rural and remote areas may not be able to access local outpatient support for eating disorders and may require further support from acute facilities or outreach services such as EDOS. • Discussion around AITRC admitting young people with psychosis. It was felt that there are more contemporary community based models of care for this cohort. It was acknowledged that CYMHS may need to be more proactive in linking to early psychosis resources including supported accommodation opportunities for young people with serious mental illness. • Discussion re: current long waiting times for admission precluding admission of either ED or Psychosis • The group agreed that the model of care should focus on a 3-6 month timeframe of admission. Treatments should not extend beyond 6 months unless this case had been re-presented to the complex care panel for extensive review. • Link to support services very important. • Specify more clearly re diagnostic groups and complexity of presentations Group decided there was a need for a meeting next week to review the proposed changes to date in the MOSD and to continue to discuss and integrate further changes. **NEXT MEETING: 9.30 FRIDAY 19TH FEBRUARY 2010 AT CYMHS SPRING HILL.**	Brett McDermott volunteered to co-ordinated the group's suggestions and provide feed back to Fiona Cameron who will integrate these into the service model. Revised Model to be disseminated to group prior to next meeting on 19/02/10.

Summary of Issues to consider when reviewing the Model of Service Delivery for Barrett Adolescent Centre (BAC)

Previous reviews and reports have outlined concerns including:

Safety concerns – in relation to both clients and staff –

- increase in critical incidents
- increase in 'continuous observations'
- ACHS issued 'high priority' recommendation pertaining to improving patient and staff safety in recent accreditation survey.
- Aspects of building configuration deemed 'dangerous'

Director General of Health Brief noted –

- Profile of BAC is changing
- Increased complexity, increased impairment and co-morbidity
- Less referral out options
- ALOS increased from 4 months (1994) to 10 months 2006.

McDermott Review – issues identified /Risk only

- Need for more defined admission criteria
- Need for improved risk assessment during admission
- Need for improved risk assessment tool
- Establish better linkages with broader Hospital (The Park)
- Need for staff training
- Issues around whether unit locked/ not locked

Community Visitors Report

- BAC over census
- BAC has clients over 18
- Safety issues for medium to long term residents
- Not all young people participate in programs – some 'optional'

QNU

- Letter of concern relating to staff injuries sustained trying to apprehend a young person absconding

Review of 3 Critical Incidents – key characteristics

- Female
- Over 18
- Severe and complex self harming
- Diagnosis did not reflect complexity, chronicity or severity of behaviors.
- Referral on to adult MHS or more appropriate services had not occurred

Issues considered by recent review (2009):

Governance

Lack of clarity or little evidence re:

- governance structures, lines of accountability to MHD/ Corporate QH
- Policies and procedures
- Staff performance reviews /performance management
- Clinical documentation – audit processes
- Complaints system
- Framework does not align with state legislation or QH policy directives
- Poorly defined scope of clinical practice for medical, nursing and allied health
- Professional development
- Clinical Supervision
- Research and evidence based practice
- Role of BAC in statewide CYMHS plan unclear
- Role of BAC in The Park hospital unclear
- Recording and review of critical incidents and 'near misses'
- Poor communication including handover impacts on continuity of care

Clinical Model

- Lack of evidence based treatments
- Current practices predominantly 'milieu therapy' and 'adventure therapy'
- Poor evaluation of current behavioral management programs and associated staff development and training despite previous recommendations to address this
- Need for individualized behavior management plans
- Alternatives to continuous observations

Nursing Model of Care

- Model unclear – best described as task allocation or functional

Patient Journey

- Long waiting times for admission
- More clarity re: Referral pathways, inclusion and exclusion criteria
- Need access to acute medical management at local hospital
- Need access for more intensive acute psychiatric care
- Intensive discharge planning at point of referral
- Integration of BAC with local community services
- Partial hospitalization – used for transition care back to community care
- Difficulties with discharge planning due to remoteness of referring services
- Out of home care / discharge placement for older adolescents

- Transition to adult MHS
- More assertive discharge planning

Treatment evaluation

- Negligible evaluation

Clinical Leadership

- Lack of clarity and structure

Staffing profiles (nursing)

- Varied skill mix
- Lack of external CYMHS experience
- Vague reporting lines – discipline meeting structures

Nursing staff training and education

- Limited opportunities for Child and Adolescent education
- Problematic Clinical Supervision structures

Queensland Government
Queensland Health

Meeting to Review Model of Service Delivery (MOSD) for Adolescent Integrated Treatment and Rehabilitation Centre (AITRC)

(formerly known as Barrett Adolescent Centre (BAC))

MINUTES			
Chair:	Judi Krause, A/Executive Director, RCH&HSD	**Date:**	19 February 2010
Secretariat:	Fiona Cameron, A/Statewide Principal Project Officer, CYMHS	**Time:**	9.30am – 10.30noon
Venue:	Seminar Room, Institute of Child and Youth Mental Health Services, Spring Hill		
Apologies:	Dr Trevor Sadler, Director, Barrett Adolescent Centre – West Moreton South Burnett District Dr Penny Brassey, Clinical Director, Child and Youth Mental Health, Townsville Dr James Scott, Child /Adolescent Psychiatrist ECYMHS & Evolve TS Brisbane North		
Present:	Fiona Cameron, Statewide Principal Project Officer CYMHS Judi Krause, A/Executive Director, RCH&HSD Erica Lee, Manager, CYMHS Mater, Mater Hospital & Health Service District **Via Teleconference Link** Dr Michael Daubney, Director, CYMHS, Metro South Health Service District Dr Brett McDermott, Director, CYMHS Mater, Mater Hospital & Health Service District		

Agenda Item	Action/Person
19.2.2010 • Discussion was based around the revised BAC MOSD document. • Changes were made based on recommendations from the meeting on the 7.2.2010 • Discussion included: • Thoughts that the name should reflect the placement of Barrett in the CYMHS continuum of care e.g. the words CYMHS and Extended were suggested as possible inclusions. • The need to reflect in the model the day program and how it works • Length of stay – group agreed that the length of stay should be changed from 3-6 months to 6 months with provision in the model to allow for longer stays in certain individual cases and after approval from the panel. • Model needs to reflect that the centre works in collaboration with Education Queensland. • Make up of panel to include the team leader, Education Queensland Representative • It was felt that the section that describes the four broad groups of adolescents with persistent mental illness with sever impairment (under "Who is the Service for? Section p.2) should be re worked and possibly broken up into two sections with headings of Functionality and Diagnosis Should be broken up into two sections	Group agreed to give this issue more thought and feedback at next meeting. Erica Lee to rewrite this section and sent to Fiona.

Agenda Item	Action/Person
• Addition of information around eating disorder clients and the need to be referred to specialist services and exclusion of eating disorder clients who need nutritional resuscitation. Further discussion around exclusions. It was agreed to add under exclusions, • Excessive violence 2. Sexualised behaviour 3. Clients with Intellectual impairment but with out mental health issues. In the section "What does the Service do" the group felt that the model needed to add: • how shared care works with BAC • clarification added in around the mental health needs of parents/carers • the role of the panel/panel functions • clinical standards around risk assessment • changes to the description of interventions used to include validating environment and a safe contained environment • inclusion of adventure and recreation based activities in therapies used In the section "Service and operational procedures" changes made include: • take out work integrated and add in supervision Under " Staff Training: • it was agreed to add in that staff would be expected to integrate into the Key Skills training offered through CYMHS Group agreed that in addition to providing the BAC Steering Committee the suggested changes made to the model that a list of recommendations is also made. These recommendations include: 1. That further development of the day program to provide a local service is needed. 2. That the current building design of the new centre to be based at Redlands where the building is designed to include 6 pods is not in line with the current 6 month model of care being suggested by the work group. Group decided there was a need for a meeting next week to review the proposed changes to date in the MOSD and to continue to discuss and integrate further changes. **NEXT MEETING: 9 am FRIDAY 26TH FEBRUARY 2010 AT CYMHS SPRING HILL.**	**Brett** to provide Fiona with some suggestions around changes to the program design and eligibility sections. **Fiona** to work changes into new draft.

Agenda Item	Action/Person
• Discussion re: where AITRC would be best placed under CYMHS continuum of care. It was recommended by the group that line management is undertaken by a well resourced CYMHS service with a proven record of administrating state wide services e.g. Children's Health Service District (CHSD), with the Mater taking this responsibility in the interim period until the establishment of Queensland Children's Hospital in 2014. • Brett highlighted the need to have AITRC linked into a continuous reform process as per other CYMHS services to ensure contemporary service delivery. • The group discussed issues around the AITRC including; many anomalies in the model e.g. referrals from private practitioners, long length of stay for some consumers, discharge planning challenges etc. It was determined that referrals to AITRC should be from CYMHS services and not from private practitioners who would not have been able to offer a comprehensive multi-disciplinary approach to community based care. It was agreed by the group that this approach was a minimum pre – entry standard. • James Scott highlighted that the best treatment gains are often in first 6 months of treatment .James suggested that it would be useful to look at the ***Rivendell*** model in NSW. http://www.sswahs.nsw.gov.au/MHealth/ • Discussion around phases of treatment and group thought 6 months was a reasonable overall time frame for treatment. Suggestions were the initial phase would be focussed on rapport building, developing a therapeutic alliance, risk assessment and developing shared treatment goals, the second phase would involve intensive treatment (evidence based, DBT, IPT-A, trauma focussed CBT etc.) in conjunction with systemic approaches and the third phase would be assertive move toward discharge and re-integration back into the community/ either referring CYMHS team or adult mental health. • Group discussed the possibility of recommending a multi disciplinary complex case conference process for entry to AIRTC. This panel could consist of senior AITRC staff, key stakeholders from CYMHS and possibly key stakeholders from external agencies. This would assist with commitment of referring agencies for ongoing involvement and assist with consistency and equity of admissions. Recommendations & Issues for consideration **Clinical Governance:** Recommendation for MOSD to be changed to reflect clinical governance changes to Mater CYMHS in the interim until establishment of QCH. • **Referrals**: o Clarification and consistency needed in referral process. o Clarification around what type of clients is suited to the centre. o Multi disciplinary complex case conference process for referrals suggested • Recommendation for the model to be changed to reflect referrals from CYMHS services only.	

QUEENSLAND HEALTH
MENTAL HEALTH BRANCH
BRIEF FOR NOTING

Our Ref:	Dept ref no. File ref no. (if known)
Date:	17 November 2009
TO	Dr Aaron Groves, Director Mental Health
FROM	Ms Pam Lane, District Chief Executive Officer, Darling Downs – West Moreton Health Service District
SUBJECT	External Review Report – Barrett Adolescent Unit
Requested by	Shirley Wigan, Executive Director Mental Health

RECOMMENDATION(S)

- That you note the contents of this brief.

BACKGROUND SUMMARY

- In January 2009, an external review of the Barrett Adolescent Unit was commissioned to examine consumer incidents and make recommendations regarding the safe care of consumers of the Barrett Adolescent Unit.

ISSUES

- The final report from this review was received by the District on 29 September, 2009 (Attachment 1).
- The final report and recommendations are critical across a number of domains and have a potential for negative impact on staff working within the unit. This impact needs to be considered in the context of staff anxieties and ambivalence regarding the future relocation of the unit to Redlands Hospital.
- Whilst it is acknowledged that these recommendations are appropriate and reflect sound corporate and clinical governance, it is further acknowledged that there may be existing systems and processes in place in relation to some of the recommendations which may not have been identified during the 2 day review process.
- Attachment 2, lists each recommendation and the current status or recommended strategy to progress the required actions.
- It is proposed that the report and recommendations will be released to staff in the near future.
- Implementation of relevant local recommendations to be implemented by the Barrett Adolescent Unit Management team with oversight by The Park Management Committee.

- A representative from the District Mental Health Service will be nominated to participate in the reference group for the development of the Model of Service delivery for the redeveloped Adolescent Extended Care Unit to support implementation of consistent contemporary practice throughout the transition.

CONSULTATION WITH STAKEHOLDERS

- Consultation to date has occurred between the DCEO, EDMH, Mental Health Unit and The Park Executive.
- Release of the report to Barrett Adolescent Unit staff may result in Industrial Organisation involvement.
- It is recommended that the report be provided to EDMH for Metro South, for consideration in development of the model of service for the Extended Adolescent Service at Redlands Hospital.

FINANCIAL IMPLICATIONS

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ATTACHMENTS

- Attachment 1 – Final Report "Review of Barrett Adolescent Centre"
- Attachment 2 – 2009 Review of Barrett Adolescent Centre – Recommendations
- Attachment 3 – Terms of Reference

NOTED or APPROVED / NOT APPROVED
Director Mental Health
Comments

Dr Aaron Groves
Director Mental Health

/ /

Author: Katrina Mathies A/DSO Division of Mental Health Darling Downs – West Moreton Health Service District	Signed on: 17 November 2009	**Cleared by:** (DM/SD/Dir) Shirley Wigan Executive Director Mental Health Darling Downs – West Moreton Health Service District	Signed on: 17 November 2009
Cleared by: (CEO/DDG/DivHead) Pam Lane DCEO Darling Downs – West Moreton Health Service District	Signed on: <date>		

2009 REVIEW OF BARRETT ADOLESCENT CENTRE

(Final Report)

Reviewers: Garry Walter, Martin Baker, Michelle George

Psychiatrist Director MH Rivendell

Psychologist Rivendell

Nurse Unit Manager.

BACKGROUND

For a considerable period of time, concern has been expressed about the role, function and capacity of the Barrett Adolescent Centre (BAC) to provide an appropriate, effective and safe service for its client group. Most recently, the ACHS indicated concerns about the capacity of BAC to provide safe care. The local governing body has decided that environmental changes (including relocation) are necessary. These have been agreed to and are underway.

The present review has been commissioned in the knowledge that the proposed environmental/geographical shift will take place. The reviewers were asked to focus upon the philosophy and clinical practices of the unit, with a view to assessing whether the unit is safely meeting the needs of the consumer group, and to make recommendations for change and improvement.

PREVIOUS REVIEWS AND REPORTS

ACHS Review

In a recent accreditation survey by the ACHS, BAC received a "High Priority Recommendation" from the ACHS to ensure that immediate modifications are made to improve patient and staff safety. In making this and other recommendations, the ACHS observed:

- Patients admitted to BAC have severe and complex clinical pictures;
- BAC has limited choice over which patients it accepts;
- In the Park Hospital redevelopment, BAC has lost access to facilities;
- There are aspects of BAC's configuration and related building issues that are dangerous;

- There has been an increase in critical incidents;
- There has been an increased use of "Continuous Observation".

The ACHS made a number of other recommendations around staffing and infrastructure needs.

DOH Brief

A brief to the Director General of Health in Queensland noted that the profile of consumers treated in BAC had changed since the opening of the new Acute Child and Youth Mental Health Beds in Queensland and that BAC was now treating more complex and impaired cases. Apparently, the Acute Units are now referring to the BAC if there are no obvious community placement options. This has resulted in more complex cases in BAC and even less "referral out" options. In support of this contention is the fact that Average Length of Stay in BAC has risen from four months in 1994 to ten months in 2006.

McDermott Review

This review considered: the impact of critical incidents on BAC; current risks at BAC; BAC management practices, staff, environment and systemic issues; and, BAC responses to critical incidents. The recommendations included:

- Admission criteria and a more clearly defined target group;
- Better Risk Assessment in the admission process;
- Improvement of the risk monitoring process, especially the "Risk Assessment Tool";
- Improving the relationship with other parts of Park Hospital;
- Providing more certainty about the future of BAC.

Also included were recommendations about staff training, whether the unit is open or locked, the material fabric of the Unit, and the role of BAC within Queensland Mental Health Planning.

Community Visitors Report

This report noted that:

- BAC was over Census;
- BAC had clients in it who were over age;
- "The Unit is not of a standard to safely house medium to long term residents";
- "Not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis".

Queensland Nurses Union

The Union had written a letter of concern, specifically around the injuries sustained by a nurse trying to apprehend a client who had run away.

CRITICAL INCIDENTS

In addition to the above reports, the present reviewers were provided with three incidents to consider. The local governing body believed these to be emblematic of the difficult issues BAC faces and expressed a desire for the reviewers to examine these incidents within the broad purpose of the review. These reports related to three young women who had been inpatients at BAC for some time. The reviewers found that the incidents that occurred were characterised by the following elements:

- All the patients were female;
- All were near or over the age of 18 years;
- All exhibited severe and complex self-harming behaviours;
- All had been given diagnoses that did not seem to adequately reflect the chronicity, severity and complexity of the behaviours;

- Referral on to Adult Mental Health Services or other more appropriate services did not appear to be an option that had been realistically considered for any of the patients.

The reviewers conducted an incident and file review of the cases and have incorporated considerations around the incidents into the broader observations and recommendations of the report.

On the basis of the above materials, meetings with stakeholders and key staff on 26 and 27 February 2009, and attendance at a staff/stakeholder ongoing education meeting, we offer the following observations and recommendations:

OBSRVATIONS AND *RECOMMENDATIONS*

Governance

In terms of both corporate and clinical governance, a number of the usual mechanisms, processes and systems for ensuring proper governance did not appear to be in place at BAC. Specifically, there did ***not*** appear to be:

1. Clear lines of responsibility and accountability to senior levels within Queensland Health for the overall quality of clinical care;
2. Clear local policies that are integrated with wider policies aimed at managing risks;
3. Procedures for all professional groups to identify and remedy poor performance;
4. Much in the way of Quality Improvement activities. A comprehensive approach would include consideration and use of
    - Clinical guidelines/Evidence-based practice;
    - Continuing Professional Development;
    - Clinical Audits;
    - The effective monitoring of clinical care deficiencies;

- Research and development;
- "Caldicott principles" to manage the collection and use of patient information;

To elaborate, the role of BAC in the hospital and State plan remains unclear. BAC does not feature in the hospital organisational charts, nor is its role articulated in a State-wide plan for child and adolescent mental health services. While patient safety was certainly a priority at BAC, there was a focus on physical environmental issues and less emphasis on a systematic approach that included formal reporting and documenting in the medical record for all incidents, including "near misses", and a process for reviewing incidents to inform staff and to effect change in client management to improve patient safety.

To support the above process and address other clinical documentation issues, regular reviews of medical records (file audits) are often used in other centres; this did not seem to be the practice at BAC.

Policies and procedures sighted had been in place a long time with little evidence of a review of their continued appropriateness.

There did not appear to be a system in place to manage, respond to or analyse complaints either from within the client population in the unit or from the broader community.

While we did not specifically ask about this issue, it is feasible that Performance Reviews are not a regular part of professional practice at BAC and, if they are, they do not appear to be targeted at assisting clinicians to maintain best practice and improve patient care.

BAC does not appear to have a framework which aligns with State legislation, Queensland Health policy directives, and local protocols governing the credentialing and defining the scope of clinical practice of medical, nursing and allied health practitioners working in the unit. In the absence of this framework, aspects of

recruitment, the capacity to adopt particular clinical models and a coherent approach to professional development and clinical supervision are all compromised. For example, it was evident that clinical practice at the unit was established on principles that had been developed some time ago. Apart from the external reviews of the unit, there was little evidence that BAC had recently reviewed and audited its clinical model against current accepted best practice and evidence based care.

Communication around continuity of care of clients in the unit, but particularly between nursing staff on each shift and between shifts, is poor and poorly documented.

Recommendations:

1. *That generally accepted mechanisms of clinical and corporate governance are introduced or enhanced within BAC. These would include:*
2. *The State and hospital should give a clear determination of the role and function of BAC.*
3. *This information (about role and function) needs to be disseminated in written form to all stakeholders.*
4. *The role and function should be operationalized and a reporting framework developed such that the unit is shown to be fulfilling its function.*
5. *That a procedure is developed to provide a framework governing the credentialing and defining the scope of clinical practice of practitioners at BAC.*
6. *That an integrated risk management approach is introduced into all aspects of BAC functioning, ensuring it is evidence based and aligned with a broader Hospital, Area and State Risk Management approach.*
7. *All incidents (including "near miss" events) should be reported and documented and regularly reviewed in a broad staff forum to identify problems and improve client safety.*
8. *Regular file audits be undertaken to ensure the medical record is capturing all appropriate patient centred data and to identify areas and indicators for improvement.*

9. *All policies should be reviewed as to their appropriateness and rewritten or updated to reflect desired practice.*
10. *That a system for managing, responding to and analysing complaints be introduced to improve community and client satisfaction with BAC.*
11. *That Performance Review processes are established or enhanced to assist clinicians maintain best practice and improve patient care.*
12. *That audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.*
13. *Clinical handover should be refined and implemented; its nature will be dependent on the integrated model of care adopted, but it should involve all relevant clinical staff and provide nursing staff, in particular, with the opportunity to comment on consumers that they have had direct care responsibilities for on a particular shift.*

Clinical Model

Noting that the clinical population serviced by BAC has changed in recent years (with a greater proportion of more severely ill clients, extensive comorbidity etc), one of the major problems is the apparent lack of evidence-based treatments employed by the unit.

The reviewers had a number of interventions described to them; however, Milieu Therapy and Adventure Therapy were the two overriding interventions highlighted as encapsulating the clinical approach of the programme.

Typically, **Milieu Therapy** is a form of psychotherapy that involves the use of therapeutic communities. It has been used as a viable treatment modality for children for over fifty years in residential and inpatient settings. Milieu Therapy is potentially a powerful therapeutic tool when individual dynamics and the social system can be combined in a planned and meaningful way to manage and change behaviour and relationships in settings such as BAC.

There was little evidence presented to the reviewers that Milieu Therapy at BAC is a planned intervention in which everyday events and interactions are therapeutically designed for the purpose of enhancing social skills and building confidence. Rather, the evidence and the finding of the reviewers was that afternoons and evenings are unstructured times with no program and that the BAC nursing staff are not engaged in this type of therapy, partly because they are not trained in it and partly because they spend much time in the continuous observation of clients.

Adventure Therapy is the creation of opportunities to explore the unknown in a safe environment through team based adventure activities. This therapeutic approach has the capacity to engage adolescents and young people. There is a small body of literature about the intervention and, while the data about effectiveness from that literature is equivocal, its use at BAC is not contraindicated. Its drawbacks, however, are that it is not an activity that can be intensively introduced into the day to day running of the unit and that as a stand-alone intervention its outcomes are poor.

It is noted that the loss (as reported in early reviews) of positions and facilities will have compromised the capacity of BAC to successfully implement structured out of hours activity and the Adventure Therapy Programme.

The A1-A7 programs are behaviour management programs employed to manage difficult and challenging behaviours. It has been previously noted that they have been used for many years without documented evidence that they are effective or that they have been systematically reviewed.

A previous review conducted in 2003 recommended the BAC close the programs for several days each year to invest time in program review, management, procedural and training issues. There is no evidence that this recommendation has been acted upon.

The recommendation made previously (2003) to close the program for several days to undertake review and development activities is considered to remain integral to the successful functioning of BAC.

Behaviour management plans continue to have a place within the clinical model in managing difficult behaviours; however, these plans may benefit from being individualised more, and eliminating their availability in pre-typed form that serves to inhibit consumer and staff creative problem-solving skills.

Time and effort could be directed at identifying interventions, other than continuous observation, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance. Pursuing the idea of a high dependency unit may prove to be the most judicious use of human and financial resources.

Recommendations about unstructured periods of the day made here are reiterated from those made in the previous review (McDermott et al, August 2003, p 40) that the risk of critical incidents occurring could be reduced by ensuring small group sizes and structuring time outside of school hours with therapeutic group activities. The therapeutic milieu and adventure therapy style interventions may be utilised - the important aspect here is that they are planned and integrated into a holistic therapeutic approach

It is worth emphasising that while it may be argued that the various types or aspects of treatment – Milieu Therapy, Adventure Therapy - described above have a role, these should not be the cornerstone of a contemporary treatment program, nor the optimal "model of care". For example, patients with eating disorders may benefit from using the "Maudsley Eating Disorders Model", those with challenging personalities may warrant Dialectical Behaviour Therapy (DBT), etc.

Finally a previous review noted that "not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis" While appreciating that attainment of autonomy is an important task of adolescence, the reviewers believe a more directive approach about treatment in agreement with the client will be more productive.

Recommendations:

1. *A model of care should be formulated, based on the currently available evidence and the nature of clients presenting to the service.*
2. *The recommendation made previously (2003) to close the program for several days to undertake a review and development of a model of care is reiterated.*
3. *That the increase in risk associated with unstructured time is noted and that structured interventions are considered for these periods.*
4. *If BAC is seen as a Therapeutic Community utilising a Milieu approach, that this approach is formalised, key activities identified and documented, and appropriate training and supervision for staff provided.*
5. *That Adventure Therapy may continue but, if so, this should be seen as a component part of an overall therapeutic approach.*
6. *That interventions other than continuous observation be introduced, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance.*
7. *The different presentations to the service and variety of disorders encountered will require a range of tailored treatments and, consequently, individual treatment plans should be developed and documented in the medical record and an appropriate range of evidence based interventions should be utilised to meet the individual needs of an increasingly complex group of clients.*
8. *Staff require adequate training and clinical supervision to ensure the new treatments are delivered optimally and that they are modified as new evidence becomes available.*
9. *Individual treatment contracts should be developed with patients and parents/carers. The contract should stipulate the expectation of participation in BAC programmes by clients/parents/carers and the consequences for non participation.*

Nursing Model of Care

It is unclear which model of care the nursing staff at BAC are presently utilising. However, it appears that the Functional or Task Allocation model may be closest to

reflecting how the team are functioning. In this model, the nurse is allocated tasks to complete, rather than patients to care for. The particular tasks that may be allocated to a nurse working at BAC include continuous observation, medication and escort.

The *Queensland Health Nursing Model of Care – Toolkit for Nurses* (2003) notes that while this model may useful in situations where there is a staffing crisis or that it may be more efficient for certain care, its weaknesses include depersonalised care, ritualised and repetitive tasks, and reduced job satisfaction.

During the visit, some nursing staff identified that it was particularly stressful being allocated to escort duty, during which time the nurse is required to be a continuous escort for consumers attending appointments usually outside BAC. Nurses reported feeling anxious and unsupported having to remain alone with consumers in what is usually an unfamiliar environment.

Recommendations:

1. *Consideration should be given to changing to a Patient Allocation Model or a Team Nursing Model, or a combination of both (the Combination Patient Allocation & Team Model). The strengths of each model are outlined in Queensland Health Nursing Model of Care – Toolkit for Nurses (2003, pp6-7).*

   [Patient allocation sees an individual nurse allocated to a group of patients and undertaking total patient care for that group. It has the advantages of providing personalised and holistic care while increasing the sense of autonomy and accountability and allowing more opportunities for communication with other health professionals. Team nursing involves dividing work between a group of nurses who are allocated to care for a number of patients. The Team Nursing Model strengths are identified as improving collaboration, flexibility and time efficiency as well as having a supportive/teaching function. The Combination Patient Allocation & Team Model combines the strengths of team nursing with patient allocation.]

Patient Journey

The "Report of the Site Options paper for the Development of the Barrett Adolescent Centre" identified a number of issues related to the patient journey of clients admitted to BAC. These included:

- The need for acute medical management at a local general hospital at regular intervals;
- Occasional need for more intensive acute psychiatric care;
- The need for intensive discharge planning at point of referral;
- Integration of BAC with services at the local community of origin;
- Partial hospitalisation as a method of transition from BAC to community management;
- The remoteness of referring services, making the above patients difficult to manage;
- Out of home care for increasingly older adolescents and young people who cannot return to their family of origin;
- Transitioning to suitable adult mental health services if the adolescent requires long term treatment and has reached an age where this transition is necessary.

The management or the difficulties in managing these issues has created some significant problems for BAC. The reviewers were advised that:

- Admissions to BAC are increasingly severe and complex;
- There is a perception that BAC has a limited choice over whom it accepts;
- There are referrals on from the CAMHS Acute Units if there is no obvious community placement option and that BAC becomes a treatment option of "last resort";
- A number of clients who are accepted are homeless;
- A number of clients are referred from very remote parts of Queensland – often by NGOs with little local CAMHS type support.

The concept of continuity of care is based around the notion of seamless transitions between treatment episodes, and this does not appear to be the case at BAC.

While some of these issues will be addressed when the unit is relocated to a site adjacent to an acute hospital, there appear to be significant problems with all of: referral to the unit, waiting time to admission for accepted patients, length of stay, and discharge planning and discharge placement.

The BAC has 15 inpatient beds gazetted for use of adolescents with challenging mental health problems requiring medium to long term treatment. At the time of the visit, there were 9 inpatients. The nursing staff on duty were unable to clarify how the remaining beds were being utilised. [One of the clinical nurses performs the role of Clinical Liaison Officer, coordinating the intake activities of the service. The clinical liaison nurse informed the reviewing team that BAC has developed exclusion criteria that include: conduct disorder, predatory behaviour, criminal behaviour, aggression, substance misuse and moderate-severe intellectual impairment.]

An obvious indicator of this constellation of problems is the increasing age of the clients. At the time of the review, one third of the inpatients (3 out of 9) were over the age of 18 years. Those 3 individuals had admission dates of November 2007, August 2006 and April 2005, meaning length of stay for them was approaching 2, 3 and 4 years respectively.

Thus, consumers are not necessarily discharged at 18 years of age and there appears to be a lack of clearly understood or communicated process to transition these young people to adult services.

An assertively managed approach to admission and discharge will need to be adopted by BAC wherever it is located. The following recommendations can define the parameters of this approach.

Recommendations:

1. *That advice be provided to referring agencies about the nature of the services offered by BAC.*
2. *That clear inclusion and exclusion criteria be formulated.*
3. *That referral forms for referring agencies be updated.*
4. *That service level agreements, Memoranda of Understanding or shared protocols be used as the basis of agreement for the transfer or sharing of care between BAC and other units. These would include but not be restricted to:*
5. *Agreements with local Acute Hospitals for assistance in the management of the physical sequelae of self harm.*
6. *Agreements with local Acute Hospitals for assistance in the management of the physical complications of eating disorders.*
7. *Agreements with local Acute Mental Health Facilities for assistance in the management of acute and extreme behavioural disturbances.*
8. *Agreements with local Acute Mental Health Facilities with regard to the transition of older adolescents from care at BAC to care in Adult Mental Health Services.*
9. *That responsibility for accepting admissions and managing discharges be clearly articulated in the Unit policies and that this include the position(s) responsible for the decision making.*
10. *That the length of admission, and planned discharge date, for prospective admissions, be agreed upon by referrer and BAC staff prior to admission.*
11. *That there is firm agreement, prior to admission, about which service will have an ongoing role in the patient's management upon discharge (failure to agree on this will result in the patient not being admitted to BAC).*
12. *That homelessness in the absence of an identified and agreed upon strategy for accommodation at discharge be an exclusion criteria for admission to BAC.*
13. *That the concept of step up/step down facilities and halfway houses, possibly managed by NGOs, be explored as methods of transitioning clients back to the community, especially those clients who will require out of home care.*
14. *That a target for Length of Stay be set for BAC – this can be aspirational, but should be no more than 12 months. Any client that exceeds this target on*

clinical grounds should be identified and intensively managed to find alternative clinical placement including, for older clients, placement with Adult Mental Health Services.

15. *That planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission.*
16. *That regular (eg twice yearly) meetings of BAC staff with key referring agencies occur to improve the referral, treatment and discharge processes.*
17. *That data regarding referrals, wait times, lengths of admission etc be reviewed regularly and in different forums (eg at meetings of senior BAC staff and Park Hospital and Old Mental Health)*

Treatment evaluation

There appears to have been negligible evaluation of treatments delivered by BAC.

Recommendations:

1. *Routine use of standardised outcome measures.*
2. *Additional (specific) measures be used for the specific disorders managed by the unit (eg depression rating scales for those patients with depression etc).*
3. *Regular use of patient and parent/carer satisfaction surveys.*
4. *Affiliation with an academic unit to facilitate treatment evaluation.*
5. *Introduction of a regular meeting to specifically address the process of outcome measurement at BAC and the (outcome) results obtained for patients.*

Clinical leadership

One of the major problems of BAC relates to leadership and leadership structure. While several staff (e.g. psychiatrist, NUM, liaison nurse, senior allied staff) have considerable experience, there does not appear to be a clear Executive structure nor forum for the Executive to meet. In relation to nursing, while nursing staff reported

that they weer all were very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted, and the reporting lines were vague.

Similarly, it was unclear whether the Nurse Unit Manager and the Director attended regular meetings in their roles as providing the leadership group at BAC.

Recommendations:

1. *Appointment of an Executive whose members have clear roles and responsibilities*
2. *Clear delegation and succession planning (for example, when the Director, NUM, liaison nurse etc go on leave, others are appointed to act in these roles – this also provides career development opportunities for various staff).*
3. *The Director should implement professional development seminars for all the staff and these should reflect the practice of other service providers. Examples of new and innovative therapies, presented by people external to BAC, should be included.*
4. *BAC should provide a regular (eg quarterly) report to Park Hospital and State mental health about its programs and use of both tested and innovative approaches.*
5. *The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.*

Staffing profiles (nursing)

BAC consists of a large multidisciplinary team; as with most inpatient services, the nursing establishment make up the bulk of this team. BAC currently maintains a nursing establishment of 23.9 FTE. Six nurses are rostered on each shift on

weekdays. The nurses work continuously in 8 hour shifts. The nursing team is led by the Nurse Unit Manager and 4 Clinical Nurses, one of which holds an Intake/Community Liaison position.

As in all nursing teams, there are varying levels of clinical skill and experience amongst the individuals. At BAC, there are a number of staff who have been working there for many years and some staff who are relatively new to Child and Youth Mental Health (CYMH). Consultations with nursing staff present on the day of the visit suggested that there were no nurses who had experience with another CYMH service outside BAC. This indicates the team may be disadvantaged by a lack of current exposure to contemporary nursing practice within the CYMH speciality.

While all nursing staff reported being very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted and the reporting lines were vague.

Recommendations:

1. *More robust interactions between nursing staff of BAC and other CYMH services should be facilitated; one way to address this may be found in secondment activity negotiated between services.*
2. *The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.*

Nursing Staff Training and Education

Individual consultations with nursing staff during the visit identified a general desire for more educational/training opportunities, specifically in adolescent mental health.

There appeared to some issue with the budget limiting nursing staff access to their professional development funds to pay for development activities.

The previous BAC review conducted by McDermott et al in 2003 recommended more training and education for staff on adolescent issues. It is clear from discussions with nursing staff that this education is still somewhat haphazard and limited.

Clinical supervision structures are problematic. The whole team attends group supervision with a specialist clinical supervisor, who is also a member of the team. Additionally, nursing staff identified a need for more clinical supervision.

Recommendations:

1. *The use of professional development funds by nursing staff should not be compromised by budgetary constraints. The provision of the money to undertake development activities is an award condition.*
2. *Nursing staff would benefit from regular and relevant in-service, and a program or calendar of such in-service could be developed and then facilitated through rostering. There appears to be generous blocks of time that could be regularly quarantined for staff development during the time the young people are attending school.*
3. *Structures for group clinical supervision should be reviewed and strengthened by sourcing a clinical supervisor not currently working at BAC.*

Finally, while staff may understandably be unsettled by the prospect of significant changes as recommended in this report, the proposed rebuilding of the facility at a new location constitutes an unprecedented opportunity to reflect on BAC's purpose, mission, systems and work practices. With a motivated leadership team employing good change management skills, BAC and key stakeholders can seize this chance to review the service and maintain BAC's commendably long record of service provision to young people in Queensland.

4th March 2010

Dr. David Crompton
Executive Director Clinical Services
Metro South Mental Health Service

Dear David

Please find enclosed the draft Model of Service Delivery (MOSD) for the Adolescent Extended Treatment and Rehabilitation Centre (AETRC) formerly known as Barrett Adolescent Unit. As requested by you at the Redland Facility Project Team Meeting on 4th February this document has been reviewed by a working group of the Statewide Mental Health Network Child and Youth Sub Group. This group comprised of Erica Lee, Manager Mater CYMHS, Dr. Brett McDermott, Executive Director Mater CYMHS, Dr. Penny Brassey, Clinical Director, Townsville CYMHS, Dr. Michael Daubney, Clinical Director, Metro South CYMHS, Dr. James Scott, Child Psychiatrist, RCH CYMHS, Fiona Cameron, A/Statewide Principal Project Officer, CYMHS, Dr. Trevor Sadler, Clinical Director, AETRC (who provided input via email as he is currently overseas) and myself. Recommendations have been further reviewed by Denisse Best, Allied Health Leader, Queensland Children's Services.

The group acknowledged that reviewing the MOSD was a complex task which was not conducive to the four week timeframe. The group were able to meet on three occasions with email communication in between sessions.

The emphasis has been on addressing clinical governance issues, positioning AETRC in the integrated CYMHS continuum of care and refining referral, treatment and discharge processes. The group recommended clinical governance of AETRC be incorporated within the QCH (the Mater in the interim period) as this would address some of the key themes identified in the recent reviews. It would facilitate the establishment of clear reporting relationships, address risk management and patient safety issues and enable multidisciplinary staff to link into existing frameworks of clinical supervision, staff development and clinical education and peer support networks. It would also ensure that the national mental health reform agenda is embedded into the operational management of AETRC.

There are a range of recommendations relating to the continuum of care including referrals being reviewed by a multidisciplinary intake panel consisting of key stakeholders, treatment being defined to a six month period in most cases, a suite of evidence based treatments being available which will be tailored to suit the individual's needs and more assertive discharge planning processes being adopted.

In relation to resources required from Redland Hospital it would be envisaged that they would support acute medical emergencies and other medical issues that can be managed

locally. AETRC as an integrated component of the Mater/ QCH would have access to a range of specialists who could provide support.

In relation to the proposed building design of AETRC when it is relocated to Redlands it is recommended that this be reviewed in lieu of the changes to the MOSD. The cottage style of accommodation may not be conducive to the proposed six month treatment model and some components of this may need to be modified. It is noted that not all group members had an appreciation of the current status of the proposed building design for AETRC. It would be recommended that the group have the opportunity to familiarise themselves with this prior to further comment. The group (or part thereof) would like to be involved in any discussions relating to building re-design.

While some significant changes have been made to the original draft MOSD the group would like to emphasise that this document should not be viewed as the final version of the MOSD for AETRC. Further work is required to finalise this document and encapsulate the detail of the above recommendations. The group view it as imperative that we continue to work on this document and are consulted with in relation to any changes that are proposed.

As you were aware Dr. Trevor Sadler, Clinical Director of AETRC, was unable to participate in these group discussions. He has sent us a range of email information in relation to the current treatment programs at AETRC and his observations from visiting other adolescent units overseas. It should be noted that there was not group consensus on all issues. Trevor felt strongly that the model proposed above did not encapsulate the complexity of the AETRC cohort and was simplistic in nature. The group note that Trevor is critical of the 6 month treatment time frame suggesting there is no evidence for this period of care. The group note that there is equally no evidence for a 1-3 year admission and these lengthier periods of care are more costly, block beds and appear developmentally inconsistent with generalising change to the patient's local setting. For your information I have enclosed the information that Trevor forwarded to the group.

Please do not hesitate to contact myself (or any member of the group) in relation to the above information if further clarity or discussion is required.

Kind Regards

Judi Krause
Acting Executive Director
Royal Children's Hospital
Child and Youth Mental Health Service
Children's Health Services.

c.c. Shirley Wigan – Executive Director Mental Health Toowoomba MHS
Aaron Groves – Director Mental Health

Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

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

Model of Service

1. What does the Service intend to achieve?

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

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

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

The key functions of the AETRC are to:

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

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

Programs will include:

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

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

Length of Admission:

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

Level of Care:

The level of care is determined by:

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

2. Who is the Service for?

The AETRC is available for Queensland adolescents;

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

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

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

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

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

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

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

Suitability for admission will be undertaken by an **intake panel** that will consist of:
- the AETRC director
- referring specialist and/or Team Leader
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders

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

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

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

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

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

3. What does the Service do?

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

The key components of AETRC are defined below:

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

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

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

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

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

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

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

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

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

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

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

4. Service and operational procedures

The AETRC will function best when:

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

Caseload

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

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

Staffing

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

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

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

Hours of Operation

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

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

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

Staff Training

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

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

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

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

5. Clinical and corporate governance

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

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

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

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

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

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

7. How do Services relate to each other?

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

8. How do consumers and carers improve our Service?

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

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

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

9. What ensures a safe, high quality Service?

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

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

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

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

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

Legislative Framework:

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

10. Key resources and further reading

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

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

Project Plan

Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

Children's Health Queensland Hospital and Health Service

October 2013

V 1.1

A DOCUMENT PURPOSE

The Project Plan is used to guide the project implementation and the process for project control. It defines:

- project approach and strategy
- responsibilities and accountabilities for project strategies/ tasks
- project schedule, including key milestone points and the delivery of identified outputs
- dependencies within the project and with other projects
- resources required (financial, human and material), and financial management processes
- risk management strategies
- communication management strategy
- human resource management strategies

The project plan is also used to facilitate communication among the stakeholders.

B DOCUMENT CONTROL

Version	Date	Prepared by	Comments
V0.1	30/07/13	A/Director of Strategy, MH&SS, WM HHS	Initial draft for consideration with key stakeholders.
V0.2	01/08/13	A/Director of Strategy, MH&SS, WM HHS	Revisions made following meeting with Sharon Kelly, Stephen Stathis and Judi Krause 01/08/13.
V0.3	16/08/13	A/Director of Strategy, MH&SS, WM HHS	Revisions made following meeting with Stephen Stathis and Judi Krause on 15/08/13 and based on CE teleconference 16/08/13.
V0.4	19/09/13	Project Manager, SW AETRS	Revised for CHQ HHS format
V1.0	21/10/13	Project Manager, SW AETRS	Endorsed by SW AETRS Steering Committee Approved by CE DoH Oversight Committee

**Drafts should use format vX.1 (e.g. start at v0.1). Final versions should use format vX.0 (e.g. v1.0).*

Distribution

Name	Title	Function*
	Chief Executive and Department of Health Oversight Committee	Approve
	SW AETR Steering Committee	Endorse
Sharon Kelly	Executive Director Mental Health & Specialised Services	Feedback
Deborah Miller	A/Executive Director, Office of Strategy Management, CHQ HHS	Feedback
Judi Krause	Divisional Director CYMHS CHQ HHS	Feedback
Stephen Stathis	Clinical Director, CYMHS CHQ HHS	Feedback
Leanne Geppert	A/Director of Strategy, MHSS WM HHS	Feedback

**Functions include: Approve, Review, Feedback*

Document Storage and Archive

During conduct of the project, documentation will be stored electronically under: \\Qldhealth\.qhb-cl3_data13.qhb.co.sth.health\CHQ\District - Office of Strategy Management\Projects\SW AETR.

A standard directory structure and file naming convention will be developed for use by the Project Manager.

C GLOSSARY

Abbreviation	Meaning
BAC	Barrett Adolescent Centre
CE	Health Service Chief Executive
CE DoH Oversight Committee	Chief Executive and Department of Health Oversight Committee
CHQ EMT	Children's Hospital Queensland Executive Management Team
CHQ HHS	Children's Hospital Queensland Hospital and Health Service
CYMHS	Child and Youth Mental Health Services
DETE	Department of Education Training and Employment
ECRG	Expert Clinical Reference Group
HHSs	Hospital and Health Services
MH	Mental Health
MHAODB	Mental Health Alcohol and Other Drugs Branch
MHSS	Mental Health and Specialised Services
NGO	Non-Government Organisation
QPMH	Queensland Plan for Mental Health
SW AETR	Statewide Adolescent Extended Treatment and Rehabilitation
SW AETRS	Statewide Adolescent Extended Treatment and Rehabilitation Strategy
The Park	The Park Centre for Mental Health
WM HHS	West Moreton Hospital and Health Service

TABLE OF CONTENTS

1 Project Description

1.1 Background

Queensland's public mental health system has undergone significant reform over the past ten years. The reform agenda includes a shift from institution-based service models, including extended treatment and rehabilitation, to more contemporary models of care that align with state and national policy. The impact of these important reforms has seen the care of consumers move primarily into community-based settings, where they are supported to engage in their own local neighbourhoods and facilities. This has been particularly vital for consumers requiring medium to longer-term care.

In alignment with the Queensland Plan for Mental Health 2007-17 (QPMH), a key area for reform within Mental Health and Specialised Services (MHSS) in the West Moreton Hospital and Health Service (WM HHS) is the development of The Park Centre for Mental Health (The Park) as an adult-only forensic and secure mental health campus. The high secure services have been expanded and, in July 2013, a new service option was established on campus, the Extended Forensic Treatment and Rehabilitation Unit.

In light of these significant changes, it is no longer safe or contemporary to provide long-term inpatient care for adolescents at the Barrett Adolescent Centre (BAC) on The Park campus. Compounding these changes at a service provision level, the existing infrastructure of the BAC is unable to be refurbished and the building will be decommissioned.

Through Stage 1 of the QPMH, an adolescent extended treatment unit was funded to replace the existing 15-bed BAC. The replacement service was to be located at Redlands within Metro South HHS, and had an indicative commissioning date of November 2013. Upon operation of the replacement 15-bed unit, the existing BAC would be decommissioned.

The Redlands adolescent extended treatment capital program encountered multiple delays and a significant budget over-run. There were unresolvable environmental barriers associated with the site, and the Department of Health ceased the development and redirected the capital funds toward other high priority health initiatives. Operational funding for the Redlands Facility, of approximately $2 million for 2013/14, has been retained and approved by the Department of Health to fund new adolescent mental health extended treatment and rehabilitation service options.

In December 2012, WM HHS initiated the Barrett Adolescent Strategy to identify new service options for adolescents requiring mental health extended treatment and rehabilitation in Queensland. An Expert Clinical Reference Group (ECRG) was convened, consisting of a consumer representative, a carer representative, an interstate Child and Youth Psychiatrist, multi-disciplinary Child and Youth clinician representation (including north Queensland), a representative of BAC, a representative of the BAC School, and a Non-Government Organisation (NGO) representative. The ECRG was chaired by the Director of Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch (MHAODB). The ECRG reported up to the WM HHS via a Planning Group, which was chaired by the Executive Director of Mental Health & Specialised Services, WM HHS.

In May 2013, a preamble and seven recommendations were submitted by the ECRG and considered by the WM HHS Board (Attachment 1). This was followed by comprehensive consultation with the Minister for Health, the Queensland Mental Health Commissioner, CHQ HHS,

Department of Education Training and Employment (DETE), and the Department of Health. The seven recommendations were accepted by the WM HHS Board.

On 6 August, 2013, the Minister for Health, the Honourable Lawrence Springborg MP made an announcement that adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from the Barrett Adolescent Centre at that time will be supported through their transition to other contemporary care options that best meet their individual needs.

1.2 Business Need

To deliver on the Minister's commitment, a new statewide mental health service model for adolescent extended treatment and rehabilitation (AETR) is required by early 2014.

The foundation work for this initiative has now concluded and approval is sought to move into the implementation phase, of which this Project Plan forms the basis.

1.3 Purpose / Objective

- Develop service options within a statewide mental health model of service for adolescent extended treatment and rehabilitation, within a defined timeline.
- Develop an Implementation Plan to achieve the alternative model of service for adolescent mental health extended treatment and rehabilitation, within a defined timeline (noting mobilisation of implementation activities will occur as a separate project phase).
- Ensure continuity of care for adolescents currently admitted to BAC, and on the wait list, through a supported discharge / transition process to the most appropriate care option/s that suit individual consumer needs, and that are located in (or as near to) their local community.
- Within the context of a changing service model in early 2014, review the admission criteria to BAC for all new consumers post 5 August 2013.
- Oversee the redistribution of BAC operational funds, and other identified funding, to adolescent mental health service models to support the identified target group.
- Develop a consistent and transparent Communication Plan regarding the implementation of the new service options.
- Consider in all decision-making the key principles and recommendations as defined through the ECRG and Planning Group of the Barrett Adolescent Strategy (Attachment 1).
- Discharge all adolescents from the BAC facility by 31 January 2014, to enable finalisation of The Park campus as an adult-only forensic and secure mental health service facility.

1.4 Outcome and Benefits

Achievement of the project purpose will create a range of benefits including:

- High quality, effective extended treatment and rehabilitation mental health service options available to consumers that are based on contemporary models of care and take into account the wide geographical spread of Queensland.
- Increased access for adolescent consumers to their families, community and social networks by having greater access to more local mental health services.
- Improved, strengthened inter-sectoral partnerships in delivering adolescent mental health care.
- Value for money in the delivery of care for adolescents requiring extended treatment and rehabilitation mental health care.

1.5 Assumptions

- Key stakeholders will work in partnership to implement this phase of the initiative. The lead governing body for the project will be CHQ HHS, in partnership with WM HHS and the Department of Health.
- Identified funding sources will remain available to the identified adolescent target group and their mental health service needs. The identified funding sources include:
    - BAC operational funding (amount to be defined);
    - $2 million operational funding from the ceased Redlands Adolescent Extended Treatment and Rehabilitation Unit;
    - $1 million operational funding for NGO-delivered services (e.g. Residential Rehabilitation); and
    - Other potential Department of Health funding as defined by Mental Health Alcohol and Other Drugs Branch. This will include temporary 'bridging' funds to support the transition process from the current service model to the newly defined service options.
- The Mental Health Alcohol and Other Drugs Branch will provide project funding of $300,000 to support the temporary appointment of two project officers to CHQ HHS and one project officer to WM HHS.
- The stakeholders of this project will contribute resources (including staff time and content expertise) for the duration of the project.
- Timely approval will be received from the project stakeholders to enable major stages of the project to be implemented as planned.
- The Steering Committee and Working Groups will commit to action tasks both in and out of session to meet defined timelines, and thus support the timely completion of this project and the achievement of outcomes for the consumer group.
- Timeframes associated with this project will align with the timeframes for procurement processes to engage NGO services.

- The transfer of consumers to alternative care options will be underpinned by individual consumer choice and health care needs, and will be supported by the relevant 'home' Hospital and Health Service (HHS).
- Workforce management strategies, to support BAC staff, will be developed and managed by WM HHS.
- The governance of the new service options will be held by CHQ HHS and a model will be defined as a priority.
- The site/s for delivery of any potential bed-based service option will be identified and governance arrangements will be defined as a priority.
- Consideration will be given to all recommendations for service needs that were defined by the ECRG. This will also include consideration of alternative contemporary service options including Intensive Mobile Youth Outreach Services, Day Programs, residential rehabilitation services, and bed-based services.
- Service options identified will be modified (as required) to suit the needs of the target group within a Queensland setting, and will take into account the wide geographical spread of Queensland.
- Service options will broadly align with the draft National Mental Health Service Planning Framework.
- Not all service options within the statewide model that will be proposed will be available by early 2014. However, there is a commitment to ensure there is no gap to service delivery for the adolescent target group.

1.6 Constraints

- There is no capital funding currently identified to build new infrastructure.
- Transfer processes and time frames of operational funding to new service providers and HHSs need to be defined and negotiated.
- Timeframes and imperatives associated with the procurement processes of NGO contracting may be restrictive to timely progress.
- Alternative service options for BAC consumers must be available by early 2014, when The Park transitions to an adult-only forensic and secure mental health facility.
- Service options will align with the following strategic and planning directions:
  1. *National Mental Health Service Planning Framework (under draft)*
  2. *The Blueprint for better healthcare in Queensland* (2013)
     a. Health services focused on patients and people;
     b. Providing Queenslanders with value in health services;
     c. Investing, innovating and planning for the future.
  3. *Queensland Plan for Mental Health (2007-17) (QPMH)*
     a. Integrating and improving the care system;
     b. Participating in the community;
     c. Coordinating care.
  4. *Business Planning Framework: A tool for nursing workload management – Mental Health Addendum*

- Service options will meet in-scope activity based funding classifications as defined by the Independent Hospital Pricing Authority (2013-14), which includes:
    - All admitted activity
    - Crisis assessment and treatment
    - Dual diagnosis
    - Home and community-based eating disorders
    - Mental health hospital avoidance programs
    - Mobile support and treatment
    - Perinatal
    - Step-up step-down
    - Telephone triage
- CYMHS non-admitted activity is currently deemed out-of-scope by Independent Hospital Pricing Authority (2013-14). It should be noted that this may have financial implications for the model of service developed. In the meantime, the Mental Health Alcohol and Other Drugs Branch (MHAODB) are advocating for CYMHS non-admitted activity to be 'in-scope' for Activity Based Funding.
- Queensland has early / developing experience in the delivery of some models being proposed (e.g. models like Y-PARC, Intensive Mobile Youth Outreach Service, residential rehabilitation for adolescent mental health consumers, and other partnership models between the public and non government sectors).

1.7 Dependencies

There are no identified project inter-dependencies identified.

1.8 Project Scope

1.8.1 In-Scope

- End-to-end recovery-oriented adolescent mental health extended treatment and rehabilitation services
- Linkages to other adolescent mental health services that do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)
- Linkages to Adult Mental Health Services in so far as to ensure smooth transition from Adolescent Mental Health Services
- Linkages to primary care service providers in so far as to ensure smooth transition to and from Adolescent Mental Health Services
- Governance and resource arrangements for the statewide adolescent mental health extended treatment and rehabilitation services, including, financial, workforce, and assets.
- The target consumer group is:
  - 13 - 17 years old, with flexibility in upper age limit depending on presenting issue and developmental age (as opposed to chronological age).
  - Severe and persistent mental health problems that may include co-morbid alcohol and other drug problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development.
  - Mental illness is persistent and the consumer is a risk to themselves and/or others.
  - Medium to high level of acuity requiring extended treatment and rehabilitation.

1.8.2 Out of Scope

- Individual consumer clinical treatment plans
- Current BAC facility operations
- Decommissioning of the BAC building
- Any system requirements or enhancements for electronic consumers records
- Implementation of new service options (will occur as a separate project phase)
- Other adolescent mental health services that do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)
- Non-adolescent mental health services
- Primary care service providers and their processes

1.8.3 Scope Changes

Scope changes will be managed under the Project Control approach as per **Section 2.8**.

2 Project Planning

2.1 Project Overview

2.1.1 Related Projects/Activities

Service Planning in Queensland:

- Queensland Plan for Mental Health 2007-17
- CYMHS in Queensland
- CHQ Transition Strategy
- Service Planning Frameworks and Funding Models
- Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.1
- Business Planning Framework: A tool for nursing workload management – Mental Health Addendum

Service Planning in Australia:

- National Mental Health Service Planning Framework

2.2 Key Deliverables

The table below details the key milestones / products / activities to be delivered by the project:

Key Milestone / Product / Task / Activity	Responsible Officer	Completion Date
Project Initiation	Ingrid Adamson	30 August 2013
Project Plan and Communications Strategy	Ingrid Adamson	22 October 2013
BAC Consumer and Staff Engagement Strategy	Leanne Geppert	22 October 2013
SW AETR Service Model	Stephen Stathis	30 November 2013
Governance Model (including financial and workforce requirements) for the SW AETR Service Model	Ingrid Adamson	30 November 2013
Interim consumer clinical care plans (for current BAC and wait list consumers)	Anne Brennan	31 December 2013
Implementation Plan for SW AETR Service Model	Ingrid Adamson	31 January 2014
Mobilisation of Phase Two: Service Options Implementation	Stephen Stathis / Ingrid Adamson	February 2014

2.3 Cost Management

2.3.1 Budget

Direct Labour	Stream/Level	FTEs	Total Cost
CHQ – HSS:			
Project Manager 09/09/13 to 30/06/14 (10 months)	AO8.4	1	$ 120,000
Clinical Director 14/10/13 to 13/12/13 (10 weeks)	MO2.2	0.4	$ 30,000
WM HHS:			
Project Officer 23/09/13 to 30/06/14 (10 months)	AO7	1	$ 100,000
TOTAL			**$ 250,000**
Additional Requirements			**Total Cost**
Communication and media strategies to raise awareness of initiative and promote new service model Room hire and catering expenses for workshops and forums Travel expenses for clinical representation at workshops and forums Travel expenses for interstate MH site visits Other additional administrative overheads			**$ 50,000**
TOTAL PROJECT BUDGET			**$ 300,000**

Source of Funding

- MHAODB has committed to providing temporary project funding to CHQ HHS and WM HHS for 2013/2014.
- Secretariat and Chairing of Steering Committee is the responsibility of CHQ HHS.
- All matters related to the BAC closure is the responsibility of WM HHS

Ongoing Operational Funding:

Operational Funding for new/enhanced service options will be sourced from:

- BAC operational funding (to be defined);
- $1.8 million operational funding from the ceased Redlands Adolescent Extended Treatment and Rehabilitation Unit;
- Operational funding for NGO-delivered services (e.g. Residential Rehabilitation) (to be advised); and
- Other potential Department of Health funding as defined by Mental Health Alcohol and Other Drugs Branch. This will include temporary 'bridging' funds to support the transition process from the current service model to the newly defined service options.

2.3.2 Responsibilities

The table below shows details of the cost management/monitoring activity and who is responsible:

Cost Management Activity	Responsible	When and How
Project expenditure	Project Manager, SW AETRS	Existing cost centre management practice

2.4 Time Management

2.4.1 Schedule

The draft project schedule is shown as a high level Gantt chart at **Appendix A**.

2.4.2 Schedule Changes

Changes will be managed under the Project Controls Approach as per **Section 2.8**.

2.5 Human Resource Management

2.5.1 Resource Plan

The table below contains a list of the human resources required for the project.

Role	FTE	Employee/ Contractor	Name(s) (if known)	From	To
Project Manager	1	Employee	Ingrid Adamson	09/09/13	30/06/14
Project Officer	1	Employee	Laura Johnston	23/09/13	30/06/14
Clinical Director	0.4	Employee	Stephen Stathis	14/10/13	13/12/13

2.6 Risk Management

2.6.1 Overall Assessment of Project Risks

Significant key risks to the project are listed below:

Risk Event & Impact	Rating	Treatment	Owner
Project Performance			
Schedule compliance – timeframes are exceeded	High	• Active monitoring and reporting • Variances reported to SW AETR Steering Committee and escalated to CE DoH Oversight Committee, where required	Project Manager
Scope creep	Medium	• Active monitoring and reporting • Variance reported to SW AETR Steering Committee and escalated to CE DoH Oversight Committee, where required	Project Manager
Insufficient funding	Medium	• Active monitoring and reporting • Variance reported to CE DoH Oversight Committee, where required	Project Manager
Communication gaps between Working Groups, Committees, and other forums	Medium	• Project Manager to act as consistent conduit between all parties • Regular status updates to all parties	Project Manager with CHQ Media and Comms

Risk Event & Impact	Rating	Treatment	Owner
Current Health Service Delivery			
Loss of specialist BAC staff	Medium	• Recruitment of contractors, in the interim, to meet service needs • Enact communication strategies to keep staff, and other stakeholders informed • Develop recruitment strategy for future service options	WM HHS CHQ HHS
Union action in response to employees requiring placement	Medium	• Engage with union and keep informed of workforce strategies	WM HHS
BAC incident resulting from co-location of adult forensic consumers	Medium	• Timely discharge of consumers • Park Campus safety and security measures	WM HHS
Critical incident with an adolescent during transition from BAC facility	Medium	• Appropriate, detailed Consumer Clinical Care Transition Plans	WM HHS and Local HHS
Negative messages given to families and carers	High	• Regular, open, transparent communications with families, carers, and consumers	WM HHS
Future Health Service Delivery			
Poor quality of service options developed	Medium	• Undertake sufficient research to inform service option development, and to instil confidence in the service model • Manage timeframes to allow quality development of service options • Consult with stakeholders to test validity of service model • Pilot service options with current BAC and wait list consumers • Engage with other Departments and organisations to ensure comprehensive service model (e.g. DETE, Child Safety, Housing, headspace, etc.)	CHQ HHS
Low level of support for new service options/service model	High	• Clear communication strategies regarding impact of change and benefits • Training, education and support for staff	CHQ HHS
Absence of capital and growth funding to support services	High	• Utilise existing operational funds • Explore operational expenditure options versus capital intensive options • Advocate for additional funding to support service options	CHQ HHS
Critical incident with an adolescent prior to availability of new or enhanced service options	High	• Appropriate Consumer Clinical Care Plans • Clear communication strategies with service providers regarding the development and rollout of service options • Develop an escalation process for referral of consumers whose needs fall outside of existing service options	Local HHS CHQ HHS

Risk Event & Impact	Rating	Treatment	Owner
Reputational Risk			
Reputational and political implications from any adverse incidents or media	High	• Clear communication strategies regarding impact of change and benefits • Proactive workforce and community engagement • Regular communication to Premier, Minister, and CEs regarding initiative, to keep fully informed of progress and issues	WM HHS and CHQ HHS

Risk severity has been determined using the risk matrix (as per CHQ HHS Risk Management Process).

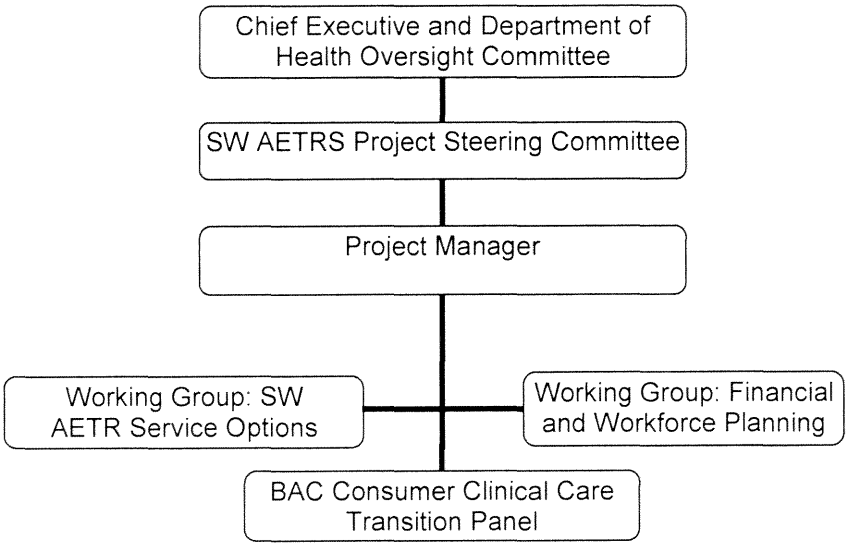
2.6.2 Risk Register

A Risk Register will be maintained to track the identified risks, their severity, and manage their treatment.

2.7 Project Governance and Control

2.7.1 Project Organisation

The diagram below identifies the Project Organisation and the reporting relationships of the Project team:



2.7.2 Roles and Responsibilities

Refer to **Appendix B** for details of the responsibilities of the project positions.

2.8 Project Controls

2.8.1 Reporting

The table below outlines the project reporting to be completed:

Report	Communication	Audience	Frequency
Update Briefs	Prepared by the Project Manager to provide a summary of progress	Project Sponsor Steering Committee CE DoH Oversight Committee CHQ EMT MH Clusters	Fortnightly
Status Report	Prepared by the Project Manager to provide a summary of progress, achievements, issues and risks	Project Sponsor Steering Committee CE DoH Oversight Committee	Monthly
Board Paper	Prepared by the Project Manager to provide a summary of progress, achievements, issues and risks	CHQ Board	Monthly
Project Issue and Change Request	Prepared by the Project Manager when Exception Planning or other action is determined by the key stakeholders	Project Sponsor Steering Committee	As required
Project Completion Report	Prepared by the Project Manager at the end of the project; to include follow-on action recommendations and lessons learned.	Project Sponsor Steering Committee	End of Project

2.8.2 Tolerance

The Project Manager is to report exceptions to the Project Sponsor and Steering Committee if at any time:

a) The forecast project milestone dates will not be met, or

b) The financial expenditure target is likely to vary by +/- 5%.

The following indicates the tolerances for this project as approved by the Project Sponsor:

Tolerances	Project Sponsor	Project Manager
Risk	One risk moves from High to Extreme	One risk moves from High to Extreme
Time	+ or – one week	+ or – one week
Cost	+ or – 5% change in $	+ or – 5% change in $

Tolerances	Project Sponsor	Project Manager
Quality	Less than 90% acceptance criteria met	Less than 90% acceptance criteria met
Customer Expectations	Less than 90% acceptance criteria met	Less than 90% acceptance criteria met

2.9 Communication Management

The Statewide Adolescent Extended Treatment and Rehabilitation Strategy Communications Plan will outline the detail regarding proactive engagement of all relevant stakeholders throughout this initiative. Below is a list of these key stakeholders and their information needs.

2.9.1 Key Internal Stakeholders

Group/Individual	Impact / Influence	Summary of Information Needs
Premier and Minister for Health	Strategic oversight	Progress updates and issue awareness • Briefs • Speaking notes
DDG Health Services and Clinical Innovation	Strategic oversight	Progress updates and issue awareness • Briefs • Status reports
Qld Mental Health Commissioner – Lesley van Schoubroeck	Strategic oversight	• Briefs
CHQ HHS: The Board CE – Peter Steer ED – Deb Miller	Project Sponsor Responsible for: • Governance of the project • Development of the future model of service • Provision of information and support to staff impacted by new service options • Communications and media regarding the future model of service • Achievement of project objectives	Complete visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports
WM HHS: The Board CE – Lesley Dwyer ED – Sharon Kelly	Project Partner Responsible for: • Clinical care for current BAC and wait list consumers • Transition of BAC operational funding • Provision of information and support to BAC staff	Complete visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports

Group/Individual	Impact / Influence	Summary of Information Needs
	• Communications and media regarding BAC • Achievement of project objectives	
Mental Health, Alcohol and Other Drugs Branch ED – Bill Kingswell	Project Partner Responsible for: • Funding for the project and identified service options • Provision of national and state information and data regarding policy and service planning as relevant to the project • Participate in statewide negotiations and decision-making	Visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports
Executive Director, CYMHS - Judi Krause	Steering Committee Co-Chair	Complete visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports
Clinical Director, CYMHS – Stephen Stathis	Steering Committee Co-Chair	Complete visibility of initiative progress, including risks and issues • Project Documentation • Regular communiqués • Status Reports
Other HHSs with acute inpatient units and MHSS	• Service provision to consumers • Participate in discussions and negotiations relevant to the service options being considered • Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs	Awareness and understanding of interim service options during transition period and endorsed future service options, through: • Briefs • Regular communiqués
Mental Health Executive Directors, Clinicians and other staff	• Service provision to consumers • Participate in discussions and negotiations relevant to the service options being considered • Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs	Awareness and understanding of interim service options during transition period and endorsed future service options, through: • Briefs • Regular communiqués
BAC Staff	• Service provision to BAC consumers	Implications of service changes to consumers and own employment • Regular communiqués

2.9.2 Key External Stakeholders

Group/Individual	Impact / Influence	Summary of Information Needs
Department of Employment, Training, and Education	Service provision to consumers Adapt current service delivery to suit new service options identified	Awareness and understanding of interim service options during transition period, and endorsed future service options
Mater Hospital	Service provision to consumers	Awareness and understanding of interim service options during transition period, and endorsed future service options
NGOs	Service provision to consumers Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs	Awareness and understanding of interim service options during transition period, and endorsed future service options
Carer Representatives	Impact on the consumer/s they are representing	Enhanced service delivery options to meet increasing demands
Families	Direct impact on their family	Availability of enhanced mental health care options for their children
Existing and Potential Consumers	Direct personal impact	High quality mental health service options closer to home
Interstate Mental Health Counterparts	Participate in discussions regarding contemporary service options	Contribution sought for service model development Understanding of impact of Qld changes to their MH services, if any
SaveBarrett.org group	Influence on community perception of initiative	Provide clear, informative, transparent messages to reduce negative or speculative information
Media	Influence on community perception of initiative and public image of Qld Health	Provide clear, informative, transparent, positive messages to reduce negative or speculative information
Unions	Influence on QH workforce	Provide clear, informative, transparent, positive messages to reduce negative or speculative information
Opposition Parties	Influence on community perception of initiative and public image of current government	Provide clear, informative, transparent, positive messages to reduce negative or speculative information

Communication and engagement mechanisms include, but are not limited to:

- Committee & Working Group participation
- Information Fact Sheets
- Briefing Notes
- Speaking Notes
- Status Reports
- Face-to-face briefings and presentations
- Phone and email communication
- E-Alerts
- Intranet and Internet web pages
- Media releases and responses
- Community announcements

2.10 Quality Management

2.10.1 Applicable Standards

Standards which apply to deliverables produced by this project, or management of the project, are detailed in the table below:

Project Element	Applicable Standard
Project Management	Queensland Health / Children's Health Queensland (CHQ) Methodology
Risk Management	CHQ Risk Management Framework
Procurement	Qld Government's State Purchasing Policy – (refer to the latest version)

2.10.2 Quality Control Activities

The table below identifies the quality criteria for each major product and the technique for checking its quality:

Deliverable	Quality Criteria	How
Statewide adolescent mental health extended treatment and rehabilitation service model	Evidence-based Sustainable Statewide No gaps in service delivery Conforms with other statewide service plans Conforms with other national or international models	Stakeholder feedback on quality of model
Successful discharge and transition management of all current BAC and waitlist consumers	Individual needs are being met Mental health outcome measures Continuity of service	Consumer/family feedback and clinical outcomes
Service Implementation Plan	Clearly identified timeframes, activities, and stakeholders involved in the delivery of new or enhanced service options	Stakeholder feedback on comprehensiveness of plan
Communication Plan	Awareness of the project Understanding of the outcomes Engagement throughout delivery	Volume and nature of stakeholder feedback

2.10.3 Responsibilities

Responsibilities	Who
Define, implement, and control project quality Ensure that the project products, processes, and deliverables satisfy the requirements of this project plan Examine and escalate, as required, any reported deficiency	Project Manager
Ensure timeliness of each project task (as scheduled in Gantt Chart)	Project Manager

Responsibilities	Who
Ensure the quality of the products and deliverables	Project Sponsor Project Manager
Make critical decisions regarding the project and its product	Project Sponsor
Maintain the Deliverables Register, listing documents, their reviewers and recording that the review has occurred.	Project Manager

3 Project Evaluation

3.1.1 Project Evaluation Methodology (Process and Impact Evaluation)	Timely management of risks, issues, and deliverables Compliance with CHQ project management methodology
3.1.2 Post Implementation Review (PIR) (Outcome Evaluation)	Achievement of project objectives and outcomes: • Consumer, family, and carer feedback reflecting quality, effectiveness, and accessibility of extended treatment and rehabilitation mental health service options. • Service data demonstrating increased local access to extended treatment and rehabilitation mental health services, and demand management across Queensland. • Staff feedback demonstrating improved service provision across Queensland. • Feedback from service providers demonstrating improved, strengthened inter-sectoral partnerships in delivering adolescent mental health care. • Financial assessment demonstrating value for money in the delivery of care for adolescents requiring extended treatment and rehabilitation mental health care.

4 Recommendations (Project Manager)

Next Step	☒ Progress to Implementation* ☐ Cease Comments:		
	Prepared By	Name*:	Ingrid Adamson
		Title*:	Project Manager – SW AETRS
		Work Unit / Site*:	Office of Strategy Management
		Date*:	14/10/13
		Phone Number*:	
		Email*:	
	Prepared and Cleared By	Name*:	Judi Krause
		Title*:	Executive Director
		Work Unit/Site*:	CYMHS
		Phone Number*:	
		Email*:	
		Date*:	14/10/13
		Comments:	
	Prepared and Cleared By	Name*:	Stephen Stathis
		Title*:	Clinical Director
		Work Unit/Site*:	CYMHS
		Phone Number*:	
		Email*:	
		Date*:	14/10/13
		Comments:	

5 Approval by Executive Management Team Member

Name:	Dr Peter Steer
Title:	Health Service Chief Executive, CHQ HHS
Signature:	
Date:	
Comments:	

APPENDIX A: PROJECT GANTT CHART

Under development

APPENDIX B – ROLES AND RESPONSIBILITIES

Role	Responsibilities and Accountabilities
Project Sponsor	• Ultimately responsible and accountable for the delivery of project outcomes • Ensure the purpose of the project is clearly articulated to all stakeholders and aligns with the strategic direction of the organisation/s • Ensure the project's deliverables appropriately reflect the interests of stakeholders • Endorse the selection of a project manager with skills and experience commensurate with the project's strategic significance, cost, complexity and risk • Negotiate membership of and Chair the project Steering Committee to ensure that its composition adequately reflects the interests of key stakeholders • Ensure the project is appropriately and effectively governed • Receive status reports concerning the progress of the project and assist the project accordingly by resolving escalated issues; and • Advocate for the project to ensure the appropriate level of internal and external support and access to resources required to successfully complete it
Steering Committee	The Steering Committee monitors the conduct of the project and provides advice and guidance to the project team and the Project Sponsor. The general responsibilities of the Steering Committee include: • reviewing progress of project to plan and major project deliverables; • reviewing financial status of project (actual to budget) and monitoring the continued applicability of project benefits; • reviewing issues raised and agreeing action plans for their resolution; • understanding and advising the risks of the project raised with the Committee; • understanding and providing advice for the management of the dependencies of this project with other projects; Specific responsibilities of the Steering Committee are to: • Review key deliverables of the Working Group and Reference Group prior to approval by Project Sponsor. • Inform decision making regarding changes to the project and provide oversight to the change control process (e.g. system changes, schedule alterations, budget). • Provide expert advice to the Project Sponsor on the communication plan, training strategy and implementation timetable. • Facilitate communication to a wide variety of stakeholders in

Role	Responsibilities and Accountabilities
	relation to the development and implementation of the Clinical Consumables service model. • Provide advice and facilitate consumer engagement • Provide expert advice to the Project Sponsor on the scope and planning for the development and implementation project.
Chief Executive CHQ HHS	The Chief Executive's role is: • Receive regular information about the project from weekly status reports and project documentation. • Be a point of escalation for issues and risks that have broad implications for the HSD and cannot be resolved by the Project Sponsor.
Working Group	The purpose of the Working Group (WG) is to: • Support the Project Manager to meet her/his responsibilities by undertaking specific project activities to inform, develop and implement the plan. • Set an example of high functioning team behaviours and a culture of performance through the effective conduct and management of committee functions and member interactions. The function of the WG is: • Under the guidance of the Project Manager, research, develop and implement specific elements of an effective outcome; • Provide specific advice to the Steering Committee as required; • Raise issues requiring resolution with the Project Manager as soon as they arise, and assist in their resolution; • Raise new risks as they arise with the Project Manager, and assist in their mitigation; • Ensure individual members of the working group are tracking the progress of their assigned deliverables and raise any slippage encountered with the Project Manager as soon as identified; and, • Work co-operatively with all project team members.
Project Manager	• Manage project tasks, resources, risks/issues and services for the successful delivery of the project objectives and outcomes. • Manage the implementation of the project using contemporary change management principles and practices. • Consult and collaborates with and works proactively with staff, community, Family Advisory Council and other key stakeholders. • Complete or contribute to project deliverables and project reports • Secretariat and organiser for Steering Committee, and other Groups, as required.

Terms of Reference

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

1. Purpose and Functions

The purpose of the Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee (Governance Committee) is to:

- Develop a pilot service model of residential rehabilitation for young people (16 – 18 years) with mental health problems that may benefit from extended mental health treatment care in a community setting.
- Contribute as relevant to the preparation of a contractual service agreement between service partners of YPETRI House.
- Provide strategic and operational governance for the ongoing delivery of services through YPETRI House, during the pilot period from February to December 2014, to ensure that milestones and key deliverables of the initiative are met in the required timeframes, and that all accountabilities are fulfilled.
- Establish a multidisciplinary Referral Panel that will receive and triage statewide referrals into YPETRI House.
- Provide governance to the risk management process and associated mitigation strategies of the pilot initiative, and escalate in a timely manner to the Adolescent Mental Health Extended Treatment Initiative (AMHETI) Steering Committee and/or Chief Executives of Children's Health Queensland and Aftercare.
- Prepare and provide update reports to the to the AMHETI Steering Committee and the Chief Executives of Children's Health Queensland and Aftercare, as required.
- Provide an escalation point for the resolution of issues and barriers associated with the delivery of quality services by YPETRI House.
- Prepare an evaluation of the pilot program following its conclusion in December 2014.

2. Guiding principles

- The *Health Services Act 1991*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Authority

Committee members are individually accountable for their delegated responsibility and collectively responsible to contribute to advice provided by the Committee to the Chair in the interests of a whole-of-service position.

The Committee will endorse all key deliverables for approval by the Chief Executives of Children's Health Queensland and Aftercare.

Decision Making:

- Recommendations of the Governance Committee will be by majority and will be made in writing to the AMHETI Steering Committee.
- If there is no group consensus in relation to critical matters, the co-Chairs will jointly escalate the issue/s to the AMHETI Steering Committee and/or Chief Executives of Children's Health Queensland and Aftercare (whichever is appropriate to the issue at hand).
- Decisions (and required actions) will be recorded in the minutes of each meeting.

4. Frequency of meetings

Meetings will be held fortnightly on Thursday from 3.30pm for one hour duration unless otherwise advised.

In addition, the Chair may call additional meetings as necessary to address any matters referred to the committee or in respect of matters the committee wishes to pursue within its Term of Reference.

Attendance can be in-person or via teleconference.

The Governance Committee is life limited for the duration of the pilot of YPETRI House until December 2014. The Chair will advise the Committee members approximately one month prior to the dissolution of the Governance Committee.

5. Membership

Medical Director	CYMHS, CHQ HHS	Co Chair
National Operations Manager	Aftercare	Co Chair
Project Manager	AMHETI, CHQ HHS	Member
Service Manager	Aftercare	Member
A/Director of Strategy	MHSS, West Moreton HHS	Member
A/Director	Planning and Partnership Unit, MHAOD Branch	Member

Membership will take into account issues associated with confidentiality and conflicts of interest (including contestability).

Chair:
The Committee will be co-chaired by the Medical Director of CYMHS CHQ and the National Operations Manager of Aftercare (or their delegate). The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Each Chair will hold their seat for two quarters of the 12 month period – January, February, March (Aftercare) / April, May, June (CHQ HHS) / July, August, September (Aftercare) / October, November, December (CHQ HHS).

Secretariat:
The Secretariat will be provided by CHQ, who will facilitate the provision of the:

- Venue
- Agenda
- Minutes of previous meetings
- Briefs for any agenda items that require endorsement by the Chair three (3) working days prior to the meeting.

Proxies:
Proxies are not accepted for this Governance Committee, unless special circumstances apply and specific approval is given for each occasion by the Chair.

Other Participants:
The Chair may request external parties to attend a meeting of the committee. However, such persons do not assume membership or participate in any decision-making processes of the committee.

6. Quorum

The quorum will be half the number of official committee members plus one.

7. Reporting

The Governance Committee provides the following:

- Reports (verbal and/or written) to the AMHETI Steering Committee and/or the Chief Executives of Children's Health Queensland and Aftercare, as required.

8. Performance and Reporting

Performance will be determined by the purpose and functions of this TOR being met within the required timeframes.

The Secretariat will coordinate the endorsement of status reports and other related advice to be provided to the AMHETI Steering Committee and to the Chief Executives of Children's Health Queensland and Aftercare, as required.

Members are expected to respond to out-of-session invitations to comment on reports and other advice within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

Members must acknowledge and act accordingly in their responsibility to maintain confidentiality of all information that is not in the public domain.

Document history

Version	Date	Author	Nature of amendment
1.0	02/12/13	Senior Project Officer, MHSS, West Moreton HHS	Initial Draft
1.1	14/01/14	Senior Project Officer, MHSS, West Moreton HHS	Incorporated initial feedback
1.2	31/01/14	Senior Project Officer, MHSS, West Moreton HHS	Incorporated feedback
1.3	09/03/14	A/Director of Strategy, MHSS, West Moreton HHS	Transferred to CHQ template. Reflected changes in Committee roles and responsibilities, and establishment of Referral Panel.
Final	11/03/14	Secretariat, YPETRI Governance Committee	Finalisation of feedback.

Previous versions should be recorded and available for audit.

Terms of Reference: Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

"BB"

Agenda

Meeting Details

Thursday 9 January 3.30pm – 4.30pm
Conference Room
Administration Building
The Park

Teleconference Details

Attendance

Ivan Frkovic, National Operations Manager, Aftercare

Myf Pitcher, Service Manager, Aftercare

Ingrid Adamson, Project Manager, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy, Children's Health Queensland, Hospital and Health Service (HHS)

Elisabeth Hoehn, Program Director, Future Families, Children's Health Queensland, HHS

Judi Krause, Executive Director, Child and Youth Mental Health Service, Children's Health Queensland, HHS

Stephen Stathis, Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland, HHS

Vanessa Clayworth, A/Clinical Nurse Consultant, Barrett Adolescent Centre, West Moreton HHS

Michelle Giles, Director, Allied Health and Community Mental Health Community Programs, West Moreton HHS

Leanne Geppert, A/Executive Director, Mental Health and Specialised Services (MH&SS), West Moreton HHS (Chair)

Laura Johnson, Principal Project Officer, MH&SS, West Moreton HHS

Apologies

Marie Kelly, A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch

Alex Bryce, A/NUM, Barrett Adolescent Centre, West Moreton HHS

ITEM NO.	DISCUSSION ITEM	RESPONSIBILITY
1	Welcome and overview of Steering Committee	Leanne Geppert
2	Update from West Moreton HHS	Leanne Geppert
3	Update from Aftercare	Ivan Frkovic
4	Aftercare Budget	Ivan Frkovic
5	Service Agreement	Leanne Geppert
6	General business	Leanne Geppert

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Meeting Details

Day and Date Thursday 9 January 2014

1. Attendees

Name	Position
Leanne Geppert (LG)	A/Executive Director, Mental Health and Specialised Services, West Moreton Hospital and Health Service (HHS) (Chair)
Terry Steadman	Clinical Director, Mental Health and Specialised Services, West Moreton HHS
Michelle Giles (MG)	Director, Allied Health and Community Mental Health Community Programs, West Moreton HHS
Ivan Frkovic (IF)	National Operations Manager, Aftercare
Myf Pitcher (MP)	Program Manager, Aftercare
Stephen Stathis (SS)	Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland (CHQ), HHS
Elisabeth Hoehn	Program Director, Child and Youth Mental Health Service, CHQ, HHS
Judi Krause	Divisional Director, Child and Youth Mental Health Service, CHQ, HHS
Ingrid Adamson (IA)	Project Manager, SW AETR, CHQ HHS
Stuart Cowper	Director Management Accounting, Financial Services, CHQ, HHS
Kristen Breed	A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
Karissa Maxwell	Principal Project Officer, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
Bernice Holland (BH)	Administration Support Officer, Mental Health and Specialised Services, West Moreton HHS
Laura Johnson (LJ)	Project Officer, Mental Health and Specialised Services, West Moreton HHS

2. Apologies

Marie Kelly (MK)	A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
Vanessa Clayworth (VC)	A/CNC, BAC, West Moreton HHS
Alex Bryce (AB)	A/NUM, Barrett Adolescent Centre (BAC), West Moreton HHS

3. Discussion Action Registry

	Item	Discussion and Follow Up	By Whom	By When
1	Welcome	Apologies noted above. Aftercare will chair the next meeting. Please note invited guests attending to discuss Aftercare budget.		

2	Update from West Moreton HHS	Young people have returned from Christmas break. Holiday program ongoing. No major challenges. The holiday program will finish on 24 January 2014. The closure of the Barrett Adolescent Centre building is on schedule for the end of January. Team is currently finalising transition plans and seeking alternative options for the remaining inpatients.	LJ/LG	
3	Update from Aftercare	The Holiday Program was quieter over the Christmas and New Year period due to young people being on leave. This week has been very busy. The Holiday Program contracts have been signed off by the young people. Average attendance at the Holiday Program is between five and seven young people. [redacted] Costs for the Holiday Program to be sent to CHQ. Currently in the process of recruiting to the positions. Are seeking nominations from CHQ and West Moreton for representatives. Details of representatives to be provided to Aftercare as soon as possible. Have a received a good calibre of applicants for the positions. Draft model of service has been circulated to the group. Feedback to be provided in tracked changes to IF by COB Wednesday 15 January 2014.	IF/MP IF	16/1/14
4	Aftercare Budget	The budget for the residential and life skills programs was tabled by Aftercare. The budget has been based on the Time Out Housing Initiative in Cairns. Discussion was held on several items. The budget has been updated including leasing items instead of purchasing. CHQ are seeking further clarity and will send questions to Aftercare.		
5	Service Agreement	The Service Agreement has been drafted and is currently being finalised. Need to follow up with Funding and Contract Management Unit about separate agreement for Holiday Program. LG suggested that a possible option could be for West Moreton to fund the Holiday Program. LG will follow up with SS about this.	LJ	16/1/14

6	General Business	Nil.		

Next meeting: Thursday 16 January 2014

Terms of Reference: Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Agenda

Meeting Details

Wednesday 15 January 3.30pm – 4.30pm (Site visit from 2.30pm at 38 Vine Street, Greenslopes)
*Meeting will be held at coffee shop

Attendance

Ivan Frkovic, National Operations Manager, Aftercare (Chair)

Myf Pitcher, Service Manager, Aftercare

Ingrid Adamson, Project Manager, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy, Children's Health Queensland, Hospital and Health Service (HHS)

Elisabeth Hoehn, A/Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland, HHS

Judi Krause, Executive Director, Child and Youth Mental Health Service, Children's Health Queensland, HHS

Michelle Giles, Director, Allied Health and Community Mental Health Community Programs, West Moreton HHS

Leanne Geppert, A/Executive Director, Mental Health and Specialised Services (MH&SS), West Moreton HHS (Chair)

Laura Johnson, Principal Project Officer, MH&SS, West Moreton HHS (Secretariat)

Apologies

Marie Kelly, A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch

Stephen Stathis, Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland, HHS

Kristen Breed, A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch

ITEM NO.	DISCUSSION ITEM	RESPONSIBILITY
1	Welcome and apologies	Leanne Geppert
2	Update from West Moreton HHS	Leanne Geppert
3	Update from Aftercare – Feedback on MOS	Ivan Frkovic/ Myf Pitcher
4	Service Agreement	CHQ/West Moreton
5	General business - Updated Terms of Reference	Leanne Geppert Laura Johnson

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Meeting Details

Day and Date Wednesday 15 January 2014

1. Attendees

Name	Position
Leanne Geppert (LG)	A/Executive Director, Mental Health and Specialised Services, West Moreton Hospital and Health Service (HHS) (Chair)
Ivan Frkovic (IF)	National Operations Manager, Aftercare
Myf Pitcher (MP)	Program Manager, Aftercare
Judi Krause (JK)	Divisional Director, Child and Youth Mental Health Service, CHQ, HHS
Ingrid Adamson (IA)	Project Manager, SW AETR, CHQ HHS
Laura Johnson (LJ)	Project Officer, Mental Health and Specialised Services, West Moreton HHS

2. Apologies

Marie Kelly (MK)	A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
Stephen Stathis (SS)	Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland (CHQ), HHS
Elisabeth Hoehn	Program Director, Child and Youth Mental Health Service, CHQ, HHS
Kristen Breed	A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
Michelle Giles (MG)	Director, Allied Health and Community Mental Health Community Programs, West Moreton HHS

3. Discussion Action Registry

	Item	Discussion and Follow Up	By Whom	By When
1	Welcome	Apologies noted above.		
2	Update from West Moreton (WM) HHS	Holiday Program ends next Thursday 23 January 2014. No change since last week. Payment for Holiday Program being progressed by WM.	LJ/LG	
3	Update from Aftercare -Draft Model of Service	Discussion on length of stay at Greenslopes. The draft model of service indicates a three month stay, some debate over whether this should be longer, concerns raised over through put of service. Case workers will be planning exit with young person on their entry to the service. Discussion on young people paying a	IF/MP	

	Item	Discussion and Follow Up	By Whom	By When
		proportion of their Centrelink benefits during stay, as this will also teach budgeting and cost of living. Aftercare looking at putting contributions into a trust account and then the funds are given back to the young people at end of stay. Discussed importance of engaging families/carers, including a monthly review. Some brokerage funds may be available for when a young people leaves the service eg. Engaging local service to provide support for up to three months. Discussed referral process including the establishment of a statewide panel, needs to be included in the model of service. The Holiday Program attendance over the last two weeks has been good. Looking at having a Goodbye Party on Thursday 23 January 2014 with pizza making. Will provide a summary report including lessons learnt and benefits.		
4	Service Agreement	Currently being finalised by CHQ. Aftercare and CHQ negotiating final budget. Need to also ensure that evaluation is included.		
5	General Business - Updated Terms of Reference	The Terms of Reference have been endorsed by the Statewide Adolescent Extended Treatment Rehabilitation Steering Committee. There were some minor changes to the membership. LJ to send updated Terms of Reference to IA.	LJ	16/1/14

Next meeting: Thursday 23 January 2014

Terms of Reference: Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Agenda

Meeting Details

Thursday 23 January 3.30pm – 4.30pm
Conference Room
Administration Building
The Park

Teleconference Details

Attendance

Ivan Frkovic, National Operations Manager, Aftercare (Chair)

Myf Pitcher, Service Manager, Aftercare

Ingrid Adamson, Project Manager, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy, Children's Health Queensland, Hospital and Health Service (HHS)

Elisabeth Hoehn, A/Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland, HHS

Judi Krause, Executive Director, Child and Youth Mental Health Service, Children's Health Queensland, HHS

Kristen Breed, A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch

Michelle Giles, Director, Allied Health and Community Mental Health Community Programs, West Moreton HHS

Laura Johnson, Principal Project Officer, MH&SS, West Moreton HHS (Secretariat)

Apologies

Marie Kelly, A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch

Stephen Stathis, Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland, HHS

Leanne Geppert, A/Executive Director, Mental Health and Specialised Services (MH&SS), West Moreton HHS

ITEM NO.	DISCUSSION ITEM	RESPONSIBILITY
1	Welcome and apologies	Ivan Frkovic
2	Update from West Moreton HHS	Laura Johnson
3	Update from CHQ HHS	Ingrid Adamson
4	Update from Aftercare – Feedback on MOS	Ivan Frkovic/ Myf Pitcher
5	Service Agreement	CHQ/West Moreton
6	General business	Ivan Frkovic

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Minutes / Actions – Unconfirmed

Meeting Details

Day and Date Thursday 23 January 2014

1. Attendees

Name	Position
Kristen Breed (KB)	A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
Emma Foreman (EF)	Principal Project Officer
Myf Pitcher (MP)	Program Manager, Aftercare
Ingrid Adamson (IA)	Project Manager, SW AETR, CHQ HHS
Laura Johnson (LJ)	Project Officer, Mental Health and Specialised Services, West Moreton HHS
Bernice Holland (BH)	Project Support Officer, Mental Health and Specialised Services, West Moreton HHS
Judi Krause (JK)	Divisional Director, Child and Youth Mental Health Service, CHQ, HHS

2. Apologies

Stephen Stathis (SS)	Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland (CHQ), HHS
Elisabeth Hoehn (EH)	Program Director, Child and Youth Mental Health Service, CHQ, HHS
Michelle Giles (MG)	Director, Allied Health and Community Mental Health Community Programs, West Moreton HHS
Leanne Geppert (LG)	A/Executive Director, Mental Health and Specialised Services, West Moreton Hospital and Health Service (HHS)
Ivan Frkovic (IF)	National Operations Manager, Aftercare (Chair)

3. Discussion Action Registry

	Item	Discussion and Follow Up	By Whom	By When
1	Welcome	Apologies noted above. IF made several attempts to dial in without success. Apology noted and LJ chaired meeting.		
2	Update from West Moreton (WM) HHS	Last week of HDP Business as usual.		
3	Update from CHQ HHS	Budget with Oversight Committee for consideration. Awaiting feedback regarding SLA.		
4	Update from Aftercare - Feedback on MOS	Week has been "up & down" due to transfer of inpatients. 3-4 young people have participated in HDP but have been difficult to motivate. Staff apathy has made the week challenging. Residential –		

		Set up is going ahead with recruitment back on track. Interviews being held Thurs 30 Jan & Mon 3 Feb. Establishment funding has been approved. Beds have been purchased for the house and various trade works have happened. Day Program – MP & IF to speak with JK & IA re: comments on MOS delivery. Day Program to now be known as Lifestyle Program to fall in line with reference made by CHQ.	MP, IF, JK & IA	By 06/02/14
5	Service Agreement	Currently being finalised. MHAOD Branch to review and provide feedback after Aus Day long weekend. Comments will then be forwarded to Aftercare.	MHAOD	By 31/1/14
6	General Business	Referral pathways into Residential to be discussed. Process needs to be finalised before contact can be made with young people or their families. All parties confirmed that no young people or their families have been contacted in regards to transitioning to the Residential program.		

Next meeting: Thursday 06 February 2014

Meeting Agenda

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Date:	22nd May 2014
Time:	4:15pm – 5pm
Venue:	Teleconference
Video/ Teleconference Details:	

Chair:	Ivan Frkovic	National Operations Manager, Aftercare
Secretariat:	Ingrid Adamson	Project Manager, AMHETI, CHQ HHS
Attendees:	Myf Pitcher	Program Manager, Life Skills Program, Aftercare
	Leanne Geppert	A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS
	Marie Kelly	A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
	Emma Foreman	Principal Project Officer, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
	Judi Krause	Divisional Director, CYMHS, CHQ HHS
Apologies:	Stephen Stathis	Clinical Director, CYMHS, CHQ HHS
Guests:	Susan Hunt	Project Officer, AMHETI, CHQ HHS

Item no	Item	Action Officer
1.	**Presentations**	
1.1	Nil	
2.	**Meeting Opening**	
2.1	Welcome and Apologies	Chair
2.2	Statement of Conflict/Interest	Chair
2.3	Confirmation of Minutes from the previous meeting *(attached)*	Chair
3.0	**Business**	
3.1	Business Arising from Previous Meetings	
	• Terms of Reference for Referral Pathway – feedback	IA
	• Update re Aftercare access to CIMHA	IA
	• Update on TOHI approach aligning to YPETRI (if any)	IF/MK
	• YPETRI Communication Strategy Update	MK
	• Age group extension	All
4.0	**Matters for Discussion**	
4.1	•	
5.0	**Matters for Noting**	
5.1	•	
6.0	**Standard Agenda Items**	
6.1	Update from CHQ HHS	SS
6.2	Update from Aftercare	IF/MP
	• Current consumer update	
	• Referrals for YPETRI House	
6.3	General Business	All
7.0	**For Information**	
7.1		

Next Meeting

Date: Thursday 5th June 2014

Time: 3.30pm to 4.30pm

Venue: Teleconference

Actions

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Date:	22/05/2014	Time:	4:15pm	Venue:	Teleconference

Chair:	Ivan Frkovic, National Operations Manager, Aftercare
Secretariat:	Ingrid Adamson, Project Manager, AMHETI, CHQ HHS
Attendees:	Myf Pitcher, Program Manager, Life Skills Program, Aftercare Leanne Geppert, A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS Emma Foreman, Principal Project Officer, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch Judi Krause, Divisional Director, CYMHS, CHQ HHS
Apologies:	Stephen Stathis, Clinical Director, CYMHS, CHQ HHS Marie Kelly, A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
Guests:	Susan Hunt, Project Officer, AMHETI, CHQ HHS

Item No	Topic	Action	Comm'ee member	Due date
1.	**Presentations**			
	Nil			
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Confirmed	EF, MP	
3.	**Business**			
	Business Arising from Previous Meetings			
3.1	• Terms of Reference for Referral Pathway – IF raised concerns regarding workload over time. IA confirmed that delegates/proxies are possible under the protocol. Committee endorsed the protocol. • Update on CIMHA Access – CIMHA team were receptive to granting access to other service providers however the issue is that providers can access ALL consumer information. It is not currently possible to restrict providers to existing consumers without significant system changes. • The Novell team also declined a generic Novell login for Aftercare. • The matter of external providers accessing Qld Health systems has gone to senior Executives with the potential for this to be raised with Parliament toward the end of the year. • IA commented that even if Novell access could be granted, CIMHA access still remains an issue. IA queried whether there were enough numbers across mental health providers, both adult and youth, to generate ground swell for change. • LG enquired into a workaround in the meantime. MP advised that CYMHS case managers receive	Load Referral Protocol onto QHEPS for staff to access.	IA	05/06

Item No	Topic	Action	Comm'ee member	Due date
	regular updates via email from YPETRI staff. CYMHS clinicians are however reluctant to re-write information for returning to YPETRI staff.			
	• LG raised the potential of developing a brief seeking provider access to CIMHA. It was noted that MHAODB might be the best place for this to come from. EF is going to enquire as to whether this could be progressed by MHAODB. At the same time, EF will enquire as to how adult mental health providers receive case information from clinicians.	Enquire about a brief for provider access to CIMHA. Enquire into Adult MH approach to clinical information for providers	EF EF	05/06 05/06
	• Update on TOHI – IF advised that this is on hold until the agreement extension has been finalised. There is general support for alignment however it will require a further review of model of care and staffing profiles for this. • Update on YPETRI Communication Strategy – MP noted that information was not making it to workers on the ground. SS advised he would send an email to CYMHS teams telling them about the service. SS also encouraged MP to approach CYMHS teams and units. • MP has spoken with the RBWH adolescent unit and West Moreton CYMHS; and from next week planned to speak with Nundah, Caboolture, and Bayside CYMHS.			
	• Discussion was had about the information being shared. It was agreed the Referral Protocol should be provided to CYMHS staff. For clarity, it would be good if they could access this from QHEPS where they will also find information about the continuum of adolescent mental health services.	Send link to Referral Protocol to MP	IA	05/06
	• It was agreed the Model of Service should also be made available. EF will enquire as to whether there are any issues in making the draft MOS available on the CHQ site. • JK asked MP hold off on approaching CHQ CYMHS at this stage in light of all the other workplace changes currently in place. JK invited MP to speak with CYMHS managers in the first instance. • Continued discussion regarding age group extension. SS asked MP to proactively approach teams and, if no major take up by the end of May, to then increase the age range of the cohort. IA raised concern that this would step outside the scope of the pilot and that time is needed to generate awareness. Questioned whether end of May is appropriate at this time. EF noted that the age range was an issue when piloting the TOHI and it eventually will need to be addressed. • MP noted that she has had enquiries about taking 15 ½ year olds rather than youths from the upper age range. Committee agreed this could be a cohort to look at for YPETRI in the first instance.	MHAODB to determine if MOS can be put up on CHQ site.	EF	05/06

Item No	Topic	Action	Comm'ee member	Due date
4.	**Matters for Discussion**			
4.1	• Nil			
5.	**Matters for Noting**			
5.1	• Nil			
6.	**Standard Agenda Items**			
6.1	**Update from CHQ HHS** • Nil update from CHQ			
6.2				
6.3	**General Business** • Evaluation Update - SH advised that she met with IF and MP and they have agreed to leverage the TOHI evaluation approach for YPETRI. SH has also commenced work on the ethics approval process. A draft document will be circulated in the near future with further discussion at the next meeting. • IA raised SH's membership on the panel, noting potential for conflict of interest if SH's role includes evaluating the services. Committee to consider SH's role on panel and whether it is as formal member or guest.	Consider SH's role for decision at next meeting.	Committee	05/06
7.	**For Information**			
7.1				
Next meeting: Thursday 5th June 2014, 3:30pm – 4.30pm				

Meeting Agenda

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Date:	5th June 2014
Time:	3.30pm – 4.30pm
Venue:	Teleconference
Video/ Teleconference Details:	

Chair:	Stephen Stathis	Clinical Director, CYMHS, CHQ HHS
Secretariat:	Ingrid Adamson	Project Manager, AMHETI, CHQ HHS
Attendees:	Judi Krause	Divisional Director, CYMHS, CHQ HHS
	Myf Pitcher	Program Manager, Life Skills Program, Aftercare
	Marie Kelly	A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
	Emma Foreman	Principal Project Officer, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch
Apologies:	Ivan Frkovic	National Operations Manager, Aftercare
	Leanne Geppert	A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS
Guests:	Susan Hunt	Project Officer, AMHETI, CHQ HHS

Item no	Item	Action Officer
1.	**Presentations**	
1.1	Nil	
2.	**Meeting Opening**	
2.1	Welcome and Apologies	Chair
2.2	Statement of Conflict/Interest	Chair
2.3	Confirmation of Minutes from the previous meeting *(attached)*	Chair
3.0	**Business**	
3.1	Business Arising from Previous Meetings	
	• Update re Aftercare access to CIMHA and workaround	EF
	• SH's participation as a member of the Governance Committee (or Guest)	Chair
4.0	**Matters for Discussion**	
4.1	• Nil	
5.0	**Matters for Noting**	
5.1	• Nil	
6.0	**Standard Agenda Items**	
6.1	Update from CHQ HHS	SS
	• Evaluation Update	SH
6.2	Update from Aftercare	IF/MP
	• Current consumer update	
	• Referrals for YPETRI House	
6.3	General Business	All
	• Face to Face Governance Meeting at YPETRI House (on Ivan's return)	
7.0	**For Information**	
7.1		
	Next Meeting	

Date: Thursday 12th June 2014
Time: 3.30pm to 4.30pm
Venue: Teleconference

Actions

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

Date: 05/06/2014 **Time:** 3:30pm **Venue:** Teleconference

Chair:	Stephen Stathis, Clinical Director, CYMHS, CHQ HHS
Secretariat:	Ingrid Adamson, Project Manager, AMHETI, CHQ HHS
Attendees:	Myf Pitcher, Program Manager, Life Skills Program, Aftercare Marie Kelly, A/Director, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch Emma Foreman, Principal Project Officer, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch Judi Krause, Divisional Director, CYMHS, CHQ HHS
Apologies:	Ivan Frkovic, National Operations Manager, Aftercare Leanne Geppert, A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS
Guests:	Susan Hunt, Project Officer, AMHETI, CHQ HHS

Item No	Topic	Action	Comm'ee member	Due date
1.	**Presentations**			
	Nil			
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Confirmed	EF, MP	
3.	**Business**			
	Business Arising from Previous Meetings			
3.1	• Update on CIMHA Access and workaround – EF has talked to CIMHA team, who are looking at access for Partners in Recovery and seeking legal advice. No feedback as yet but will keep pursuing this. In the interim, MP advised they will continue using separate systems involving hard copy information. • MK raised whether we should look at services outside mental health to see how information is exchanged. SH mentioned Dept. of Corrections are in this situation and also follow a hard copy information approach. • Discussed SH's participation on governance committee – MP and IF feel that there would be more objectivity from non-participation. SS proposed guest status. • EF and MK raised that the YPETRI evaluation could form part of a larger evaluation across all of the AMHETI services. SH confirmed that this was the current approach being progressed. • Committee resolved SH would participate as a guest.			

Item No	Topic	Action	Comm'ee member	Due date
4.	**Matters for Discussion**			
4.1	• Nil			
5.	**Matters for Noting**			
5.1	• Nil			
6.	**Standard Agenda Items**			
6.1	**Update from CHQ HHS** • Nil			
6.2	[redacted]	[redacted]	MP	19/06
6.3	**General Business** • SS raised that a face to face meeting be held when IF is back from leave. Have asked MP to email with some proposed dates and times when it might be suitable to hold the meeting at YPETRI House.	Circulate a date/time for future face to face meeting at YPETRI House	MP	19/06
7.	**For Information**			
7.1	• TOHI initiative – approval has come through to extend the agreement. MK confirmed that the initiative will only continue if it links in with AMHETI. MHAODB will organise a meeting to discuss alignment in collaboration with Aftercare and CHQ.			
Next meeting: Thursday 19th June 2014, 3:30pm – 4pm				