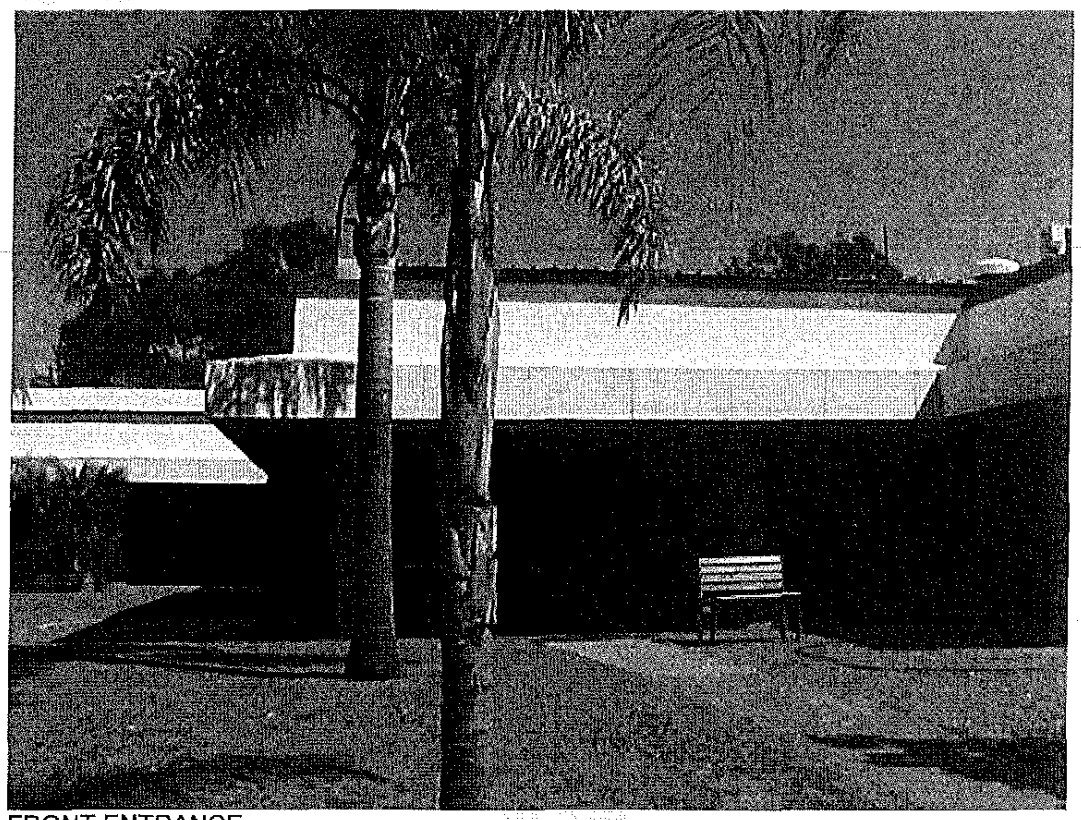
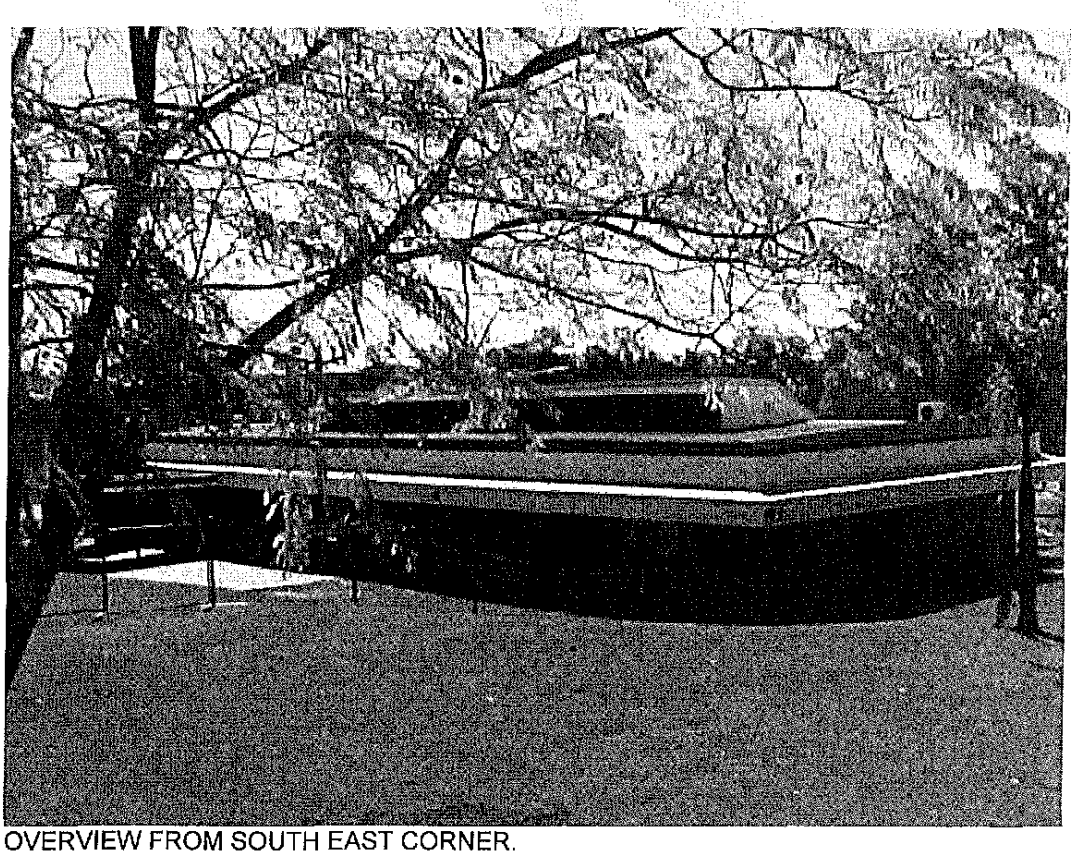
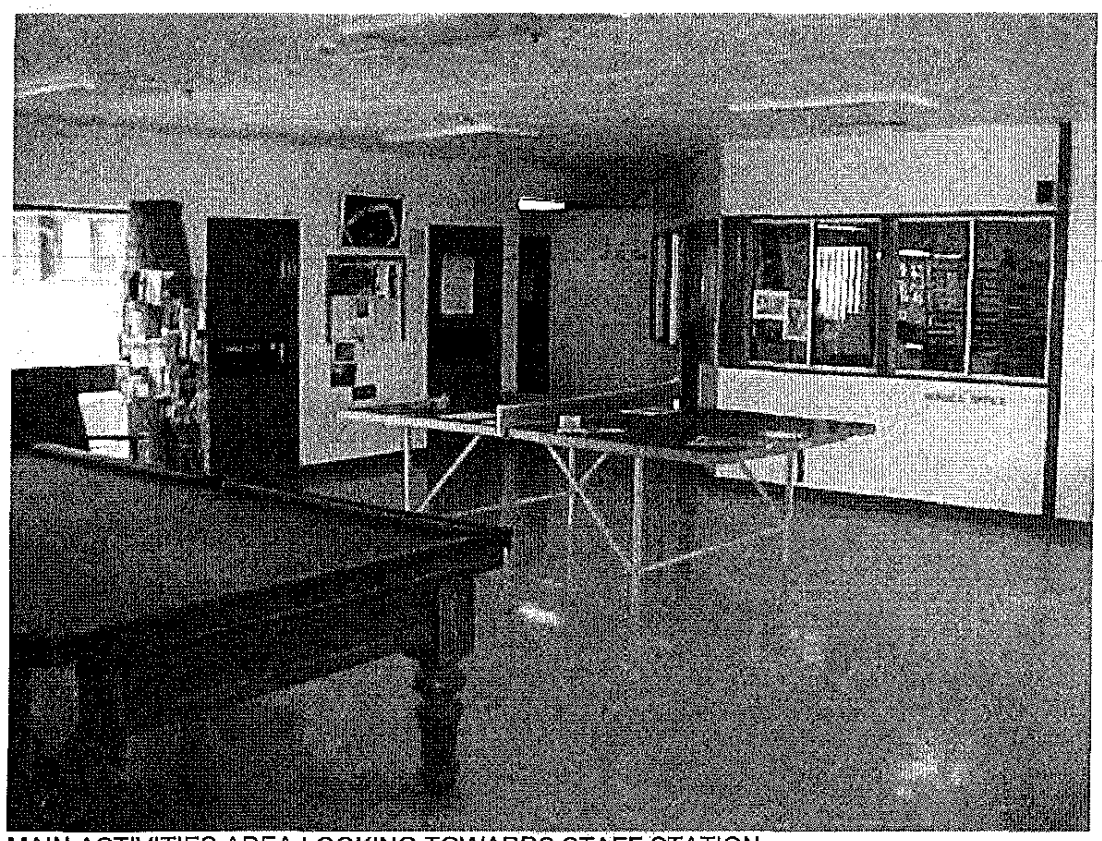


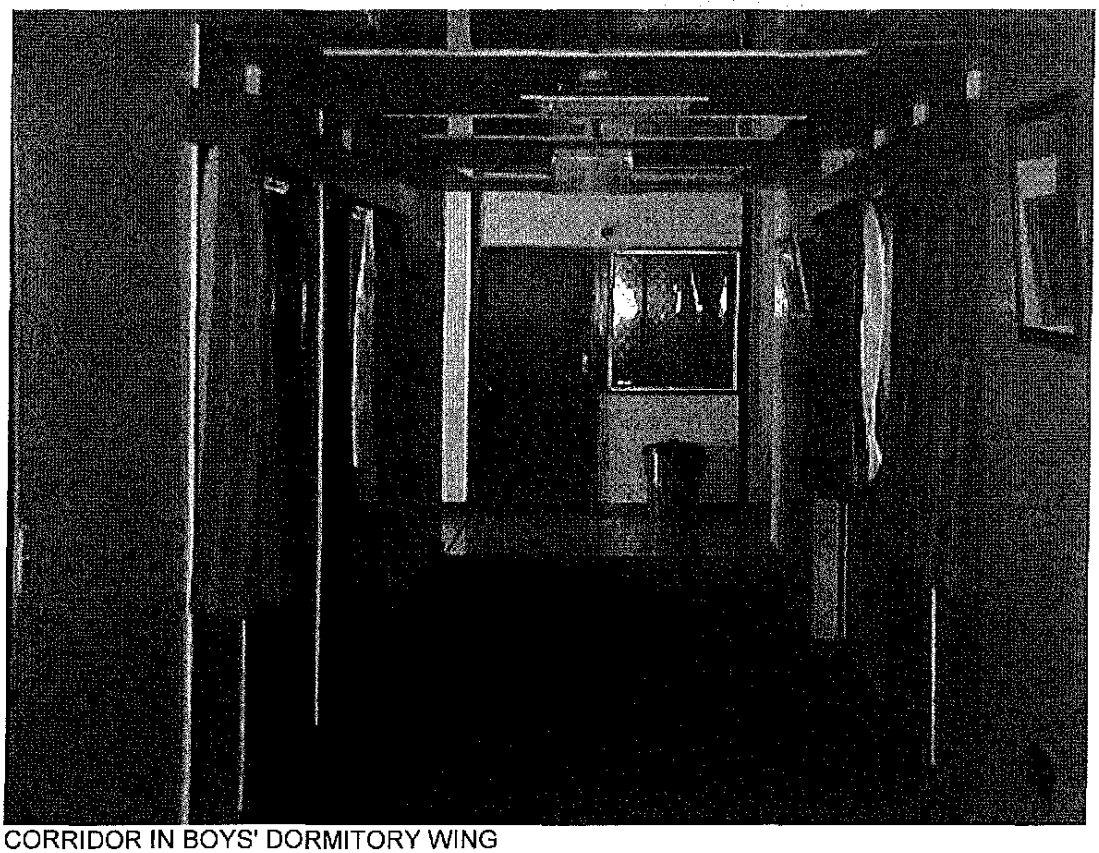
FRONT ENTRANCE.



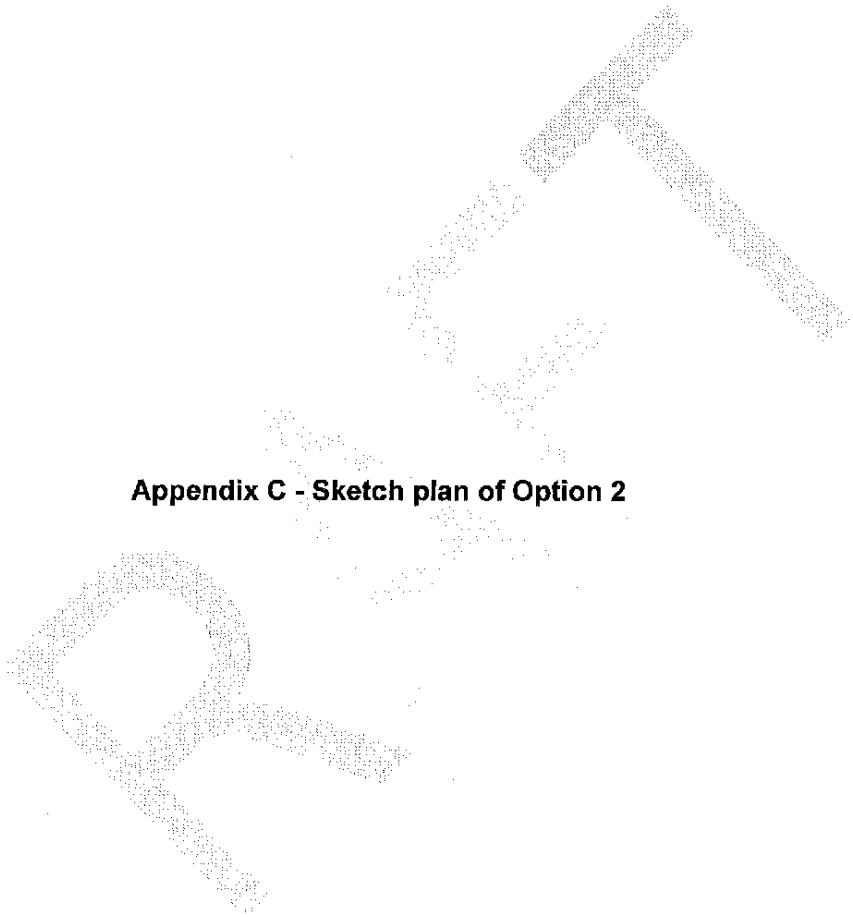
OVERVIEW FROM SOUTH EAST CORNER.



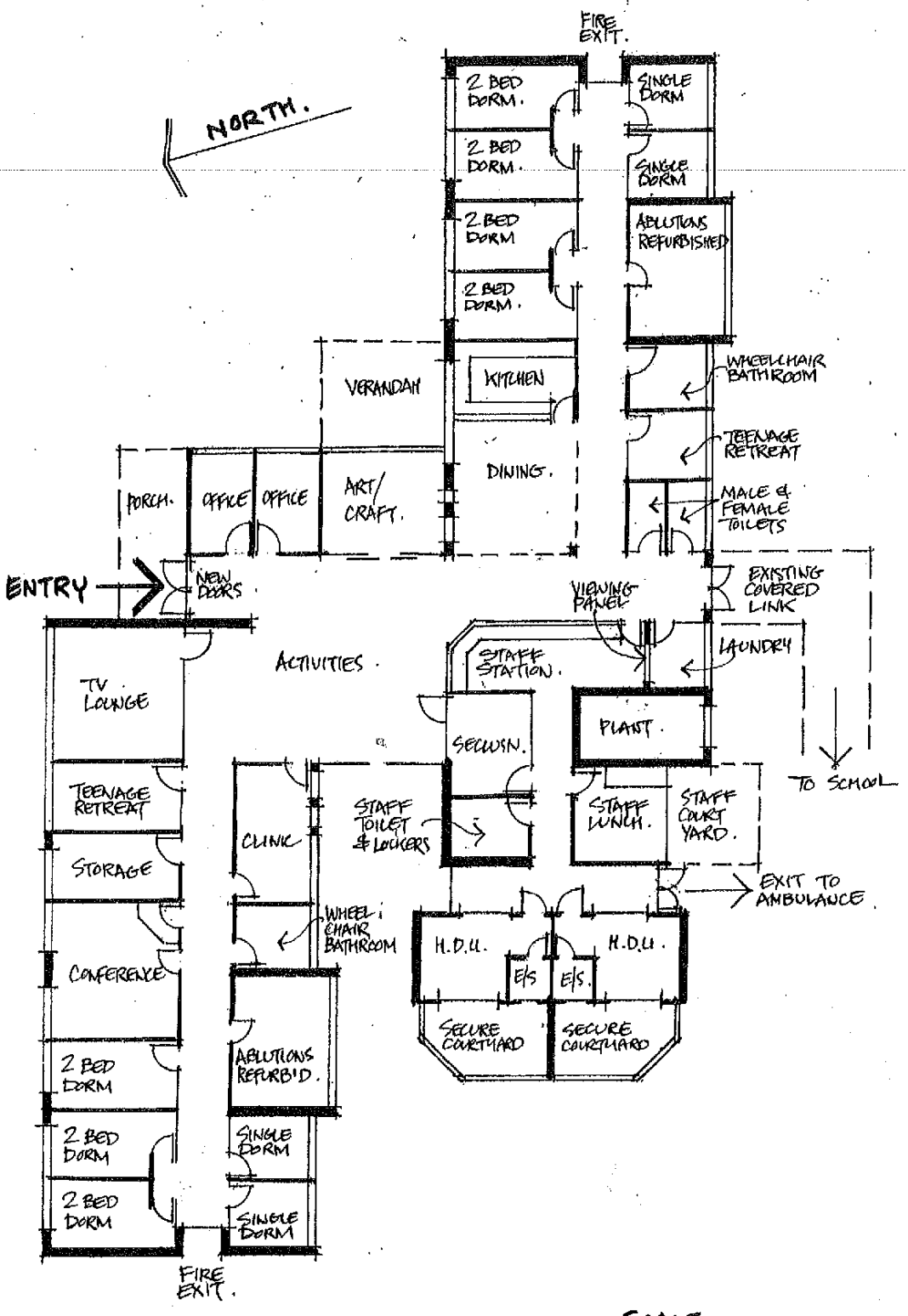
MAIN ACTIVITIES AREA LOOKING TOWARDS STAFF STATION.



CORRIDOR IN BOYS' DORMITORY WING

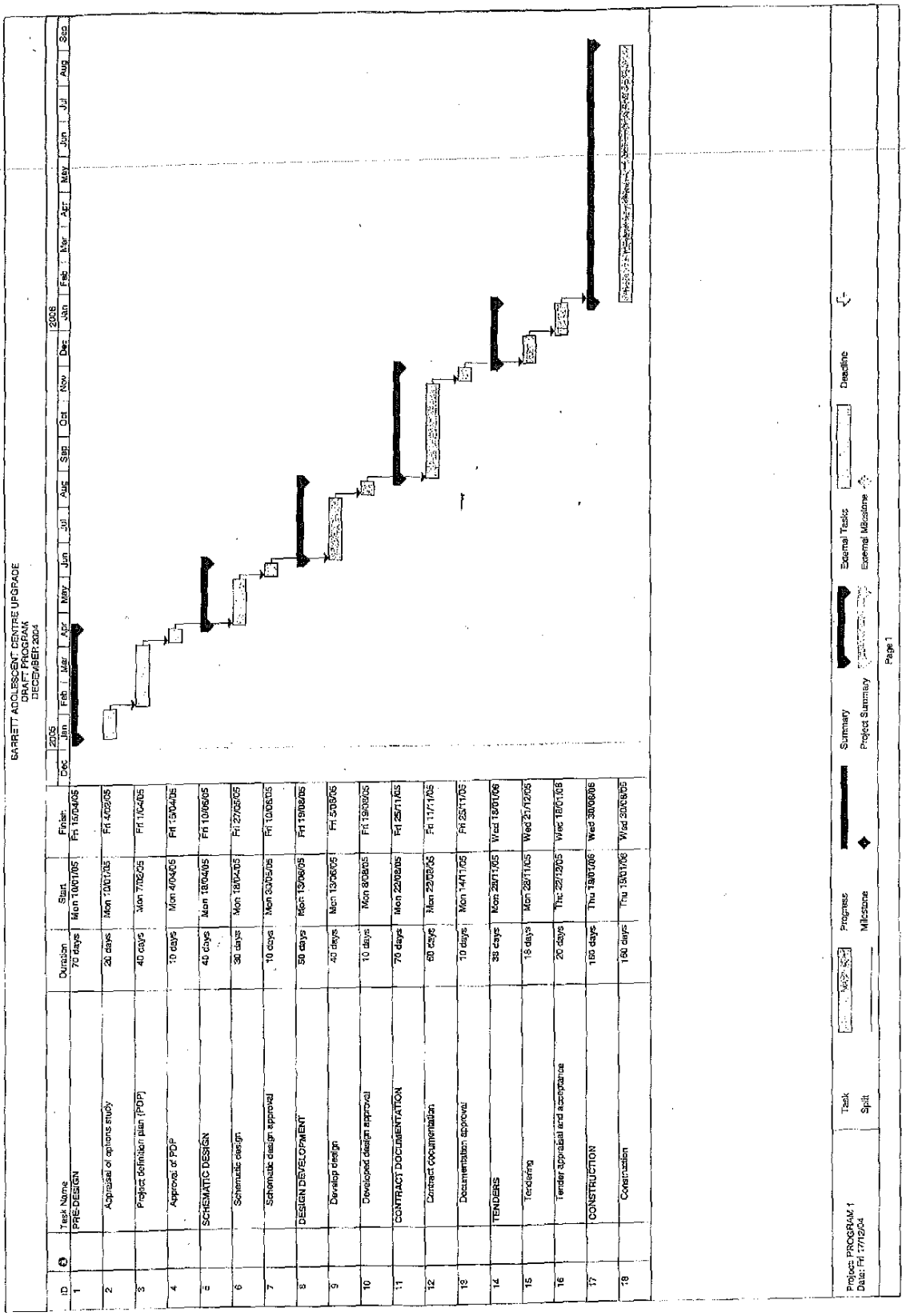


Appendix C - Sketch plan of Option 2



BARRETT ADOLESCENT CENTRE.
FLOOR PLAN AS PROPOSED.
OPTION 2

Appendix D - Preliminary program



ID	Task Name	Duration	Start	Finish
1	PRE-DESIGN	70 days	Mon 10/01/05	Fri 15/04/05
2	Appraisal of options study	20 days	Mon 10/01/05	Fri 4/02/05
3	Project definition plan (PDP)	40 days	Mon 7/02/05	Fri 1/04/05
4	Approval of PDP	10 days	Mon 4/04/05	Fri 15/04/05
5	SCHEMATIC DESIGN	45 days	Mon 18/04/05	Fri 10/06/05
6	Schematic design	30 days	Mon 18/04/05	Fri 27/05/05
7	Schematic design approval	10 days	Mon 30/05/05	Fri 10/06/05
8	DESIGN DEVELOPMENT	50 days	Mon 13/06/05	Fri 19/08/05
9	Develop design	40 days	Mon 13/06/05	Fri 5/08/05
10	Developed design approval	10 days	Mon 8/08/05	Fri 19/08/05
11	CONTRACT DOCUMENTATION	70 days	Mon 22/08/05	Fri 25/11/05
12	Contract documentation	60 days	Mon 22/08/05	Fri 11/11/05
13	Documentation approval	10 days	Mon 14/11/05	Fri 25/11/05
14	TENDERS	35 days	Mon 28/11/05	Wed 18/01/06
15	Tendering	15 days	Mon 28/11/05	Wed 21/12/05
16	Tender appraisal and acceptance	20 days	Thu 22/12/05	Wed 18/01/06
17	CONSTRUCTION	150 days	Thu 19/01/06	Wed 30/08/06
18	Construction	150 days	Thu 19/01/06	Wed 30/08/06

[Insert *RecFind number if known]* [File *Reference No. if known]*

Queensland Health
BRIEFING NOTE FOR INFORMATION

TO: *Dr Mark Mattiussi, Acting General Manager, Southern Area Health Service*

FROM: *Pam Lane, District Manager West Moreton Health Service District*

..... OK Dated / /
Approved / not Approved **Further information required** ..... Dated / /

SUBJECT: Redevelopment of Barrett Adolescent Unit

PURPOSE

To seek the Area Health Manager's approval to give priority to the redevelopment of the Barrett Adolescent Unit. The current building was built to accommodate adults in the 1970's according to standards of care which are no longer acceptable in any other mental health facilities in Queensland and not designed to meet the needs of adolescents requiring longer term treatment and rehabilitation.

RECOMMENDATION

- That the redevelopment of the Barrett Adolescent Unit occur as a priority

CURRENT ISSUES

The current complex is advantageously situated at The Park – Centre for Mental Health, but the current buildings were never designed for their current purpose. The shared dormitory and bathroom areas necessitate patients being exposed to another patient's behaviours in extreme distress, there is no secure area for intensive care nursing for patients who are acutely suicidal or requiring life saving interventions, and the unit has to absorb functions (eg. dining and recreation areas) which were formerly provided for in other areas of The Park - Centre for Mental Health leading to increasing constrictions on internal space, and loss of therapy areas. There are maximum limits on admissions of any one gender, in spite of a high ratio of female to male referrals.

PROPOSED ACTIONS

- The Mental Health Unit commissioned a feasibility study to determine the costs of upgrading the current facility -v- that of rebuilding it. The design of an upgraded facility continued to enshrine many of the current deficits – inadequate patient safety, lack of privacy for patients, fixed gender ratios, inadequate dining and recreational facilities. Although it contained a secure bed area, this was of inadequate size and nature for those who are severely distressed for considerable periods of time
- The study recommended redevelopment as the preferred option
- The Southern Area Health Service is understood to be negotiating with Capital Works to progress the redevelopment

BACKGROUND

Author's Name: Kevin Fjeldsoe Position: Executive Director Unit/Dist: Mental Health Services, WMHSD Tel No: Date: 10.01.2006	Cleared by: (DM/ED) Name: Pam Lane Position: District Manager Unit/District: WMHSD Tel No: Date: 10.01.2006	Cleared by: (ZM/SED) Name: Position: Unit/Zone Tel No: Date:	DDG	DG

EXHIBIT 75

Adolescents admitted to the Barrett Adolescent Centre increasingly have a history of severe and complex mental disorders secondary to trauma and abuse. It is the course of such disorders for the levels of emotional distress to intensify leading to increasing self harm, suicidal acts and at times, aggression to property or to others before recovery occurs. The present buildings contain many defects in the pattern of construction which render them as substandard in treating adolescents with these and other severe and complex issues.

Queensland Health have been continually updated on the increasing acuity of patients admitted to the Barrett Adolescent Unit, the inadequacies of the current building, and dangers inherent in other buildings in the near vicinity formerly owned by Queensland Health, and now managed by the Department of Public Works as part of the Westgate Redevelopment Strategy.

The immediate financial implications of this current incident are the replacement of panels of reinforced glass to the skylights with some possible reimbursement from the patient. A quote is being obtained to replace all skylight panels with toughened glass. Measures are being undertaken to prevent patients from accessing the roof of this and other buildings. All have been potentially life threatening. All have necessitated the involvement of the police, ambulance and fire brigade.

Over the last five years, there have been numerous briefs provided in relation to serious incidents or near misses associated with limited capacity to provide services safely in the existing building.

- WHERE CHIEF EXECUTIVE OFFICER APPROVAL/ENDORSEMENT OF AN ADMINISTRATIVE ACTION IS REQUESTED, THE AUTHOR OF THE REQUEST MUST QUOTE:
  The relevant section of legislation or regulation that specifically enables the requirement for Chief Executive Officer approval; or
- State the absence of any delegation that allows for the exercise of a particular power.

MEDIA IMPLICATIONS AND KEY MESSAGES (Optional)
[Mention potential impact on public attitude, perceptions or judgements]

COMMENTS

Author's Name: Kevin Fjeldsoe Position: Executive Director Unit/Dist: Mental Health Services, WMHSD Tel No: Date: 10.01.2006	Cleared by: (DM/ED) Name: Pam Lane Position: District Manager Unit/District: WMHSD Tel No: Date: 10.01.2006	Cleared by: (ZM/SED) Name: Position: Unit/Zone Tel No: Date:	DDG	DG

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

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

2. THE BARRETT ADOLESCENT PROGRAM

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

QUEENSLAND HEALTH

CHILD AND YOUTH MENTAL HEALTH PLAN

2006-2011

EXECUTIVE SUMMARY

The Queensland Health Child and Youth Mental Health Plan 2006-2011 ("the Plan") has been developed in the context of the broader Queensland Health Mental Health Plan 2006-2011. It represents a balance between maintaining the objectives towards which the Queensland child and youth mental health system has been striving under previous Plans and other strategic documents, and a new emphasis on innovative solutions to address persistent gaps in service delivery.

Enhancements required to implement the Plan are as follows. A summary table (Attachment 1) suggests a phased roll-out for these enhancements.

Workforce Enhancements

- Traineeships (entry level/PO1) x 30
- Nurse Educators (NO3) x 8.5
- CYMHS Educators (PO4) x 3
- Training Officers (PO3) x 13
- Allied Health Upgrades and Enhancements (PO5 to PO6 x 3, PO4 to PO6 x 2,
- PO4 to PO5 x 3)
- Team Leader Upgrades (up to 35 expected from PO4 to PO5)
- New Professional Senior PO5 x 3
- New Professional Senior PO4 x 5
- Administrative Support (AO2) x 14
- Leave relief/backfill enhancements (PO3) x 0.5 FTE x 17
- Service Development Officers (AO6) x 10.0
- Consumer Consultants x 19
- Advanced Health Worker (007)
- New Workforce Project $487 197

Intensive Treatment Enhancements

- Redevelopment of inpatient units – CAFTU, Mater, RBWH
- Modifications to paediatric wards – quarantined fund of $1.3m
- Staffing enhancement – CAFTU, Mater
- Day programs – Townsville, Toowoomba, Logan, Gold Coast, Sunshine Coast, Brisbane North
- Expansion of day program - Mater
- Full staffing, Gold Coast Adolescent Unit – 2 x NO1, 2 x PO3
- Redevelopment of Barrett Adolescent Centre - $17m capital works, 44 FTEs
- 20% loading on bed day costs for child and adolescent inpatient facilities
- Increase in Patient Transit Scheme to facilitate admissions to day programs

Continuing Care Enhancements

- e-CYMHS – full-year recurrent costs by Year 5 - $863 450 + $770 656
- Community staff – to minimum ratio of 40:100 000 child and youth population
- Speech pathology enhancements – 20.0 FTE x PO3, 1.0 FTE x TO2/OO4
- Young adult outreach services – 16.0 FTE x PO3/NO2

Infant and Early Childhood Mental Health Enhancements

- Capital Works $5,200,000
- Recurrent Staffing Costs $7,745,522 or 7,602,332

Emergency Psychiatry Enhancements

- Emergency Psychiatry Teams – Stage 1 = 48 x PO3/NO2, Stage 2 = 48.5 x PO3/NO2
- Acute Care Teams – Stage 1 = 47 x PO3/NO2, Stage 2 = 37 x PO3/NO2
- Resourcing to establish 24-hour phone line
- Resourcing to establish new accommodation options

Intersectoral Collaboration Enhancements

- 16 x FTE (PO3/NO3) Partnerships Facilitators
- 6 Joint Assessment Clinics – 6.0 x FTE Psychologist (PO3), 1.8 x FTE Administrative Officer (AO2), 1.2 x FTE Psychiatrist
- Special Assessment Unit – 0.5 x FTE Psychiatrist, 1.0 x FTE Registrar, running costs equal to approximately 1/3 Mater inpatient unit's current budget

Eating Disorders Enhancements

- Stage 1 – 8.0 FTE x PO4 Care Co-ordinator positions
- Stage 2 – Intensive outpatient treatment - 4 x teams of 6 FTEs + Psychiatrist + Registrar, plus 2.0 FTE x PO3/NO2 for regional enhancement
- Stage 3 – 6.0 FTE x PO4 Care Co-ordinator positions

Promotion, Prevention, Early Intervention Enhancements

- Services for Children of Parents with Mental Illness (COPMI): 8.5 x FTE PO3/NO2
- Consultation/Liaison Services: 12.5 x FTE PO3/NO2 + 0.5 FTE Registrar
- Resourcing for mental health policy and infrastructure, mental health promotion, mental illness prevention, and early intervention, as outlined in the Mental Health Promotion, Illness Prevention and Early Intervention Subgroup Report 2006

Forensic Mental Health Enhancements

- Southern/Central Child and Youth Forensic Outreach Service – 7 x FTEs
- Northern Child and Youth Forensic Outreach Service – 4 x FTEs
- Southern and Central Area MHATODS – 6.5 x FTEs + 0.5 FTE psychiatrist
- Northern Area MHATODS – 3.5 x FTEs + 0.5 FTE psychiatrist
- Statewide Child and Adolescent Forensic Psychiatrist – MO2
- MST Teams ($1m) x 3
- 12-bed unit for adolescents with mental health issues and high risk behaviours, involved in the juvenile justice system

Dual Diagnosis Enhancements

- 2.0 x FTE for ADAWS service (Mater CYMHS)
- 60.0 x FTE to establish ADAWS-type services in Townsville, Royal Children's Hospital, Sunshine Coast, and Gold Coast
- 2.0 x FTE to enhance the capacity of the CYMHS team in Cairns to provide an aftercare service for adolescents who have been treated for drug and alcohol issues

Indigenous Mental Health Enhancements:

- 1.0 FTE x AO2
- 2.0 FTE x PO3/NO2
- 3. 0 FTE x TO2/004 Indigenous Mental Health Workers

Capital Works Requirements

- Office Accommodation for Community Mental Health Staff
- Accommodation for rural and remote staff
- Redevelopment of inpatient units – CAFTU, Mater, RBWH
- Modifications to paediatric wards
- Day programs
- Future inpatient facilities
- Redevelopment of Barrett Adolescent Centre
- 12-bed unit for adolescents with mental health issues involved in juvenile justice system

Corporate Governance Enhancements

- AO6 Senior Project Officer
- AO7 Principal Project Officer Child & Youth Mental Health – permanently fund

INTRODUCTION

There are two complementary ways to conceptualize mental health services for children and young people. The Child and Youth Mental Health system as a whole can be viewed as a form of "early intervention". There is evidence that positive intervention in a child's early development can prevent or ameliorate the impact of mental health problems in later life. On the other hand, considering the present rather than the future, children and young people suffer a range of severe and complex mental health problems which require a service system incorporating early intervention, treatment, and rehabilitation. Child and youth mental health services are seeing a rise in the severity and complexity of mental health problems, at younger ages. The current service system is overstretched and cannot provide the continuum of care to deal with this rising acuity. Unless the current service system is expanded to fill the gaps and provide safe, quality care for children and young people with serious mental health issues, the negative impacts on individuals, families, and the community, will only increase.

The Queensland Health Child and Youth Mental Health Plan 2006-2011 ("the Plan") has been developed in the context of the broader Queensland Health Mental Health Plan 2006-2011. It represents a balance between maintaining the objectives towards which the Queensland child and youth mental health system has been striving under previous Plans and other strategic documents, and a new emphasis on innovative solutions to address persistent gaps in service delivery.

The Queensland Health Child and Youth Mental Health Plan 2006-2011 is predicated on a number of existing strategic documents:

- National Mental Health Plan 2003-2008
- Future Directions for Child and Youth Mental Health (1996)
- Mental Health Unit Strategic Plan 2003-2008
- Ten Year Mental Health Strategy (1996)
- Child and Youth Mental Health Beds Report (2003)

In addition to an extensive consultation process, the Plan has also been informed by recent reference materials. Key documents will be noted at the end of relevant sections.

The Queensland Health Child and Youth Mental Health Plan 2006-2011 is a practical document. It is not about aspirations: it is about outcomes. To make a real difference to the mental health of children, young people, and families in Queensland, it is necessary to invest significant new resources in a comprehensive system of mental health care. This system must address the spectrum of mental health needs, from promotion, prevention and early intervention, through treatment, to relapse prevention and rehabilitation. The initiatives outlined in this Plan represent expansion where components of service are shown to be working effectively in a limited context, and evidence-based innovations to fill the gaps where it has been identified that consumers do not currently receive the service necessary to promote recovery. Each component of the enhanced system is dependent on the others.

The four major new emphases of the Queensland Health Child and Youth Mental Health Plan 2006-2011 are:

1. **Emphasis on developing the child and youth mental health workforce.**

Work in child and youth mental health services is difficult, stressful, and complex. It requires a range of knowledge and skills, from understanding the physical, cognitive, behavioural, emotional and social development of children and young people, to understanding family systems and how to work with the young person's community context, to collaborating with other agencies and service systems (eg. schools, Child Safety, juvenile justice) in the interests of desired outcomes. This Plan proposes a comprehensive system for recruiting, deploying and training the CYMHS workforce, providing practice supervision and professional development, and ensuring workers are appropriately supported to provide safe, quality mental health services for children, young people, and families, wherever they may live in Queensland.

An identified challenge to recruitment and retention in the CYMHS workforce is the lack of a defined career progression for certain groups of staff, notably allied health professionals and indigenous mental health workers. This Plan proposes a number of strategies to establish career pathways, including the introduction of entry level training positions, rotational positions, greater support for CYMHS staff seeking to pursue further study, Team Leader upgrades, and an expanded tier of allied health professional senior positions in larger services.

In CYMHS, as in adult mental health services, there are a number of "gaps" in service delivery which cannot be efficiently and effectively filled using the existing workforce. Two major categories of "other professions" have been identified as requiring development. One is the group of therapeutic specialists which includes art therapists, music therapists, leisure therapists, exercise therapists, adventure therapists, and some highly specialized family therapists. The other is the group of non-clinical support workers, who are referred to by titles such as recovery support workers or rehabilitation therapy aides. This Plan outlines a pilot project to evaluate the use of youth/family support workers in a CYMHS service.

2. **Emphasis on a statewide system of care for children, young people and families, with sufficient resources in individual Districts to provide general mental health services, proactively supported by centres of specialist expertise at Area and state levels.**

It is recognized that the principle of providing services close to where people live is especially important for children and young people, who are usually more dependent than adults on their social support systems including family of origin, extended family or community, and school.

At the same time, it is recognized that the sustainability of safe, quality health services is a major issue in regional, rural and remote centres. Consultation suggests that the type, duration, complexity and severity of mental health problems are similar in rural

areas to metropolitan areas; the differences concern service provision (existence of other support services, isolation from inpatient options, access to staff training and supervision) and total numbers of presentations. Where populations are small, presentations will be fewer than in larger centres, but will require at least the same levels of time and skill to treat when they do occur. Some disorders with low prevalence but high morbidity, such as eating disorders, pose a particular challenge in terms of building and maintaining specialist skills across the state.

To ensure an appropriate continuum of treatment options is available to every child or adolescent presenting with mental health issues, to ensure staff have access to the expertise and support required to effectively treat these issues, and to deal realistically with the difficulties of recruitment and retention in rural centres, a number of service components will operate on a "hub and spoke" model. Queensland already has two tertiary centres of child and youth mental health expertise (Royal Children's Hospital and Mater CYMHS), which are associated with tertiary paediatric hospitals, large maternity hospitals, and major universities. These tertiary centres will expand their role in providing intensive treatment, particularly specialist treatment for low prevalence disorders, highly complex presentations, and sub-specialties such as infant mental health. The tertiary hubs will also expand their role in supporting other centres through consultation/liaison, professional development, and supervision.

The Plan aims to develop a third major hub to service Northern Area, based in Townsville, and also recognizes the potential for Gold Coast to develop as a fourth major hub over the period 2006-2011 and beyond. It is likely that, by 2016, Sunshine Coast will also be emerging as a major population centre, and its potential as a future hub of child and youth mental health services should inform current planning.

Hub services must be sustainable over time, with a critical mass of experienced CYMHS staff and a demonstrated capacity to attract and retain senior professionals. They must have established and growing relationships with tertiary services and with tertiary research and education institutions. They must have the capacity to support "spokes", through the provision of clinical services (including inpatient services), consultation/liaison, and workforce support such as professional development opportunities and practice supervision.

It is acknowledged that although some larger services are not designated hubs under the Plan, specialist expertise in areas of child and youth mental health have developed and will develop in individual services. Queensland CYMHS services have a tradition of sharing their strengths, through formal and informal pathways. It is expected that some relationships among tertiary hubs, regional hubs, and spokes, will be formalized as enhancements are made, and service agreements will be established outlining service pathways and the respective responsibilities of each service level.

3. Emphasis on a continuum of treatment options, to which consumers can be matched according to clinical needs, and among which consumers can transition as their needs change, rather than a focus on "beds" and "case management".

Child and youth mental health practitioners have an increasingly sophisticated understanding of the groups of consumers who currently fall through gaps in service provision, or receive treatment in settings which are not well-matched to their needs but currently represent the only options available. The Plan emphasizes the development of new and expanded components of mental health service delivery, which will enable consumers, carers, and treating teams, to make more effective treatment decisions.

4. Emphasis on partnerships and collaborative practice, to ensure an holistic response to mental health needs including determinants of health.

Child and youth mental health professionals traditionally reject a reductionistic view of "mental illness" as a biological illness only happening to the individual. Rather, these professionals embrace a systems-based view, striving to work with the young person's family and support system to address underlying developmental needs, environmental stressors, and other factors which impact on the young person's wellness. However, in the context of limited resources, service rationing often occurs as staff find themselves under tremendous pressure attempting to meet the needs of all young people who present to the service.

A persistent theme arising through the consultation process for this Plan was the need for "FTEs, not MOUs" (full-time equivalents/positions, not Memoranda of Understanding). This statement expresses that while a number of strategic plans and other documents have outlined aspirations for partnerships between Queensland Health and other agencies, to achieve desired outcomes for consumers, these aspirations cannot be implemented without additional resources. The key is to invest a level of resourcing in the right places, in the right ways, to achieve maximum impact on consumer outcomes.

The current Plan emphasizes additional investment in aspects of mental health service delivery which the evidence-base clearly supports as repaying investment over the life-time of the young person in terms of improved quality of life, contribution to society, and cost savings to the community. Since service contexts, including the capacities of non-government organizations and private providers, differ greatly from one District to another, a principle is to provide Partnership Facilitator positions within mental health service teams to liaise and collaborate with partner organizations, and play a role in co-ordinating aspects of care from the individual to the community level.

The implementation of a dedicated resource would enable Queensland Health to leverage off the investments made in other core departments, paediatric services, and non-government community services. For example, Education Queensland has embarked on the development of a departmental Mental Health Plan, which provides significant new opportunities for partnership between Education Queensland and Queensland Health in the area of child and youth mental health. This represents an unprecedented opportunity for a well-planned collaboration to build resilience and enhance mental health literacy, promote help-seeking behaviours, and improve early detection and referral.

Understanding the "new morbidities in paediatrics" (presentations that affect speech, language, learning, and emotional and behavioural health) suggest that the relationship between mental health and child health will continue to increase in relevance. Within Queensland Health and the private health sector, linkages between CYMHS, child health, child development services, paediatricians and private practitioners need to be strengthened.

The new Mental Health – Child Safety Support Teams, the Multi-Systemic Therapy trial, and the development of therapeutic residential facilities, represent an innovative partnership between the Department of Child Safety and Queensland Health, to address the mental health needs of children and young people in care. This relationship can be expected to develop and expand over time, and with further funding to provide early intervention services to prevent young people needing to be taken into care.

MODEL OF SERVICE DELIVERY

Public mental health services for children, young people and families are generally referred to as Child and Youth Mental Health Services (CYMHS). As specialist services, they target direct service delivery to that portion of the child and youth population whose disorders are severe and complex, or at risk of becoming so, and whose needs cannot be met by other services. A significant number of adults (particularly parents/carers) receive mental health interventions through CYMHS services, in relation to the presentation of an identified child or young person.

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

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

CYMHS services are delivered by multi-disciplinary teams, typically involving the disciplines of psychiatry, psychology, nursing, social work, occupational therapy, speech therapy, and dietetics, with an increasing number of other disciplines providing input either as part of a CYMHS team or through the provision of brokered services (eg. leisure therapists, exercise physiologists, art therapists, support workers). CYMHS services aim to co-ordinate the provision of care with other providers of service to the child or young person and their family (eg. General Practitioner). CYMHS services are primarily community-based, with inpatient and day program components, and a developing number of step-up/step-down treatment options which can prevent the need for hospital admission or facilitate earlier discharge from hospital. The majority of CYMHS clientele are school-aged children, young people, and their families.

CYMHS operates in a complex, multi-system environment including crucial interactions with Education Queensland, Department of Communities, Department of Child Safety, Juvenile Justice, Disability Services Queensland, Alcohol Tobacco and Other Drug Services, Child and Youth Health, private providers, non-government organisations, and others. There are service provision implications associated with this complexity.

The Queensland Health Child and Youth Mental Health Plan 2006-2011 builds on the foundation of the existing CYMHS service, to describe a system of care which will be safe, sustainable, and capable of providing quality services to all Queensland children, young people and families in need of mental health care over the next five to ten years.

Age Range:

- Infant and Early Years (0-8 years) – specialist focus on Infant and Early Childhood Mental Health services, including adverse perinatal outcomes and the prevention of subsequent pathology, and services for young Children of Parents with Mental Illness
- Children (0-13 years) – triage, assessment, referral, treatment, outreach, continuing care and rehabilitation services for children, including emergency psychiatry, acute care teams, community Child and Youth Mental Health (CYMHS) teams, inpatient and family admissions to tertiary centres, alternative inpatient management for children in regional areas, day programs
- Adolescents (13-18 years) – triage, assessment, referral, treatment, outreach, continuing care and rehabilitation services for adolescents, including emergency psychiatry, acute care teams, community Child and Youth Mental Health (CYMHS) teams, acute inpatient units with high dependency capacity, extended inpatient treatment facility, step-up and step-down alternatives to hospitalisation, day programs
- Young Adults (18-25 years) – mental health services to young adults are provided by adult mental health services, with some specialist foci across the state, but consultation/liaison, support, and "up-reach" services may be provided by child and youth mental health services on a needs basis

Services

- Triage, assessment, referral – triage of cases according to clinical need, bio-psycho-social assessment, systemic assessment (eg. parental psychopathology), referral to other more appropriate services where CYMHS service is not appropriate, provision of advice and support to other services and families to manage issues and meet needs
- Acute care – short-term intervention as required to resolve crises, achieve stabilisation of mental health problems
- Continuing care, case management and rehabilitation – longer term treatment, service co-ordination to meet the needs of the child or young person and family, rehabilitation activities eg. school reintegration, linking with vocational readiness

There are three aspects to the model of mental health service delivery for children and young people in Queensland. Firstly, there is a set of principles which guide policy and implementation. Secondly, there is a tiered structure of services based on population and need for service. Thirdly, there are identified components of service delivery ranging from core components to specialist services to inter-sectoral linkages. These three aspects considered together constitute a service capability framework.

Currently, there is widespread agreement among stakeholders regarding the policy principles, and the components required for effective child and youth mental health service delivery. There is also general agreement that the current structure of services provides an appropriate foundation, but requires enhancement to existing core components, and considerable attention to "gaps" in service delivery.

1. Principles of Child and Youth Mental Health Service Delivery in Queensland

The Model of Service Delivery for child and youth mental health in Queensland can be contextualized within the "Spectrum of Interventions for Mental Health" outlined in the National Mental Health Plan 2003-2008.

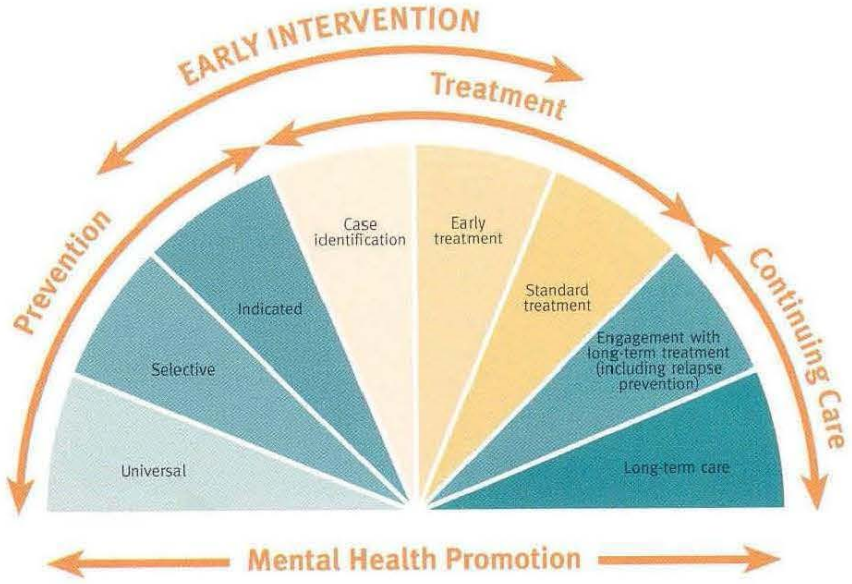


Figure 1: The spectrum of interventions for mental health problems and mental disorders

(Adapted from the Mrazek & Haggerty 1994 Mental Health Intervention Spectrum for Mental Disorders)

The "indicated prevention", "symptom identification", and "early treatment" phases fall within the scope of early intervention, and are considered part of the core business of mental health services. If sufficiently well-resourced, mental health services may also play a role in mental health promotion, universal prevention measures, and selected prevention, although this is usually undertaken in partnership with other agencies such as public health, other government agencies, the education sector, private providers, and/or non-government organizations.

A set of Principles to guide the delivery of mental health services for children and youth was articulated in Future Directions for Child and Youth Mental Health Services (1996):

1. Timely Access to Safe, Quality Service: Each child or young person with serious levels of disturbance, or at risk, should have timely access to safe, high quality mental health services, which take account of family and social circumstances, and cultural and language differences

2. Early Intervention: Service provision should include the development of strategies for identification and early intervention targeting those with known risk factors

3. Consumer-Centred: Mental health services for children, young people and families/carers must be flexible and individually tailored, taking into account developmental and social contexts as well as clinical need

4. Consumer Empowerment: Children, young people and families/carers need to be able to make informed decisions and be involved in the processes affecting them

5. Consumer and Carer Participation: Services should be developed, delivered and evaluated with the involvement of consumers and carers.

6. Inter-Sectoral Collaboration: Mental health services for children and youth will be led by Queensland Health Child and Youth Mental Health Services, and co-ordinated among adult mental health, general health, welfare and education services (including government, non-government, and private providers) in ways that ensure responsive service provision to meet the the specific needs of individual children, young people, and families/carers

7. Environmental Enhancement: The service approach will maximize the support given to the child's caring network, including parents, and build on existing strengths and opportunities within their environment

8. Evidence-based Practice: Mental health interventions will be based on the best available evidence for effectiveness, and outcomes will be monitored and reported in order to continuously improve the evidence base

9. Strengths-based Interventions: Mental health interventions will build on the existing strengths of the child, young person, and family, to improve resilience to cope with demands and stressors

10. Commitment to Workforce: Child and Youth Mental Health Services are committed to developing and maintaining a highly-skilled, well-supported workforce, consisting of the right people with the right skills in the right place at the right time to provide effective mental health services to children, young people and families/carers

2. Tiered Structure of Child and Youth Mental Health Services Across Queensland

DISTRICT	AHS	PRINCIPAL SERVICE CENTRE/NETWORK	OTHER LINKAGES/ HUBS
REMOTE TEAMS			
Cape York	N	Cairns	Remote Area Outreach Team *e-CYMHS
Central West	C	Rockhampton	*e-CYMHS
Charleville	S	Toowoomba	e-CYMHS
Torres Strait & Northern Peninsula Area	N	Cairns	Remote Area Outreach Team *e-CYMHS
COMBINED ADULT / CHILD AND YOUTH TEAMS			
Bowen	N	Townsville	
Central Highlands	C	Rockhampton	
Charters Towers	N	Townsville	*e-CYMHS
Gladstone + Banana	C	Rockhampton	
Gympie	C	Sunshine Coast	
Innisfail	N	Cairns	
Moranbah	N	Mackay	*e-CYMHS
Mt Isa	N	Townsville	*e-CYMHS
North Burnett	C	Bundaberg	
Northern Downs	S	Toowoomba	
Roma	S	Toowoomba	
South Burnett	S	Toowoomba	e-CYMHS
Southern Downs	S	Toowoomba	
Tablelands	N	Cairns	e-CYMHS
CYMHS STAND-ALONE TEAMS			
Bundaberg	C		
Fraser Coast	C		
Bayside	S		
CYMHS REGIONAL TEAMS			
Redcliffe-Caboolture	C		MH-CSST
Sunshine Coast	C		MH-CSST
Rockhampton	C		MH-CSST?
Gold Coast	S		MH-CSST, Beds
Logan-Beaudesert	S		MH-CSST, Beds
Toowoomba	S		Beds
West Moreton	S		MH-CSST?, Beds
Cairns	N		MH-CSST
Townsville	N		MH-CSST
Mackay	N		
METROPOLITAN BRISBANE STATEWIDE HUBS			
Royal Children's Hospital and Health	C		MH-CSST, Beds + Royal Brisbane &

DISTRICT	AHS	PRINCIPAL SERVICE CENTRE/NETWORK	OTHER LINKAGES/ HUBS
Service District			Women's Hospital
Mater	S		MH-CSST, Beds

AHS = Area Health Service; N = Northern AHS; C=Central AHS; S = Southern AHS
*e-CYMHS = *permanent/temporary funded RCH&HSD e-CYMHS
MH-CSST = Mental Health Child Safety Support Teams ?=possible hubs for future teams
RA Outreach Team = CYMHS Remote Area Outreach Team

3. Components of Service Delivery

For the purposes of this Plan, the components of CYMHS service delivery in Queensland can be conceptualized in terms of the following framework:

1. Promotion, Prevention, Early Intervention (including Early Treatment)
    a. Social Promotion
    b. Primary Mental Health Promotion and Prevention
    c. Infant and Early Childhood Mental Health (prevention and early intervention aspects)
    d. Children of Parents with a Mental Illness
    e. Universal, Selected, and Indicated Interventions
    f. Consultation/Liaison Services

2. Acute Care – currently a component of community CYMHS care, proposed to expand under the current plan to include:
    a. Emergency Psychiatry
    b. Mobile Acute Care Teams

3. Intensive Treatment
    a. Acute Inpatient Treatment
    b. Mental Health Admissions to Paediatric Wards
    c. Day Programs
    d. Extended Inpatient Treatment

4. Continuing Care
    a. Community Mental Health Services
    b. E-CYMHS

5. Specialist Services
    a. Infant and Early Childhood Mental Health (treatment aspects)
    b. Eating Disorders
    c. Dual Diagnosis (Mental Health/Substance Abuse Issues)
    d. Forensic Issues
    e. Transcultural Mental Health
    f. Indigenous Mental Health
    g. Child Safety Therapeutic Support

Vital "enablers" for CYMHS service delivery include:

1. Workforce Development and Support (Section 6)
2. Intersectoral Collaboration (Section 7)
3. Information Management (Section 8)
4. Research (Section 9)
5. Capital Works Infrastructure (Section 10)
6. Corporate Governance (Section 11)

SERVICE ENHANCEMENT AND EXPANSION

1. Promotion, Prevention, Early Intervention

1.1 Social Promotion

Mental health promotion, increasing mental health literacy, and reducing stigma associated with mental illness, are roles which currently fall within the jurisdiction of Public Health, through a small number of Mental Health Promotion Officers in Districts. Additional resourcing is needed in this area, to provide a broad social foundation which facilitates prevention, early intervention, and treatment. While there is evidence that large-scale media campaigns can assist in raising mental health awareness, some sections of the community require more targeted efforts – for example there is potential to partner with School of the Air, and the Royal Flying Doctor Service, to reach rural and remote families with mental health promotion messages and materials.

As has been noted in the Mental Health Promotion, Illness Prevention & Early Intervention Subgroup Report 2006 (Attachment 1), to enable these developments there is a need for social policy development, strategic development of infrastructure resources, and the kind of statewide leadership that could be provided by a Centre tasked with promoting mental health promotion, mental illness prevention, and early intervention throughout Queensland.

1.2 Primary Mental Health Promotion and Prevention

For children, young people, and families, mental health primary prevention is addressed through Child and Youth Health, General Practitioners, Paediatricians and a range of other agencies and services. Again, additional resourcing is required to adapt strategies which have proven to be effective, to the unique needs of a geographically dispersed and culturally diverse state. Home visiting programs, for example, are a proven strategy for primary prevention and promoting child wellness, however many indigenous families prefer outreach programs to centres in local communities rather than having government workers visit their homes. Parent training (eg. Triple P) is an evidence-based intervention, but may require adaptation to the needs of indigenous families, to CALD families, and in the context of various types of disability. Pre-conception counseling, perinatal screening of both parents for psychopathology, and screening children in kindergarten and the early years of primary school, are increasingly recommended as primary prevention strategies.

References:

1.3 Infant and Early Childhood Mental Health

Research indicates that the quality of relationships in the early years of life can have far-reaching effects on human development across the lifespan and that good mental health outcomes have a basis around secure parent-child attachments (*Hay, 2003*). The early years of development from conception to age six, particularly the first three years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life" (*Mustard, 1999*).

Future Families received funding from Second National Mental Health Plan, Promotion, Prevention and Early Intervention – February 2002 to develop, implement and evaluate the effectiveness of a pilot program in Infant Mental Health for implementation in sites across Queensland.

The Future Families Framework has been developed in response to identified service needs and national and state directives. In line with the *Queensland Health Prevention, Promotion and Early Intervention Framework for Mental Health (2001)*, the model uses a community capacity-building framework, and aims to address the priority mental health targets: enhancing parenting skills, child development and family functioning, and promoting strong positive attachment between parent and child. The intended outcomes are to improve maternal and infant health, increase early identification and management of individuals and families at risk of mental health problems in the antenatal and post-natal periods, and improve positive nurturing learning environments.

References:

Infant and Early Years Mental Health Plan (Attachment 2)

1.4 Children of Parents with Mental Illness

Over one million children in Australia live in households where a parent has a mental illness (VIC Health Resarch Report, November 2005). Studies have found that 25-50% of children in this situation will experience some psychological disorder during childhood, adolescence or adulthood, and 10-14% will be diagnosed with a psychotic illness at some point in their lives (Farrell et al., 1999). The literature indicates that successful interventions with these families involve work with both the parents and the children. Collaboration between adult and child and youth mental health services, and across agencies, is required to improve the engagement of these families in effective treatment and prevention programs.

Targeted investment in programs for Children of Parents with Mental Illness (COPMI) is likely to be realized in improved current functioning of the family, adults, and children, and in the future mental health of the children (and, ultimately, the next generation). For this reason, Children of Parents with Mental Illness were identified as a priority group within the Second National Mental Health Plan (1995) and the National Mental Health Plan 2003-2008, and the Australian Infant, Child, Adolescent, Family Mental Health Association has developed National guidelines to address the needs of this population.

Currently, Royal Children's Hospital offers a KOPING program for young people aged 12-18 years, which aims to increase peer support and build coping capacity. The program also offers resources, consultation liaison and support for service providers working with families affected by mental illness and/or drug and alcohol concerns.

Mater CYMHS operates a Kidz Club for primary school children of parents with mental illness, and offers resources to other services and organizations wishing to provide similar programs. Two positions have recently been funded to improve service co-ordination between the adult mental health service at Princess Alexandra Hospital, and the Mater CYMHS service.

Sunshine Coast CYMHS has developed the Sunshine Coast KOPING (SCKOPING) Network, and operates a group program (Kids Club for 8-12 year olds, Gaining Grounds for adolescents, Peer Support for graduates of these groups). Sunshine Coast has also run 2 camps in the past two years, using peer support and adventure therapy, Some 150 children have received active interventions through the direct service program, which is facilitated by 0.5 FTE. Sunshine Coast requires an additional 0.5 FTE Network Facilitator, and 1.0 FTE Program Facilitator, to make the KOPING program sustainable.

Gold Coast has a COPMI Management Committee and runs programs as a collaborative undertaking between CYMHS, the adult mental health service, and a non-government organization. Gold Coast requires a dedicated 1.0 FTE to improve sustainability.

Bayside has established a COPMI program for children and adolescents.

An enhancement of 1.0 FTE x PO3/NO2 is required to commence COPMI initiatives in Districts with substantial numbers of Children of Parents with Mental Illness, where interest in COPMI has already developed:

- Cairns
- Toowoomba
- Gladstone
- West Moreton
- Logan-Beaudesert
- Redcliffe-Caboolture

There is a need for a statewide co-ordination function for COPMI initiatives. Enhancement to establish this function is outlined in Section 9, Corporate Governance.

References:

Child and Youth Health Update December 2004
Royal Children's Hospital Website

1.5 Universal, Selected, and Indicated Interventions

Evidence is available from numerous studies at international, national, and local levels (eg. Durlak & Wells, 1997; MindMatters; Aussie Optimism; Bayside Integrated Case Management project) that a tiered promotion-prevention-early intervention approach to an identified population can curtail the development of mental health problems in that population on a number of dimensions (prevalence, severity, complexity, duration). A universal mental health promotion approach can incorporate a screening component, which enables selective intervention, which in turn enables the identification of individuals requiring indicated intervention. Such approaches are cost-effective, can be implemented with a small number of dedicated resources engaged in co-ordinating efforts across a number of agencies, and have demonstrated long-term benefits.

References:

Mental Health Promotion, Illness Prevention & Early Intervention Subgroup Report 2006
Durlak, J.A., & Wells, A.M. (1997) Primary prevention mental health programs for children and adolescents: A meta-analytic review. American Journal of Community Psychology, 25, 115-152.

1.6 Consultation/Liaison Services

Although consultation/liaison services are not restricted to early intervention, they are included under this heading in recognition that mental health issues can often be managed by general health services and other providers within the child or adolescent's environment, if appropriate consultation/liaison support is available.

Currently, the major hubs of consultation/liaison services are Mater CYMHS and Royal Children's Hospital. To provide more capacity and effective service coverage across the state, augmentation is required of:

- 2 x FTE PO3/NO2 Mater CYMHS
- 2 x FTE PO3/NO2 Royal Children's Hospital
- 2 x FTE PO3/NO2 Gold Coast
- 1 x FTE PO3/NO2 Toowoomba
- 1 x FTE PO3/NO2 Cairns
- 1 x FTE PO3/NO2 Rockhampton
- 1 x FTE PO3/NO2 Gladstone
- 1 x FTE PO3/NO2 Townsville
- 1 x FTE PO3/NO2 Logan-Beaudesert
- 0.5 x FTE Registrar and 0.5 x FTE PO3/NO2 Sunshine Coast

1.7 Cross-Agency Promotion, Prevention, Early Intervention

Many government agencies and non-government organizations invest resources in "prevention" and "early intervention", attempting to divert an individual's trajectory away from undesirable outcomes including unemployment, involvement in crime, becoming a victim or perpetrator of domestic violence or sexual assault, substance abuse, homelessness or marginal homelessness, mental illness. An effective early intervention strategy may help protect the individual from a number of these undesirable outcomes, with resulting benefits to the individual, their family, their children, and society. It is therefore logical for mental health services to combine

resources and efforts with other government departments and non-government agencies, at the level of local communities, to implement effective prevention and early intervention strategies. However, the building of partnerships and the implementation of joint strategies usually cannot be undertaken by busy services without a dedicated resource to drive this work.

Developing partnerships to address the spectrum of mental health promotion, prevention, and early intervention for children, young people and families, is a large part of the role proposed for Partnership Facilitators, to be established in CYMHS service centres. The role of these positions will be to progress partnerships between Queensland Health and other government departments, private providers or non-government agencies, which improve services to CYMHS clients and their families. These positions will play a role in communication and negotiation which occurs in relation to specific young people and their families from time to time, but the main purpose of the role is strategic development of local service networks so as to improve access, timeliness and appropriateness of interventions, safety and quality of service, and continuity of care. Supporting interagency forums will be a key responsibility. Additional detail regarding these positions is provided in section 7**.1 Partnership Facilitators**.

References:

Infant and Early Years Mental Health Plan (Attachment 1)
Mental Health Promotion, Illness Prevention & Early Intervention Subgroup Report 2006

Promotion, Prevention, Early Intervention Enhancements

COPMI: 8.5 x FTE PO3/NO2
Consultation/Liaison Services: 12.5 x FTE PO3/NO2 + 0.5 FTE Registrar
Resourcing for mental health policy and infrastructure, mental health promotion, mental illness prevention, and early intervention, as outlined in the Mental Health Promotion, Illness Prevention and Early Intervention Subgroup Report 2006

2. Emergency Psychiatry and Acute Care

The proposed model of service delivery for Emergency Psychiatry in Queensland consists of:

- Statewide name for emergency mental health teams
- Statewide 24-hour phone line to divert to local service providers
- 24 hour Department of Emergency Mental Health Staff in Principal Service Provision centres
- Enhancement to staffing in the community component of emergency mental health services
- Access to short-term crisis accommodation

Each of these components is required to respond to children, young people and families.

2.1 Emergency Psychiatry

The following benchmarks have been proposed for Emergency Psychiatry Services for the total population serviced by an emergency department:

Service Size	Hospital Beds	Shifts to cover 24 hr/ 7 day service	FTEs Required
Large	>450 beds	42	10
Medium/Small	<450 beds	21	5

These staff will be based in the Emergency Department and will also staff the 24-hour phone line, responding to calls and making scheduled calls on behalf of the acute care team and community mental health service as required (eg. for follow-up care). Based on the experience of Kids Helpline and Parentline, it can be expected that the 24-hour phone line will be accessed by children, young people and parents out of hours, and that there will be similar needs for proactive telephone support (eg. scheduled follow-up calls).

Enhancements required for Emergency Psychiatry Teams, for child and youth presentations, are as follows:

District	Staffing
RCH (Covers RCH, RBWH & TPCH)	10
Mater (Covers Mater, PAH, QEII)	10
Redcliffe-Caboolture (2 DEMS)	8.5
Gold Coast (2 DEMS)	8.5
Fraser Coast (2 DEMS)	8.5
Cairns	5
Sunshine Coast	5
Rockhampton	5
Logan-Beaudesert	6
Toowoomba	5
West Moreton	5
Townsville	5
Mackay	5
Bundaberg	5
Bayside	5

* Using Medium/Small Staffing Shifts with additions to cover services with >1 DEM
Considers that RCH, Mater & possibly eventually Townsville would be Hubs to support other services that do not operate 24 hours/7 days.
These allocations are based on PO3/NO2 FTEs. Child psychiatry and registrar input are included in these allocations.

Usage data and demand should be monitored, with a view to increasing these enhancements in the later years of the Plan.

2.2 Mobile Acute Care Teams

For child and youth mental health, mobile acute care teams are proposed to fulfill a number of functions, in the interests of a continuum of care. Mobile acute care teams:

- may provide an alternative to acute inpatient admission
- have the capacity to facilitate early discharge from acute inpatient treatment
- can provide intensive support for clients who are marginalized and hard to access, for example homeless youth, young people with concurrent early psychosis and substance abuse issues
- can intensively treat such conditions as agoraphobia, social phobia, and school refusal, which must be addressed in situ (eg. the young person's home, school, and other local environments)

For adult Mobile Acute Care Teams, a benchmark of 10 FTE per 100 000 adult population has been suggested, based on services in Victoria (10:100 000) and UK (14:150 000). For child and youth, a figure of 8 FTE per 100 000 child and youth population has been suggested. It is anticipated that fewer children and young people than adults will require a mobile acute care response, but treatment will be more complex (as the effective treatment of children and young people generally involves family therapy and work with significant others including school personnel). Again, it is expected that Mobile Acute Care Teams in Principal Service Provider centres will provide consultation/liaison services to mental health staff, general health staff, GPs, schools, and other stakeholders in Districts which do not have Mobile Acute Care Teams.

Due to the need to develop services over time, and the difficulties associated with recruiting large numbers of new staff at once, it is suggested that Mobile Acute Care Teams, like Emergency Psychiatry teams, should be established through a staged implementation with monitoring of usage rates and patterns of demand. Districts may choose to deploy Emergency Psychiatry staff and Mobile Acute Care staff flexibly in order to meet specific District patterns of need.

District	**C&Y Population 2006**	**C&Y Population Estimated Projection 2011**	**Staffing (4 FTE/ 100 000)**
RCH (Covers RCH, RBWH & TPCH)	150 001	153186	12
Mater (Covers Mater, PAH, QEII)	116 138	120476	10
Gold Coast (2 DEMS)	104 892	109485	9
Logan-Beaudesert	97 547	104399	8
Sunshine Coast	74 214	80367	6
West Moreton	54 810	57177	5
Bayside	54 851	56971	5
Townsville	52 304	54711	4
Redcliffe-Caboolture (2 DEMS)	51 346	51073	4
Cairns	42 940	44802	4
Toowoomba	42 958	43336	3
Mackay	32 190	33119	3
Rockhampton	31 473	31565	3

District	C&Y Population 2006	C&Y Population Estimated Projection 2011	Staffing (4 FTE/ 100 000)
Bundaberg	25086	25854	2
Fraser Coast (2 DEMS)	21 825	22358	2

There are 17 Health Service Districts which provide community mental health services but do not have inpatient mental health services. The general model for these services involves extending service delivery to seven days per week (one shift for Saturday and Sunday). However, it is proposed that in rural and remote centres where the child and youth population is less than 10 000, no specific additional allocation should be made for child and youth specialist weekend response. Many of these services already work with a "cradle-to-grave" model, expecting staff to be multi-skilled to see people across the age range, and to seek appropriate consultation/liaison support from the Principal Service Centre as required. These services will have access to the 24 hour phone line for support. Therefore, enhancements are requested for Mobile Acute Care responses only for CYMHS teams in Districts where the child and youth population is over 10 000. These two services are:

- Gladstone & Banana 1.0 FTE
- Southern Downs 1.0 FTE

References:

Emergency Mental Health Subgroup Report 2006

2.3 Accommodation Network

Children and young people presenting with mental health issues may require crisis accommodation because they are homeless, marginally housed, or at risk in their usual living situation. Crisis accommodation for children, young people, and families, is generally scarce and difficult to access, particularly outside business hours. Transitional accommodation, such as an older adolescent may require on discharge from inpatient care, is also difficult to source and may be even less accessible to an adolescent than to an adult. A major criticism of those crisis and transitional programs that do exist is the lack of long-term affordable accommodation available for people to transition to, particularly those who require some level of ongoing support.

There is an overwhelming need to expand the system of crisis, transitional, and long-term accommodation options, particularly for families and unaccompanied young people. Evidence shows that the provision of a range of options is necessary, to allow safe and beneficial placement based on such factors as whether the accommodation is for a family or an unaccompanied young person, children or young people's ages, the length of time accommodation is likely to be needed, and the level of supervision and support required. The range and quantum of accommodation options may vary from one District to another, but a high priority should be placed on ensuring that some options are available in every regional centre with an Emergency Department.

It is essential that Queensland Health engage with other government departments and the non-government sector to seek significant expansion in the accommodation options available for children, young people and families with identified mental health issues. Consideration should be given to addressing factors which may present barriers to young people with mental health issues accessing existing accommodation options, including substance abuse, positive symptoms of psychosis, self-harm, lack of income, and challenging behaviours.

There is a concurrent need to improve the efficiency with which mental health staff can refer clients to accommodation options. The introduction of two Information and Referral Hubs for homeless people in Brisbane, under the whole-of-government Responding to Homelessness strategy, may be an initiative that could be expanded to include mental health service providers as a partner in and user of the Information and Referral services. It is expected that Partnership Facilitators will play a role in developing these links.

It may be possible, with careful design of the model, for crisis accommodation places in the Accommodation Network to double as respite accommodation, to be used on a more planned and proactive basis by existing clients of child and youth mental health services. Consumer and carer representatives have emphasized a need for this component of care, which may be conceptualized in part as an early intervention for other members of the young person's family.

In order to progress the development of the Accommodation Network, support should be enlisted from the Statewide Co-ordinator, Homelessness Initiatives (AO7) and Senior Project Officer, Housing (AO6), based in Southern Area Health Service.

References

Emergency Mental Health Subgroup Report, 2006
Alternatives to Admission Subgroup Report, 2006
Children in Homeless Services, Australian Federation of Homelessness Organisations (2006)

Emergency Psychiatry Enhancements

Emergency Psychiatry Teams – 96.5 x PO3/NO2
Acute Care Teams – 84.0 x PO3/NO2
Resourcing to establish 24-hour phone line
Resourcing to establish new accommodation options

3. Intensive Treatment

3.1 Acute Inpatient Treatment

Inpatient treatment is sometimes the most effective way to provide intensive therapeutic intervention and monitoring for a child, adolescent or family, particularly where the environment is contributing to the mental health problems, or where a complete break is required to establish new and more functional patterns of

behaviour. However, because inpatient admission may be experienced by the young person and family as disruptive, restrictive, and potentially stigmatizing, alternative treatment settings and modalities are preferred where possible.

This Plan outlines a number of enhancements to aspects of the child and youth mental health service system, which will improve the system's capacity to treat mental health issues in the community. Providing these enhancements are put in place, there is an agreed position that no *additional* acute inpatient beds for children and young people in Queensland are required within the life of the current Plan (2006-2011). The major enhancements which will allow the system to function without building additional acute beds are:

- enhancements to community CYMHS services
- development/enhancement of Emergency Psychiatry Teams and Mobile Acute Care Teams
- development/expansion of day programs
- family admissions to tertiary hubs
- admission of children to paediatric wards with mental health support
- operation of existing adolescent units at full capacity (with the exception of Toowoomba)
- expansion of statewide system of care for eating disorders
- development/expansion of drug and alcohol treatment services for adolescents
- development/expansion of Outreach teams for marginalized adolescents and young adults
- development/expansion of joint assessment services

There are currently no designated beds for child and youth mental health north of Brisbane. There are currently acute inpatient beds designated for:

- children – Child and Family Therapy Unit, Royal Children's Hospital (10 beds); Mater Hospital (8 beds - nominal); Gold Coast (4 beds - nominal)
- adolescents – Mater Hospital (4 beds – nominal); Royal Brisbane Hospital (12 beds); Gold Coast (4 beds - nominal); Logan (10 beds – 3 currently closed); Toowoomba (6 beds – currently closed)

Treating children and adolescents within the same unit is generally not an effective model, due to:

- the difficulties of providing appropriate programs for a wide range of ages and developmental levels
- safety concerns for vulnerable children, including (potentially) mothers and babies, in the same environment as severely disturbed adolescents
- different skill sets, knowledge and approaches required by staff working with children vis a vis staff working with adolescents

Historical admission patterns show that beds designated for children, in units planned to provide both child and adolescent inpatient care, have tended to be used for adolescents (Mater inpatient unit, Gold Coast) as there is much higher demand for adolescent admissions, and a wider range of options available for managing children.

While the current Plan addresses the period 2006-2011, it is necessary to project inpatient needs in advance due to the lead time required to plan major capital works. The Plan recommends separate approaches to acute inpatient treatment for children and young people, while recognizing that a flexible approach to treatment must be based on client need rather than strict age-based criteria.

Optimum staffing profiles for child and youth inpatient facilities must be reviewed, as the existing profiles based on inpatient services for adults are inadequate for the provision of paediatric care. Inpatient care for children and young people requires higher staffing levels for the following reasons:

- greater requirement to address developmental underpinnings of mental health issues, and developmental needs
- unstructured time needs to be more closely supervised
- less use of medication, therefore more requirement for active staff input
- more family work
- children are more dependent and less skilled than adults, requiring more care and assistance with activities of daily living
- the inpatient facility has a duty of care in loco parentis, and it is unacceptable for a situation to develop where this duty of care cannot be discharged
- requirement for more active involvement with other government departments, notably Department of Child Safety, Education Queensland, and other agencies such as non-government disability support providers
- because children and young people are less socialized than adults, with less developed ability for self-regulation, their reactions to stressors may be less sophisticated, less predictable, and more aggressive. Basic flight/fight responses may produce more challenging behaviour

A loading of 20% should be added to the bed day costs for adult inpatient mental health services, in order to adequately staff inpatient facilities for children and adolescents.

3.1.1 Acute Inpatient Treatment – Child

Population growth and prevalence data suggest that an additional tertiary hub will be required in the period 2011-2016.

It is envisioned that in the short term, the Child and Family Therapy Unit at Royal Children's Hospital, the inpatient unit at Mater Hospital, and the adolescent inpatient unit at Royal Brisbane and Women's Hospital, should be rebuilt as purpose-built, ground-floor units, each with capacity to convert some beds to a High Dependency Unit as needed, access to outdoor space, and capacity to run a day program.

3.1.2 Mental Health Admissions to Paediatric Wards

A potential solution to a lack of CYMH inpatient beds in regional centres is the creation of a special care suite for mental health interventions, with capacity for parents/family "rooming in", within a paediatric ward. Costs for this service

component would include capital works (modifications to wards where needed), and 1.5 FTE x Consultation Liaison support, per site.

3.1.3 Acute Inpatient Treatment - Adolescent

Townsville

The lack of inpatient beds for children and adolescents north of Brisbane has been an issue for some time. Under the current Plan, to address the needs of Northern Area, a day program will be established in Townsville (see section 3.2, Day Programs) to service Townsville Health Service District and such out-of-District clients for whom admission to this program is likely to be beneficial and practicable. It is anticipated that the development of the day program will lead to the establishment of a critical mass of staffing and expertise in Townsville, which will support the building of a new adolescent acute inpatient unit in the period 2011-2016.

Experience suggests that 8 beds is the minimum size for an inpatient adolescent unit to be sustainable. Such a unit must be appropriately designed to provide an environment which is attractive, home-like and non-stigmatising, within the constraints of health and safety. An adolescent inpatient unit must be purpose-built with its own entrance, sufficient space (including outdoor space) for the adolescent inpatients and their visitors, and facilities for education provision (in partnership with Education Queensland). It must provide a structured program designed for adolescents, incorporating individual therapy, family therapy, education, leisure therapy/rehabilitation activities, therapeutic milieu, and group programs. From a pragmatic point of view, there is a need for the acute inpatient unit to have easy access to an adult inpatient unit, for medical cover, duress response, and economies of scale.

Beyond 2011, it is envisioned that day programs similar to the Townsville program will also be developed in Cairns and Mackay, to better address the child and youth mental health needs in Northern Area.

Gold Coast

The Child and Youth Mental Health Inpatient unit was originally operated by the Sisters of Charity as St Vincent's Hospital as an 11 bed unit, with five child and six adolescent beds. Staffing resources were insufficient to provide quality care for eleven juvenile patients, and a site visit by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) endorsed this position and disaccredited the facility.

In early 2002, a decision was made by the Sisters of Charity to reduce the number of open beds to six, permitting a reduction in both staffing numbers and costs.

This establishment was inherited when Queensland Health acquired the hospital. At times anything up to 11 beds have been operated, but doing so has required the expensive use of casual nursing staff, or 'special' nursing, and limited opportunity for therapeutic input for the children and adolescents on the unit.

To optimise the availability of acute inpatient treatment for children and adolescents in Queensland, it is recommended that all eleven beds at Gold Coast are opened. This will require 2 x FTE NO1 positions and 2.0 x FTE allied health positions.

Logan-Beaudesert

Logan Adolescent Unit currently experiences difficulty maintaining levels of psychiatry and nursing staff to allow safe utilization of all available beds. It is anticipated that this situation will be alleviated through workforce enhancements, the establishment of a day program, and other initiatives under this Plan, which will allow Logan-Beaudesert CYMHS to develop a critical mass of staff and optimize the use of available inpatient beds.

Toowoomba

A day program will be established in Toowoomba (see Section 3.2, Day Programs), and funding will be provided to facilitate access to the program by adolescents from rural Districts through weekly boarding arrangements. The adolescent acute inpatient unit in Toowoomba will remain closed for the foreseeable future, and should only re re-opened under appropriate conditions:

- sufficient demand to justify expansion to an 8-bed unit, with provision of a structured program as outlined above
- rebuilding of the unit in line with the principles outlined above
- sustainable child and youth psychiatry cover

It is recognized that Toowoomba is the principal service centre for a network of Districts comprising South Burnett, Southern Downs, Northern Downs, Roma and Charleville. Enhancement of community Child and Youth mental health services in rural Districts, the development of a day program at Toowoomba, and increased capacity for out-of-District inpatient admissions to Royal Brisbane, Logan, and Gold Coast, are strategies designed to better address the need of adolescents from rural Districts in Southern Area.

3.2 Day Programs

Day programs can function as step-up options (to provide intensive support without requiring the additional step of admission to inpatient care), a component of care while an inpatient (the young person sleeps in the acute unit but attends the day program), or step-down options (eg. the young person attends the day program from hospital some days, with gradually increasing days of attending the program from home). At this time, the need for day programs is not seen as sufficient to justify a range of specific program types, apart from a distinction between day programs for children (Child and Family Therapy Unit, Mater), day programs for adolescents (Barrett Adolescent Centre, Logan, Toowoomba), and day programs catering to a mixed range of ages (potentially, Townsville). There is therefore a need to design day patient programs to consider many types of consumers, from those requiring short-term step-up or step-down options, to those with treatment-resistant illnesses who may need to use the day program as an alternative education provider over a long term.

A day program relies heavily on a strong partnership with an education provider, to provide a structured school day and facilitate links with the school to which the young person is expected to attend or return to on discharge. Day programs for adolescents need to consider prevocational training and potentially vocational rehabilitation.

New day programs will be established in key Districts which have stand-alone Child and Youth Mental Health Teams, adequate sustainable psychiatry input, and a demonstrated need. In 2006-2011, day programs will be established in:

- Royal Children's Hospital (10-14 places)
- Townsville (20 places)
- Toowoomba (10-14 places)
- Logan-Beaudesert (10-14 places)
- Gold Coast (10-14 places)
- Sunshine Coast (10-14 places)

Expansion will be undertaken for the day programs at:

- Mater Children's Hospital
- Barrett Adolescent Centre.

Beyond 2011, with population growth and CYMHS enhancement, there is a potential for day programs to be developed at:

- West Moreton
- Redcliffe-Caboolture
- Bayside
- Fraser Coast
- Bundaberg
- Cairns
- Mackay
- Gladstone
- Southern Downs

Indicative Staffing for 12-place Day Program

	$
1.0 x NO2.3	74 643
1.0 x NO2.4	76 356
0.5 x NO3.4	43 812
0.6 x 002.4	25 806 (Allied Health Assistant)
0.31 x VMO	95 846 (Grp B 4th year)
0.1 x PO2.6	7 163 (Therapist)
0.42 x PO3.2	32 623 (Therapist)
2.7 x PO3.4	222 067 (Therapist)
1.0 x PO4.3	92 070
1.0 x PO4.4	94 491 (Team Leader)
1.2 x AO2.8	61 664 (Administrative Officer)

Pharmaceuticals and Clinical	5 122.00
Hotel Services	22 359.33
Administration	42 662.00
Property Services	3 712.00
IT & Telecommunications	35 128.00
Engineering	6 380.00
Facility Rental (subsidized)	22 221.33
Total	**$ 964 125.67**

Salaries and Wages inclusive of EB and Oncosts
Administration inclusive of:
Office & references
HR & Education
M/Vehicle, travel and freight
Program activities
Recreational resources
Toys
Consultancy

It is recognized that day programs require young people to be living nearby, in order to access the program. It has been pointed out that by 2020, some one million people are expected to be living in the Western corridor of Brisbane, close enough to access the day program at Barrett Adolescent Centre. Mater Hospital, Townsville, Logan, Gold Coast, Sunshine Coast, and Toowoomba, also service significant populations. In addition, accommodation options for young people and carers should be developed as part of the Accommodation Network. Young people could access the day program from weekly boarding type arrangements (living close to the day program with relatives, in host families, or in NGO-run residential facilities), returning home on weekends.

Capital works costs for day programs can be calculated using the allocation made by the Capital Works Subgroup, of $650 000 per bed/place. Staffing for day programs, based on existing benchmarks, is approximately 10 staff required for every 12 places. Issues of critical mass must be taken into account: a stand-alone day program may need to be larger than one associated with an inpatient unit, in the interests of sustainability.

An increase in the Patient Transit Scheme should be made, in order to subside travel costs for these young people and carers, and options to subsidize accommodation costs should be explored.

3.3 Extended Inpatient Treatment

Barrett Adolescent Centre is the only facility providing extended inpatient care for adolescents with severe and complex mental health issues in Queensland. It is currently a 15-bed inpatient unit, providing intensive multidisciplinary mental health services to adolescents aged 13-18 years. The model of care is strengths-based and recovery-focused, grounded in the assumption that clients will leave the unit and

return to mainstream living arrangements in the community, and will pursue meaningful lives through adolescence and into adulthood.

Redevelopment of the 20 year old centre has been recognized as a priority, partly due to safety issues with the current aging buildings, and the constraints imposed on service improvement by the existing buildings and staffing profile. As acute and community services have developed the capacity to treat mental health issues at the less severe end of the spectrum, Barrett Adolescent Centre has developed expertise to work with young people whose issues are extremely complex and multi-determined and who cannot be treated effectively in community or acute settings. The demand for this service is demonstrated by a growing waiting list, compounded by increasing average length of stay as the client population becomes more severe and complex. Length of stay at BAC has slowly increased over time, from an average of 6-12 months in the late 1990s, to periods of up to two years for some clients in 2003/04 (including inpatient, day patient and outpatient care).

Additional information regarding the model of care underlying the proposed redevelopment can be found in Attachments 2, 3 and 4. In brief, components of the redeveloped Barrett Adolescent Centre are to be as follows:

Inpatient Program

The redeveloped Barrett Adolescent Centre will be staffed for 18 occupied in-patient beds (14 in an open module and 6 in a closed module) and 8 day patients.

The closed module will incorporate 2 "swing" beds which can be used as a High Dependency Unit, with access to an enclosed outdoor space. This area will potentially provide extended care in a safe, more contained environment.

The Centre will have the physical capacity to open a further 2 beds as needed. It is expected that these extra beds will be fully utilized and staffed as demand on the service increases.

The redevelopment will require the rebuilding of the school and office buildings to accommodate the increased numbers of patients and staff.

The redevelopment will include the capacity for a step-down, 2-bedroom independent living unit on site, and the new model of care will incorporate accommodation for families and for adolescents attending the day program from a distance (through arrangements with a non-government provider).

Indicative staffing for the redeveloped BAC is as follows:

0.8 FTE x VMO Psychiatrist
2.0 FTE x Psychiatry Registrar
0.25 FTE x NO6 Nursing Director
1.0 FTE x NO3/4 NPC
1.0 FTE x NO3/4 CNC
1.0 FTE x NO2 Community Liaison
4.4 FTE x NO2 Clinical Nurse

1.0 FTE x NO2 Clinical Nurse (Adventure Therapist)
14.0 FTE x NO1 Registered Nurse
3.0 FTE x NO1 GDP
3.0 FTE x Enrolled Nurse
1.0 FTE x PO4 Psychologist
2.0 FTE x PO3 Psychologist
1.0 FTE x PO2/3 Music/Art Therapist
2.0 FTE x PO3 Occupational Therapist
1.0 FTE x PO2 Occupational Therapist/Leisure Therapist
1.0 FTE x PO3 Social Worker
1.0 FTE x PO3 Speech Therapist
1.5 FTE x AO2 Administrative Officer
2.0 FTE x RSO Hotel Services

Day Program

The existing partnership between Barrett Adolescent Centre (Queensland Health) and Barrett Adolescent Centre School (Education Queensland) has been a vital component of the treatment program at the Centre. Some adolescents have attended BAC day program, including the school program, as a step-up or step-down alternative to inpatient treatment. The redevelopment will capitalize on this successful partnership by expanding the day program to 8 places, to service the western corridor and provide a treatment option for adolescents who are able to maintain accommodation placements close enough to access the program on a daily basis.

Independent Living Units

The redevelopment will incorporate on-site or local step-down accommodation, in the form of independent living units (one or two bedroom flats) for older adolescents transitioning to independent living in the community. While these adolescents will be supported with ready access to the clinical resources of the unit, the units will provide a transitional setting in which to consolidate skills and confidence for independent living.

Components needed to support the clinical program

- One or more "family stay units", or access to such units through the Accommodation Network, which will enable families to participate in family therapy while their adolescent is an inpatient, and/or enable the adolescent to access the day program

- Therapeutic residential, which provides a low stimulus environment and a comprehensive rehabilitation program, run by a non-government organization, for young people participating in the day program from out of Brisbane

    - Transitional and long-term independent accommodation accesssible through the Accommodation Network, and foster care available through Department of Communities, for placement of young people post-discharge

References:

Barrett Adolescent Centre presentations

Intensive Treatment Enhancements
Redevelopment – CAFTU, Mater, RBWH
Modifications to paediatric wards – quarantined fund of $1.3m
Staffing enhancement – CAFTU, Mater
Day programs – Townsville, Toowoomba, Logan, Gold Coast, Sunshine Coast, Brisbane North
Expansion of day program - Mater
Full staffing, Gold Coast Adolescent Unit – 2 x NO1, 2 x PO3
Redevelopment of Barrett Adolescent Centre - $17m capital works, 44 FTEs as outlined above
20% loading on bed day costs for child and adolescent inpatient facilities
Increase in Patient Transit Scheme to facilitate admissions to day programs

4. Continuing Care

4.1 Community Mental Health Service Enhancement

4.1.1 Young Adults

It is recognized that a service gap occurs for young adults (18 to 25 years), whose needs may still be developmentally-based but for whom the adult mental health system is expected to provide services. Other jurisdictions have elected to establish specific Youth or Young Adult services. In Queensland, this is not considered an appropriate option, as it would create three service systems with two boundaries, compounding the existing problem of two service systems with one boundary. Rather, there is a need for flexible service provision from CYMHS services which permits "up-reach" into the age range above 18 years, and corresponding "down-reach" from adult services into the age range below 18. Examples of such flexible service delivery include the Young Adults inpatient service at Gold Coast, and the Early Psychosis program at Princess Alexandra Hospital. Flexible service provision to meet the needs of the individual relies on adequate resourcing of both the CYMHS and adult mental health service systems.

Groups who are recognized as at risk of "falling through the cracks" are:

- young people who have been CYMHS clients to age 18, and require support as they transition into the adult system
- individuals whose chronological age is 18+, but whose cognitive, social and emotional development may be far below the norms for that age-group
- individuals for whom intervention in the period 18-25 years may effectively correct a developmental trajectory towards chronic mental health problems (eg. personality disorder, agoraphobia and anxiety disorders)
- marginalized young people (eg. homeless, transient, substance abuse issues) who do not readily access clinic-based services

- young people who require sub-acute and ongoing care, particularly following discharge from inpatient treatment

The ECCO (Early Counselling Community Outreach) model currently providing outreach from Inala CYMHS represents a form of mobile outreach for transitional and marginalized young people who do not readily access clinic-based services. Augmentation of CYMHS services by 2 x PO3/NO2 FTES to provide such outreach services is required in:

- Mater CYMHS
- Royal Children's Hospital
- Gold Coast
- Sunshine Coast
- Logan-Beaudesert
- West Moreton
- Townsville
- Cairns

It is anticipated that such augmentation will involve specialist skills such as dual diagnosis (drug and alcohol) and links to youth services including accommodation services. It is recommended that there is at least one trial of vocational enhancement and readiness program in the state in partnership with relevant organizations.

Further augmentation of these teams, and establishment of ECCO-type positions in additional sites, should be considered in 2011-2016 based on usage data and identified needs.

4.1.2 Occupational Therapy

There is a general need to increase occupational therapy in CYMHS, to assist with prevocational training, vocational rehabilitation, negotiating transitions, and life skills.

4.1.3 Speech Pathology

Speech pathologists play a key role in assessment, early intervention, and treatment, where a mental health disorder contributes to a language/learning deficit, where underlying language disorder contributes to a mental health disorder, or where language disruption is a presenting/diagnostic feature of the mental illness. There is a body of evidence to suggest that speech pathology interventions such as the Hanen programs can help alter the developmental trajectory for infants and children. Speech pathology input is also valued by multi-disciplinary teams involved in the assessment and treatment of older children and adolescents with mental health issues. Clark (2005) identified that, in a population of Queensland adolescents in extended inpatient care, general language skills did not predict problem-solving ability, the majority of adolescents with eating disorders and a proportion with anxiety disorders had significantly better speaking than listening skills, and self-harming behaviour was significantly associated with language deficits. Such clinical findings suggest that, in many young people with mental health issues, receptive language and problem-solving deficits may be masked by expressive language skills in the normal range. Failure to detect, assess and treat these "hidden" deficits may result in incomplete or

mis-diagnosis, and compromise the effectiveness of therapeutic interventions such as cognitive-behaviour therapy which rely heavily on receptive language and problem-solving capacity.

General principles proposed for speech pathology input to CYMHS teams are as follows:

- 0.5 to 1.0 x FTE speech pathologist for CYMHS and Child Safety Teams with 10 or more staff
- 1.0 x FTE speech pathologist for every inpatient child or adolescent unit
- 1.0 x FTE speech pathologist for e-CYMHS program
- 0.5 x FTE speech pathologist for every ATODS/ADAWS program (Northern Area MHATODS x 0.5, Southern/Central Area MHATODS x 0.5, Mater ADAWS x 0.5, Townsville ADAWS x 0.5, Royal Children's Hospital ADAWS x 0.5, Gold Coast ADAWS x 0.5, Sunshine Coast ADAWS x 0.5)
- 1.0 x FTE speech pathologist for each CYFOS team (Northern Area CYFOS x 1, Southern/Central Area CYFOS x 1)
- 1.0 x FTE speech pathologist and 1.0 x FTE Indigenous Mental Health Worker to roll out You Make A Difference program, particularly for children of parents with mental illness and indigenous children and young people

4.1.3 Psychiatry

There will be a need to increase psychiatry and registrar input to the expanded range of CYMHS services.

4.1.4 Targets

While the Ten Year Mental Health Strategy set a target ratio of 25:100 000, many services have now achieved this target, and experience demonstrates that these staffing levels are too low to meet the needs. A new *minimum* target ratio of 40:100 000 population (0-19 years) is proposed. Attachment 5 indicates the FTEs which would be required to achieve this target in each District.

It is recognised that ratios in Districts with smaller populations are more heavily impacted by FTE changes. For example, a District such as Cape York with 4.2 FTEs and a population of 2191 has a staff to population ratio for child and youth mental health of 191.7. However this apparently high ratio gives a misleading impression of the service which can be provided by 4.2 workers, given a dispersed population over a large geographical area, lack of other support services, lack of backfill, difficulties accessing professional development and supervision, and so on.

It is also recognised that CYMHS staff work not only with individual children and young people, but with families (parents, carers, siblings, extended family) and support systems (eg. schools) as well. The workload of a CYMHS case worker is therefore more complex and extensive than is indicated by caseload numbers alone.

4.2 e-CYMHS

Currently, an e-CYMHS service is offered by Royal Children's Hospital, providing psychiatry services and some allied health input to rural and remote mental health services across the state. The service operates in collaboration with The University of Queensland Centre for Online Health, which provides infrastructure and online support on a cost-recovery basis. In order to make the service sustainable, it is necessary to permanently fund:

Year 1

1.0 FTE x Psychiatrist
1.0 FTE x PO4 Co-ordinator
0.50 FTE x AO3 Administrative Support
Start-up costs associated with Royal Children's Hospital

Year 3 (additional)

0.5FTE x Psychiatrist
1.00 FTE x PO3 Mental Health Professional

Year 4 (additional)

1.0 FTE x Registrar

Summary of Costs: e-CYMHS service

Year 1 including $18 186 start-up costs	$ 431 569
Year 2	$ 427 964
Year 3	$ 682 124
Year 4	$ 787 623
Full year effect recurrent costs by Year 5	$ 863 450

Expansion of this service should be considered for the future based on usage rates and rural population growth.

It is recognised that an e-CYMHS service to provide both clinical and professional development functions should ideally operate from both current academic hubs (Royal Childrens Hospital and Mater Hospital). However, preliminary development should be approached through collaboration with The University of Queensland Centre for Online Health, building on existing infrastructure and established service delivery. A collaborative approach to staffing and expanding the program is recommended for the future.

Development of a parallel e-CYMHS service based at Mater Hospital has the following estimated costs:

Summary of Costs: e-CYMHS service

Year 1 including $45 000 start-up costs	$ 458 383
Year 2	$ 427 964
Year 3	$ 682 124

Year 4	$ 682 124
Full year effect recurrent costs by Year 5	$ 770 656

References:

Child and Youth Staffing Ratios
e-CYMHS RCH Costing

Continuing Care Enhancements

E-CYMHS – full year recurrent costs by Year 5 - $ 863 450 + $ 770 656
Community staff – to minimum ratio of 40:100 000 child and youth population
Speech pathology enhancements – 20.0 FTE x PO3, 1.0 FTE x TO2/OO4
Young adult outreach services – 16.0 FTE x PO3/NO2

5. Specialist Services

5.1 Infant and Early Childhood Mental Health

There is currently a service delivery gap in treatment services for infants with severe, current mental health presentations including but not restricted to attachment disorder. Queensland requires an infant mental health service with capacity to treat these infants within their social ecology, including interventions for parental psychopathology. The goals of an effective treatment system for infant and early childhood mental health have been identified as:

- To provide mental health services for the assessment and management of infants and young children prebirth to three years at risk of impaired attachment relationships and other mental health problems.
- To develop sustainable infant mental health service delivery across metropolitan, regional, rural and remote settings.
- To ensure a critical mass of clinicians is trained and available to deliver infant mental health services across the state.
- To allow for a capacity to grow infant mental health services in the future.

Required Enhancements:

- 1 **Training Centre for Infant and Early Childhood Mental Health** with x1 FTE **University affiliated academic appointment** in infant and early childhood mental health (with budget including operating costs) attached to University of Queensland Department of Psychiatry with statewide responsibility for teaching and clinical support in Infant and Early Childhood Psychiatry as well as the establishment of a program for attaining Graduate Diploma/Masters in Infant Mental Health in conjunction with New South Wales Institute of Psychiatry.
- 5 **Professional Development Officers with budget to include operating costs for airfares, accommodation, catering etc.,** to work with the academic position to provide training, support and supervision to staff around the state.

- 8-bed **Statewide tertiary inpatient and day stay assessment and treatment facility** for infants, young children up to 5 years and their families with significant mental health issues, capable of working in collaboration with adult mental health and child health services to deliver a comprehensive service to families where there are parental mental health problems **and/or** severe and complex parent-child interaction difficulties. This unit will be capable of admitting families for assessment and treatment, with services delivered collaboratively by infant and early childhood mental health specialists, adult mental health and child health. There are currently 4 designated mother-baby beds located in adult mental health services around the state, but under-utilised due to safety concerns. These 4 beds, plus 4 new beds, are to make up the new 8-bed unit.
- Teams will be established in **two Metropolitan Centres** for Infant and Early Childhood Mental Health, Royal Children's Hospital and Mater CYMHS. These services are attached to large maternity hospitals and centres of paediatric expertise, and already provide extensive CYMHS services as statewide hubs. These two centres will have responsibility for:
  - Infant and early childhood mental health service delivery in the local district
  - Building the capacity of service providers in the community to establish linkages and work collaboratively to deliver infant and early childhood mental health services by disseminating information and establishing networks
  - Promoting collaboration and co-work across services and sectors as a model for infant and early childhood mental health service delivery across the state(see attached Future Families Framework)
  - Consultation/liaison and support to other CYMHS staff and MHCSST staff dealing with children and adolescents with impaired attachment relationships and a history of infant and early childhood mental health problems
  - Providing training, supervision and support in infant and early childhood mental health to CYMHS staff, MHCSST staff and community service providers in metropolitan, regional, rural and remote centres (Mater to Southern Area Health Service, RCH to Central and initially Northern Area Health Service)
  - Developing a consistent statewide approach to standards, quality and service delivery to meet the multi-determined needs of at-risk families with severe and complex mental health needs
  - Coordinating and encouraging research in infant and early childhood mental health mental health
- Teams will be developed in two **Regional Centres** for Infant and Early Childhood Mental Health (Townsville and Gold Coast) with responsibility for:
  - Infant and early childhood mental health service delivery in the local district
  - Building the capacity of service providers in the community to establish linkages and work collaboratively to deliver infant and early childhood

mental health services by disseminating information and establishing networks

- Promoting collaboration and co-work across services and sectors as a model for infant and early childhood mental health service delivery across the state see attached Future Families Framework)
- Consultation/liaison and support to other CYMHS staff and MHCSST staff dealing with children and adolescents with impaired attachment relationships and a history of infant and early childhood mental health problems
- Providing training, supervision and support in infant and early childhood mental health to CYMHS staff, MHCSST staff and community service providers in regional, rural and remote centres (Northern Area Health Service in the case of Townsville, Gold Coast and Logan-Beaudesert in the case of Gold Coast
- Working with the two metropolitan Centres to develop a consistent statewide approach to standards, quality and service delivery to meet the multi-determined needs of at-risk families with severe and complex mental health needs
- Coordinating and encouraging research in infant and early childhood mental health mental health

- **Existing regional CYMHS teams will be enhanced** with Infant Mental Health clinicians, including a capacity to respond to the needs of indigenous families. These workers will have responsibility for:
  - Infant and early childhood mental health service delivery in the local district
  - Outreach and collaborative service delivery to rural and remote districts
  - Building the capacity of service providers in the community to build linkages and work collaboratively to deliver infant and early childhood mental health services by disseminating information and establishing networks
  - Consultation/liaison and support to other CYMHS staff and MHCSST staff dealing with children and adolescents with impaired attachment relationships and a history of infant mental health problems
  - Professional development in infant and early childhood mental health to CYMHS staff, MHCSST staff and community service providers

Budget

- Current estimate from Capital Works for 8 bed unit: $5.2 million
- Staffing Costs: (see table below)
  - University Affiliated Academic Position includes operating costs
  - Professional Development Officer Positions include $20,000 operating costs per position

- All staffing costs have superannuation and payroll tax included in estimates.
- VMO cost includes 12.75% superannuation + $2000 per annum for study leave
- All staffing costs are **recurrent** annual costs

Staffing Costs for Positions Itemized in Implementation Components Table			
Position	**Per Annum Cost**	**Number of Positions**	**Total Position Costs**
University Affiliated Academic Position	$300,000	1	$300,000
VMO (9 hours per week)	$88,717	2	$177,434
Staff Psychiatrist	$250,000	4.5	$1,125,000
Psychiatry Registrar (Advanced)	$125,344	5	$626,720
Team Leader (PO4)	$84,366	5	$421,830
Nurse Unit Manager (NO3)	$77,225	1	$ 77,225
Clinical (PO3) or Clinical (NO2)	$72,813 or $68,943	37	$2,694,081 or $2,550,891
Nursing (NO2)	$68,943	10	$689,430
Speech and Language Pathologist (PO3)	$72,813	4.5	$327,659
Professional Development Officer (PO4)	$104,366	5	$521,830
Research Officer (PO3)	$72,813	2.5	$182,033
Indigenous Health Worker (TO2)	$54,750	6	$328,500
Administrative Officer (AO3)	$54,756	5	$273,780
Total Cost for Implementation Components - Staffing			$7,745,522 or $7,602,332

Infant and Early Childhood Mental Health Enhancements:	
Capital Works	$5,200,000
Recurrent Staffing Costs	$7,745,522 or 7,602,332

5.2 Eating Disorders

The average age of onset for eating disorders is 16-20 years, with a growing trend for eating disorders to develop in much younger children (onset around 11-13 years increasingly common). The prevalence and morbidity associated with these illness is greater than early psychosis, and it is estimated that an effective eating disorders service could save up to 40% of inpatient bed days (adolescent and adult).

A substantial review process over the past year has yielded a plan for the development of an effective eating disorders service in three stages over the next five years. While the plan incorporates services for both adults and children and young people, there is an expectation that some service components will be shared (eg. psychiatry cover), will support one another (eg. co-ordinators for adult services and for child and youth services in regional hubs) or have a role in relation to the entire age range (eg. Eating Disorders Subgroup of the Statewide Mental Health Network). The key components of the eating disorders plan relating specifically to child and youth services are outlined below (see Attachment 10 for additional detail).

Stage One:

1. Development of "hubs" of expertise in eating disorders:

Child/Adolescent Hubs: 1.0 x PO4 Co-ordinator based in each hub

- Townsville (Northern Area)
- Cairns (Northern Area)
- Sunshine Coast (Central Area)
- Royal Children's Hospital (Central Area)
- Mater (Southern Area)
- Logan (Southern Area)
- Gold Coast (Southern Area)
- West Moreton (Southern Area)

While coordinators would be district based, services would be provided to designated districts within their area. They would have dual reporting duties to zone/district as well as to EDOS, which would provide them with expertise, support and access to metropolitan resources where appropriate.

Stage Two:

1. Development of intensive outpatient treatment programs, using multi-disciplinary teams, in selected hubs.

Child/Adolescent Hubs:

- Townsville
- Royal Children's Hospital and HSD
- Mater CYMHS
- Gold Coast

Hub Teams:

- 1.0 FTE x Psychiatrist
- 1.0 FTE x Registrar
- 1.0 FTE x Registered Nurse
- 1.0 FTE x Dietician
- 1.0 FTE x Psychologist
- 1.0 FTE x Occupational Therapist
- 1.0 FTE x Social Worker

- 1.0 FTE x Administration Officer

Provision for the purchase of paediatricians/ physicians sessions.
Provision of a fund for subsidizing accommodation for consumers who require intensive outpatient or day program treatment, who do not live within commuting distance of hubs

Enhancement would also be provided in Stage 2 to Sunshine Coast and Logan-Beaudesert (0.5 FTE x PO3 Dietician and 0.5 FTE x PO3 Occupational Therapist).

Stage Three:

1. Employment of "Care Co-ordinator" positions (one adult, one child and youth) in each mental health service not yet serviced by an intensive outpatient treatment program or a regional hub. The role of these positions would include providing a point of contact and communication with the Eating Disorders Outreach Service, providing consultation/liaison services to general health practitioners and others involved in patient care, building relationships across agencies for service improvement, and providing training and support regarding eating disorders for relevant personnel.

Child and Youth Eating Disorders Co-ordinator Positions:
- Mackay
- Bundaberg
- Fraser Coast
- Redcliffe/Caboolture
- Bayside
- Toowoomba

Consideration should be given in the future to further development of selected sites as additional hubs of expertise: the suggested sites for such expansion are Cairns, Sunshine Coast, and Logan-Beaudesert.

Inpatient Services

While it has been suggested that three additional child and youth beds be established in four units throughout Queensland, for the treatment of children/adolescents with eating disorders, it is noted that there is inherent difficulty in adding beds to existing facilities. No new child or adolescent beds are planned for Queensland within the life of this Plan, apart from the development of a new acute unit at Townsville. Existing acute units, and the Barrett Adolescent Centre, already treat children and young people with eating disorders. With the development of hubs of expertise in eating disorders, and the establishment of Co-ordinators in key regional sites, it is expected that a general up-skilling in this specialty will occur across CYMHS services, which should improve the capacity of existing inpatient units to treat eating disorders effectively.

Day patient Programs

Similarly, it has been suggested a day patient program be developed at Mater Hospital to provide day therapy to children and young people with eating disorders. However, expansion to the day patient program at Mater is planned, along with the establishment of new day programs at Townsville, Toowoomba, Logan, Royal Children's Hospital, and Gold Coast, to provide an alternative treatment setting for children and young people with a range of mental health issues. Experience indicates that treating eating disordered patients as a segregated group may be less effective than treating these patients as a clinical "stream" within a broader day program. It is expected that the teams providing intensive outpatient treatment to eating disordered consumers at Mater CYMHS and Royal Children's Hospital will provide specialist input to the day programs.

References:
Eating Disorders Subgroup Report, 2006

Eating Disorders Enhancements

Stage 1 – 8.0 FTE x PO4 Care Co-ordinator positions
Stage 2 – Intensive outpatient treatment - 4 x teams of 6 FTEs + Psychiatrist + Registrar, plus 2.0 FTE x PO3/NO2 for regional enhancement
Stage 3 – 6.0 FTE x PO4 Care Co-ordinator positions

5.3 Dual Diagnosis (Mental Health/Substance Abuse Issues)

Co-morbid mental illness and substance abuse issues present a challenge across the spectrum from prevention to treatment and rehabilitation, in child and youth services no less than in adult services. A key recommendation from Achieving the Balance: Sentinel Events Review was closer collaboration between mental health and ATODS services. While the Sentinel Events Review was concerned with events which occurred in adult mental health services, the recommendation should also apply to child and youth mental health.

The Adolescent Drug and Alcohol Withdrawal service at Mater CYMHS currently operates with 15 FTE. It has been identified that higher staffing levels are required to operate what is in reality a dual diagnosis service for adolescents. Requirements for enhancements are:

- 2.0 x FTE for ADAWS service (Mater CYMHS), to include aftercare service
- 60.0 x FTE to establish ADAWS-type services in Townsville, Royal Children's Hospital, Sunshine Coast, and Gold Coast (15.0 FTE per team including leave relief)
- 2.0 x FTE to enhance the capacity of the CYMHS team in Cairns to provide an aftercare service for adolescents who have been treated for drug and alcohol issues
- 2.0 x FTE to enhance the capacity of the CYMHS team in Logan-Beaudesert to work with young people who have drug and alcohol issues

In 2011-2016, further enhancement to Cairns and new enhancements to other CYMHS teams should be considered in light of usage and prevalence data.

Other strategies to be considered include:

- **universal primary prevention activities** aimed at children and young people are conducted by other agencies such as Education, but will be supported by mental health services as requested
- **rotational positions** could allow ATODS and mental health staff to experience work in each other's services. An initiative is already being trialled in Cairns, whereby mental health workers are placed in the ATODS service for a period of up-skilling. These positions should be established for workers across the age-range, ensuring that skills specific to child and youth are developed
- **visiting services** provide similar opportunities on a smaller scale. In Logan-Beaudesert, ATODS staff visit the adolescent unit on a weekly basis to provide education to consumers and carers on drug and alcohol issues, and offer a consultation/liaison service to staff. A reciprocal arrangement could be made between ATODS and inpatient/community CYMHS staff in metropolitan and large regional centres
- **joint training opportunities** should be offered, and CYMHS and ATODS staff should be encouraged and supported to participate. An example of such training is "Bridging the Gap", which Royal Children's Hospital currently undertake jointly with the Hot House service for young people with substance abuse issues. Training should cover such topics as screening, early detection (signs and symptoms of substance abuse), stages of change, motivational interviewing and motivation enhancement, and specific treatment modalities (eg. goal-setting, urge-surfing, self-help techniques, cognitive behaviour therapy, environmental modification, etc.) These training opportunities should be open to GPs, non-government organizations, and other stakeholders. As the underlying principles are similar across the age-range, although substances and contexts of abuse differ, the training should be pitched for staff working with all age-groups. It should be offered in regional and rural centres, to maximize opportunities for staff to attend.

Dual Diagnosis Enhancements

2.0 x FTE for ADAWS service (Mater CYMHS)
60.0 x FTE to establish ADAWS-type services in Townsville, Royal Children's Hospital, Sunshine Coast, and Gold Coast
2.0 x FTE to enhance the capacity of the CYMHS team in Cairns to provide an aftercare service for adolescents who have been treated for drug and alcohol issues

5.3 Forensic Issues

Child and Youth Forensic Mental Health Services in Queensland have undergone extensive development since the implementation of the Forensic Mental Health Policy in 2002. The target population differs from the adult services in that young people who are at risk of involvement with the juvenile justice system are encompassed allowing for early intervention and prevention as part of the continuity of care spectrum offered.

While the existing forensic mental health models and services in Queensland have improved substantially since intensive development of best practice approaches, it is evident that to meet the needs of the target population, development and expansion of the service is required.

The Queensland Government is under pressure to alter the legal definition of juvenile offending to include young people up to the age of 18, to bring Queensland into line with most other states in Australia. It has been estimated that the addition of seventeen-year old offenders will increase the detention centre population by at least 50%. It is anticipated that a new detention centre facility or facilities will be built to accommodate the increased population. Additionally, it is recognized that young people in the 17+ group are more likely to suffer from mental health disorders at the severe end of the spectrum, and therefore be disproportionately heavier users of mental health services.

The following enhancements are indicated to address the mental health needs of young people involved in the juvenile justice system:

2007-2008

Statewide

MO2 Child and Adolescent Psychiatrist – Clinical Leader

Southern and Central Area Community Forensic Outreach Service (CYFOS)

1 x FTE Mental Health Professional (PO3/NO3)
1 x FTE Court Liaison Position

Southern and Central Area Mental Health/Alcohol Tobacco & Other Drugs (MHATODS)

1 x FTE Advanced Health Worker (TO4)
0.5 x FTE Advanced Health Worker (TO2)
3.0 x FTE Mental Health Professional
0.5 x FTE Psychiatrist

Northern Area MHATODS

1.0 x FTE Advanced Health Worker (TO4)
1.0 x FTE Mental Health Professional
0.5 x FTE Psychiatrist

2008-2009

Southern and Central Area CYFOS

1.0 x FTE Mental Health Professional
1.0 x FTE Court Liaison Officer

Northern Area CYFOS

1.0 x FTE Mental Health Professional
1.0 x FTE Court Liaison Officer

Southern and Central Area MHATODS

1.0 x FTE Mental Health Professional

Northern Area MHATODS
1.0 x FTE Mental Health Professional

2009-2010

Southern and Central Area CYFOS
1.0 x FTE Mental Health Professional
1.0 x FTE Court Liaison Officer

Northern Area CYFOS
1.0 x FTE Mental Health Professional
1.0 x FTE Advanced Health Worker (TO3)

2010-2011

Southern and Central Area MHATODS
1.0 x FTE Advanced Health Worker (TO3)

Northern Area MHATODS
0.5 x FTE Advanced Health Worker (TO3)

In addition, it is proposed that 3 trials of Multi-Systemic Therapy should be implemented, one in each Area. There is evidence that MST is an effective intervention for juvenile offenders, but the model needs to be trialled in an Australian context. Establishment costs for each team are estimated at around $1m, based on the existing MST trial at Mater CYMHS with indexation.

Adolescents with severe and complex emotional and behavioural disturbances who are involved in the juvenile justice system have specific needs which are difficult to meet effectively within existing resources and models. There are an increasing number of young people presenting with high risk behaviours and requiring inpatient admission, some of whom fall under the Classified and Forensic provisions of the Mental Health Act 2000. Currently in Queensland, various strategies are used to attempt to meet the needs of these adolescents for both treatment and containment, balancing a recovery focus with the safety of the individual and the community. These strategies may include admission to existing adolescent inpatient units or secure adult inpatient units or High Dependency Units within adult Acute Services. Each of these options poses a different set of challenges in terms of placing the young person in a developmentally appropriate environment, ensuring the provision of care by professionals with specific adolescent mental health expertise, managing the risks to which the young person may be exposed from other patients, and managing the risks the young person may pose to other patients.

A variety of specialized residential programs for these adolescents are in place in the UK, but such programs pose their own challenges including political, medico-legal, therapeutic milieu, and workforce, issues.

While considerable work would be required to develop an appropriate model of care based on best available evidence, the Queensland Forensic Mental Health Service Plan 2006-2011 has flagged the potential need for an inpatient unit to care for up to 12 adolescents with severe and complex mental health issues and high risk behaviours, who are involved in the juvenile justice system.

References:

Proposal Regarding the Future Development of Child and Youth Forensic Mental Health Services in Queensland, 2006
Queensland Forensic Mental Health Service Plan 2006-2011

Forensic Mental Health Enhancements

Southern/Central Child and Youth Forensic Outreach Service – 7 x FTEs
Northern Child and Youth Forensic Outreach Service – 4 x FTEs
Southern and Central Area MHATODS – 6.5 x FTEs + 0.5 FTE psychiatrist
Northern Area MHATODS – 3.5 x FTEs + 0.5 FTE psychiatrist
Statewide Child and Adolescent Forensic Psychiatrist – MO2
MST Teams ($1m) x 3
12-bed unit for adolescents with mental health issues and high risk behaviours, involved in the juvenile justice system

5.4 Transcultural Mental Health

CALD children and adolescents face particular life changes and challenges that may increase vulnerability and risk from factors such as:

- cultural identity; loss of sense of self
- discrimination; racism
- peer relations,
- cultural views on sexuality and sexual identity;
- family pressures; intergenerational conflict
- work, academic and career expectations of family vs young person

These factors may result in an increased risk of suicide, increased vulnerability to drug and alcohol problems, anxiety, depression, distress and poor self esteem which may be hidden by withdrawal or alternatively, aggressive and acting out behaviour.

There is a need to consider the refugee experience: separation from families, camp life, detention experience, educational disadvantages due to disrupted schooling.

A number of Transcultural Mental Health Co-ordinators have recently been funded across Queensland. It is proposed that these positions provide consultation/liaison for CYMHS services around the state. Consideration should be given to establishing additional positions in 2011-2016. The child and youth specialist positions at Mater and RCH should play a role in ensuring that the Transcultural Mental Health Co-ordinators in other centres are up-skilled in child and youth mental health. These positions are:

2006/07- 2007/08	1 x FTE at Gold Coast, Logan, PAH, Royal Brisbane and Women's Hospital, Cairns network, The Prince Charles Hospital
2007/08 – 2008/09	1 x FTE at Townsville, 0.5 FTE at West Moreton and Bayside
2008/09 – 2009/10	0.5 FTE at Sunshine Coast and Redcliffe-Caboolture

Consideration should be given to further enhancement of services for children, young people and families from CALD backgrounds in 2011-2016, based on usage rates, demand and population trends.

The Transcultural Mental Health subgroup has clearly identified a need to enhance and engage non-government organizations who work with people from CALD backgrounds, to improve access to mental health services, provide more effective mental health treatment, and ensure culturally safe and appropriate supports and follow-up. From a child and youth perspective, it is important to ensure that the needs of children, young people, and families, are considered in these partnerships and initiatives.

References:

Review of Transcultural Mental Health Services in Queensland 2005
Transcultural Mental Health Subgroup Report, 2006

5.5 Indigenous Mental Health

A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009 is a five year plan to guide the work of the many agencies, both government and non-government, that work towards improving the mental health and social and emotional well being of Aboriginal and Torres Strait Islander peoples.

The Framework has been endorsed by Commonwealth and State/Territory Governments and represents agreement among a wide range of stakeholders on the broad strategies that need to be pursued. It thus provides a common ground and a basis for cooperation among responsible agencies, which include a range of Commonwealth portfolios, State Government agencies, local government, and non-government service providers.

Development of the indigenous workforce within CYMHS teams and specialist services such as MHATODS has been incorporated within the relevant sections of the Plan. In addition, the Remote Area Child and Youth Mental Health Service requires the following enhancements to provide adequate service across the remote communities of Cape York and Torres Strait:

Indigenous Mental Health Enhancements:

- 1.0 FTE x AO2
- 2.0 FTE x PO3/NO2
- 3.0 FTE x TO2/004 Indigenous Mental Health Workers

5.6 Child Safety Therapeutic Support

The Child Safety Interagency Therapeutic and Behaviour Support Services consist of Department of Child Safety funded teams in Queensland Health and Disability Services Queensland (Behaviour Support). Enhanced participation in education through the Education Support Planning process in the Department of Education and the Arts have a close linkage with this interagency model, as does the Department of Child Safety as the referral source and case manager of the children and young people referred.

Nine Mental Health-Child Safety Therapeutic Support Teams are being established across Queensland, operating through a 'hub and spoke' model:

- Area approach to research, training, practice supervision and therapeutic residentials.
- Cross-District approach to medical staffing, clinical service delivery, and clinical and operational supervision (ie. Hub)
- District approach to enhancement of CYMHS capacity, in districts with a significant number of the target population (ie. Spoke)

It is estimated that 17% of children and young people in the care of the Department of Child Safety have complex or extreme needs. These children are the priority of the Child Safety Interagency Therapeutic and Behaviour Support Services, with some of the estimated 26% of children in care with high needs also receiving enhanced therapeutic support (eg. children under 5 years of age with high need).

The Mental Health Child Safety Support Teams are geographically distributed as Brisbane South, Logan, Gold Coast, Western, Central, Sunshine Coast/Burnett, Brisbane North, Northern, Far Northern. A trial of Multi-Systemic Therapy (MST) is being undertaken in Mater CYMS as part of the Mental Health Child Safety Initiative.

No specific enhancements are requested for child safety initiatives in mental health, given the current roll-out of the Child Safety Support Teams. It is envisioned that other enhancements for CYMHS services, emergency psychiatry and acute care teams, may assist with early intervention strategies to prevent children coming into the care of the Department of Child Safety. Potential expansion of the MST program is addressed elsewhere in the Plan.

References:

Child Safety Unit, Queensland Health 2006

6. Workforce

6.1 Competencies

CYMHS is a sub-specialty within the specialised field of mental health service delivery, and requires competencies in biopsychosocial assessment and complex psychological modes of treatment for children, adolescents, parents and families.

- Pre-entry level competencies are acquired through student placements in undergraduate and post-graduate training programs.
- Entry level competencies are acquired through postgraduate study or through supervision and training in the field.
- Progress to higher level independent practice is through training in specific modalities and continuing supervision. Gaining competency in providing supervision is an essential requirement to progress to this level.
- Experienced clinicians may further specialise their competencies through professional affiliations and training.

The current workforce is multidisciplinary with traditional representation from the disciplines of child psychiatry, medicine, nursing, psychology, social work, occupational therapy and speech pathology. Training positions in psychiatry and child psychiatry have existed as part of the workforce but have become increasingly hard to fill.

Emerging disciplines in the creative therapies (eg art and music therapy) have demonstrated application in CYMHS as have youth and welfare workers who form a major part of the non-government workforce.

Specialization in the child and youth mental workforce is a complex issue. On the one hand, there is a need to provide services close to where people live, and to avoid disrupting family and social networks. On the other hand, it is not possible to provide safe, quality, sustainable services for every sub-specialty of child and youth mental health in every District. There is a benefit in fostering "centres of excellence" in particular sub-specialties (eg. eating disorders, sequelae of trauma) which can pursue research, attract and retain quality professional staff, and provide professional development and support to other service providers through the variety of models outlined in this Plan.

In general, the Plan does not support the establishment of solo practitioners, for reasons of professional isolation and burn-out. Where a sole child and youth mental health practitioner is established, it is recommended that such positions be designated no lower than PO3/NO2, and that particular efforts are made to link these positions to the adult mental health service, relevant providers of mental health-related care for children and young people, and networks within child and youth mental health which operate at cross-District, Area, and/or state levels.

6.2 Gaps in the workforce

6.2.1 Entry Level Traineeships

There are no entry level traineeships currently available in allied health and nursing. Supernumerary training positions will be established as rotational positions (including regional and rural placements, cross-District as necessary) at:

- Royal Children's Hospital x 6
- Mater CYMHS x 6
- Townsville x 5 (for Advanced Health Worker/Professional Officer trainees, rotations to include Townsville, Cairns, outlying communities)
- Gold Coast x 3
- Logan x 2
- Sunshine Coast x 2
- Royal Brisbane Adolescent Unit x 2
- Barrett Adolescent Centre x 2
- Toowoomba x 2

Rural scholarships should be explored as a means of helping to support these positions.

6.2.2 Nurse Education

There is no systematic approach to nurse education in CYMHS incorporating early career skills development and support and access to training in work hours. CYMHS Nurse Educators (NO3) will be established in:

- Royal Children's Hospital (1.0 increasing to 1.5 to also cover Day Programs)
- Townsville (0.5 increasing to 1.0 to also cover Day Program)
- Mater CYMHS (1.0 increasing to 1.5 to also cover Day Programs)
- Gold Coast (1.0 to also cover Day Program)
- West Moreton (1.0 to cover West Moreton CYMHS and Barrett Adolescent Centre)
- Toowoomba (1.0 to cover Toowoomba CYMHS, spoke Districts, and day program)
- Sunshine Coast (0.5)
- Logan-Beaudesert (0.5)
- Cairns (0.5)

These positions can support Nurse Transition programs and rotational nursing positions.

6.2.3 Co-ordinated CYMHS Education Program

Provision of comprehensive training for CYMHS staff is an undertaking to which considerable effort has been devoted over a number of years. Currently, Royal Children's Hospital provides a training program which is open to employees of other CYMHS services. A number of training modules were developed for staff of child and adolescent inpatient staff, with broad-based academic and clinical input at both initial development and review stages. These resources are currently held by the Centre for Mental Health Learning. A CYMHS Educator (PO4) will be established in each Area, linked to the Queensland Centre for Mental Health Learning, with Training Officers at District level to assist with coordination of training needs locally:

- Royal Children's Hospital
- Mater CYMHS

- Townsville

6.2.4 Co-ordination of Student Placements

There is no active coordination of student placements, which would add value to the placement experience to prime the future workforce. Training Officer (PO3) positions will be established at:

- Royal Children's Hospital
- Redcliffe Caboolture
- Sunshine Coast
- Rockhampton
- Bundaberg
- Townsville
- Mater
- Gold Coast
- Logan-Beaudesert
- Toowoomba
- West Moreton
- Bayside
- Cairns

6.2.5 Enhanced Allied Health Career Structure

There is very limited infrastructure for supervision, training and development in CYMHS. There are insufficient numbers of specialized therapists, for example family therapists, and insufficient opportunities to incorporate emerging disciplines such as art and music therapists into therapeutic programs.

With the expansion of services proposed under the Plan, a number of new allied health professional seniors will be required. Two 2 new Team Leader positions need to be added to Mater CYMHS establishment to compensate for unfunded Team Leader positions which were drawn from clinical workforce. Sunshine Coast CYMHS has only one PO4 professional senior to cover the CYMHS and Child Safety Teams, and requires an additional PO4 position, as does West Moreton.

Significant enhancements will be made to the allied health career structure, including the capacity to provide supervision for emerging new elements in mental health service delivery:

Royal Children's Hospital:
- upgrade 3 x PO5 Professional Officers to PO6 (+ joint academic role)
- upgrade Statewide Professional Allied Health Leader from PO4 to PO6, to co-ordinate supervision, with an emphasis on supervision for rural and remote staff, and peer supervision for senior staff

Townsville:
- upgrade 1 x PO4 Professional Officer to PO5 (+joint academic role)

- Advanced Health Worker specialist (OO7) to provide statewide leadership in indigenous child and youth mental health (linked with Centre for Rural and Remote Mental Health)

Mater
- 2 x new professional senior positions PO5 (possibility of upgrade)
- upgrade 1 x Professional Officer PO4 to PO6
- upgrade 2 x Professional Senior positions PO4 to PO5 (+ joint academic role)
- 1 new Professional Senior PO4 position

Gold Coast
- 1 x new Professional Senior position PO4
- 1 x new Professional Senior position PO5

Logan-Beaudesert
- 1 x new Professional Senior position PO4

Sunshine Coast
- 1 x new Professional Senior position PO4

West Moreton
- 1 x new Professional Senior position PO4

Allied Health Enhancements of 0.5 FTE x PO3, to provide backfill:

- Central Highlands
- Gympie
- North Burnett
- Bowen
- Charters Towers
- Innisfail
- Moranbah
- Mt Isa
- Tablelands
- Northern Downs
- Roma
- South Burnett
- Southern Downs

6.2.6 Enhanced Administrative Support

There is insufficient administrative support within Districts to cater for clinic-based and outreach models of care. Based on the recommendation of 1 administrative officer per 10 clinical staff, plus 1.0 FTE per District (AO2) to assist outreach models of service delivery, enhancements should be established in:

- Royal Children's Hospital – 1.0 FTE x AO2
- Redcliffe-Caboolture – 1.0 FTE x AO2
- Sunshine Coast - 1.0 FTE x AO2
- Rockhampton - 1.0 FTE x AO2

- Bundaberg - 1.0 FTE x AO2
- Cairns - 1.0 FTE x AO2
- Townsville - 1.0 FTE x AO2
- Mackay - 1.0 FTE x AO2
- Mater - 1.0 FTE x AO2
- Gold Coast - 1.0 FTE x AO2
- Logan-Beaudesert - 1.0 FTE x AO2
- Toowoomba - 1.0 FTE x AO2
- West Moreton - 1.0 FTE x AO2
- Bayside - 1.0 FTE x AO2

6.2.7 Service Development Officers

There is limited capacity within services to undertake service evaluation in a sustainable fashion, and to use the results of evaluation to guide service development. Service Development Officers (PO3/AO6) with skills in data analysis and interpretation will be appointed within hubs, to support CYMHS service development in Districts through a hub and spoke model:

- Royal Children's Hospital - 1.5 FTE
- Mater CYMHS – 1.5 FTE
- Townsville – 1.5 FTE
- Sunshine Coast – 1.0 FTE
- Rockhampton – 1.0 FTE
- Gold Coast – 1.0 FTE
- Logan-Beaudesert – 1.0 FTE
- Toowoomba – 0.5 FTE
- West Moreton – 0.5 FTE
- Bayside – 0.5 FTE

6.2.8 Team Leader Review

There is significant variation in levels of responsibility for Team Leaders, currently designated PO4, dependent on service context. Many PO4 rural team leaders are in effect managers of their services, with the same responsibilities, demands and accountability of much higher-level managers in metropolitan areas. Many PO4 team leaders in regional and metropolitan centres also manage large teams (>10 staff) and complex service activities. There is also the issue that the PO4 streaming of team leader positions provides a disincentive for nursing staff, who can obtain better remuneration by remaining in the nursing stream since EB6. All PO4 Team Leader positions should be reviewed, and funding quarantined for upgrades (approximately 35 upgrades from PO4 to PO5, or potentially into nursing stream, expected to result from review). It is recognized that the review is likely to have implications for Team Leaders of Mental Health - Child Safety Support Teams and Forensic services.

6.2.9 New Workforce

A 12-month pilot project will be implemented in Royal Children's Hospital and Health Service District, to explore the use of youth and family support workers within CYMHS teams. It is proposed that by employing a cohort of semi-professional staff to

provide support services under the direction of health professionals, there will be a two-fold effect:

- Professional staff will be freed up to provide more intensive clinical interventions and also provide assessment and treatment planning to an increased caseload.

- Enhanced support services will be available to young people and their families while engaged in treatment, thereby reducing service gaps and enhancing recovery.

Duties and responsibilities of support workers may include: telephone contact (including assertive follow-up); structured skills training; role modelling; assistance with engagement and follow-up by enabling a higher level of contact; setting up liaison meetings and minuting clinical planning; provision of structured psycho-education information; accompanying clinical staff on home visits where necessary; life skills support; group therapy support; and assistance with health promotion activities.

Staffing:

1.0 FTE x AO6 Project Officer
1.0 FTE x TO3 Youth/Family Support Worker
1.0 FTE x TO2 Youth/Family Support Worker
2.0 FTE x 004 Youth/Family Support Worker

Total budget: $487 197 (Attachment 3)

6.3 Consumer and carer participation

Consumer and carer participation has had necessary development and acceptance within adult mental health services largely driven by mental health reform agenda against a background of activity in consumer and human rights movements. Resources are required to focus attention on the development of an appropriate model of consumer and carer participation which accommodates issues relevant to CYMHS. Consumers in CYMHS are diverse in age range, developmental need, family role, composition and living situation. They access CYMH services in a variety of ways for varied lengths of time and can be involved with a range of stakeholders in a complex service system. These characteristics need to be accommodated when defining and developing consumer and carer participation in CYMHS.

To date, very few services have been able to devote scarce resources towards consumer and care participation. The work that has been done at Mater CYMHS demonstrates a method for sustainable involvement of the voice of the parent in CYMHS, the employment of consumer consultants and the involvement of consumers and carers in service planning and delivery and staff orientation and training. Youth participation requires a similar focus but has had much less systematic attention although services have been able to harness the voice of young people around specific projects. Resource specific to CYMHS need to be allocated and linked to other dedicated consumer participation projects.

Consumer consultants are required for the following CYMHS Services:

- Royal Children's Hospital x 2
- Mater CYMHS x 2
- Gold Coast x 2
- Logan-Beaudesert x 2
- Sunshine Coast x 2
- West Moreton x 1
- Bayside x 1
- Redcliffe-Caboolture x 1
- Cairns x 1
- Toowoomba x 1
- Mackay x 1
- Rockhampton x 1
- Bundaberg x 1
- Fraser Coast x 1

Training is required for consumer consultants, with input from experience consumer consultants. Input from consumer consultants should be an essential element of the training program for CYMHS staff.

Workforce Enhancements

Traineeships (entry level/PO1) x 30
Nurse Educators (NO3) x 8.5
CYMHS Educators (PO4) x 3
Training Officers (PO3) x 13
Allied Health Upgrades and Enhancements (PO5 to PO6 x 3, PO4 to PO6 x 2, PO4 to PO5 x 3)
Team Leader Upgrades (up to 35 expected from PO4 to PO5)
New Professional Senior PO5 x 3
New Professional Senior PO4 x 5
Administrative Support (AO2) x 14
Leave relief/backfill enhancements (PO3) x 0.5 FTE x 13
Service Development Officers (AO6) x 10.0
Consumer Consultants x 19
Advanced Health Worker (007)
New Workforce Project $487 197

References:

Workforce Subgroup, Mental Health Plan 2006

7. Intersectoral Collaboration

7.1 Partnership Facilitators

The agencies, organizations and private providers operating in each District will vary. As examples, it is envisioned that the Partnership Facilitators may develop relationships with:

- adult mental health services in the local District
- Mental Health Promotion Officers (Public Health)
- School-Based Youth Health Nurses (Public Health)
- Child and Youth Health Services
- Early childhood services including childcare centres in the local District
- Schools (Education Queensland, private schools) and education personnel (eg. Behaviour Support Teachers, Guidance Officers, school counsellors)
- Prevocational and vocational education providers (eg. TAFE colleges)
- Tertiary education centres (eg. universities)
- General Practitioners
- Private service providers (eg. private Psychologists)
- Accommodation providers in the local District
- Psychosocial rehabilitation and disability support providers in the local District
- Counselling service providers in the local District
- Department of Child Safety personnel
- Disability Services Queensland personnel
- Department of Housing personnel
- Department of Communities personnel
- Aboriginal Medical Service and other indigenous-specific services
- Multicultural/transcultural health services
- Drug and alcohol services in the local District
- Local government, particularly in rural and remote communities

Partnership Facilitators (PO3/NO2/AO6) should be established in the following centres:

- Royal Children's Hospital
- Mater CYMHS
- Townsville
- Gold Coast
- Sunshine Coast
- Toowoomba
- Logan-Beaudesert
- Redcliffe-Caboolture
- Rockhampton
- West Moreton
- Cairns
- Mackay
- Bayside
- Bundaberg
- Fraser Coast
- Southern Downs

7.2 Non-government organizations

Queensland Health has recognized a need to work more collaboratively with non-government organizations, particularly where the care of a patient can be readily conceptualized in terms of clinical components to be provided by Queensland Health, and non-clinical components which can better be provided by a non-government organization. There is also recognition that some non-government organizations in some Districts have or could readily develop the expertise and capacity to provide clinical services.

A number of options could be explored in Districts, for co-location of CYMHS staff with non-government organizations, and vice versa. For example, in some Districts it may be mutually beneficial to place CYMHS workers in an Aboriginal Medical Service. Service improvement strategies such as this could be explored through the Partnerships Facilitators.

Non-government organizations indicate that being funded by various government agencies can pose a barrier to providing an holistic service or program, and that greater co-ordination of funding arrangements is required to improve service provision and sustainability. It has also been identified that competitive tendering processes work against collaborations among non-government organizations, which could increase capacity and scope of service provision if encouraged. Non-government organizations seek changes to funding models, tendering processes, and the definition of "partnerships" in relation to government agencies, to promote more equal and more effective cross-sector work.

7.3 Education Queensland

It has been proposed that effective service provision could be facilitated by the co-location of some CYMHS teams or staff in schools, or with behavioural units that serve a number of schools. Like Behaviour Management teachers, CYMHS staff could visit schools to provide support to school personnel. It is envisioned that CYMHS staff could support Guidance Officers, School-Based Youth Health Nurses, and teachers, working with children and families. Roles could include assisting with universal prevention/health promotion programs, screening and early identification, providing comprehensive assessment, assisting appropriate referral (including referral for treatment by the CYMHS service), potentially providing treatment in the school setting, assisting school reintegration for children who have been absent due to mental health issues, and providing staff training and support in relation to mental health issues.

The integration of elements of CYMHS services with school settings would require an agreement between Queensland Health and the relevant education body (Education Queensland, Catholic Education, Independent Schools), as well as local leadership and service development, the foundation for which could be laid through the Partnerships Facilitators.

7.4 Department of Child Safety

Ongoing liaison with Department of Child Safety is the responsibility of the Child Safety Unit at Corporate level, but should be maintained at local levels through the Partnership Facilitators.

7.5 General Practitioners

Victorian models, whereby mental health staff operate service co-located with general practitioners, have been shown to be effective in promoting a partnership approach to holistic care, and may have benefits for stigma reduction and increasing community understanding of mental health issues. The possibility of co-locating CYMHS staff with general practitioners could be explored in some Districts through liaison with Divisions of General Practice, and through the Partnership Facilitators at local levels.

7.6 Joint Assessment Services

1. Based on the Access Clinic model being trialled in Mater CYMHS, joint Education Queensland-Paediatric-CYMHS-Child Development Service assessment clinics for school learning and behaviour problems (including Attention Deficit Hyperactivity Disorder and disruptive behaviour disorders) will be established at:

- Mater CYMHS
- Royal Children's Hospital
- Townsville
- Gold Coast
- Sunshine Coast
- West Moreton

The mental health component of each team will consist of:

- 1.0 x FTE Psychologist (PO3)
- 0.3 x FTE Administrative Officer (AO2)
- 0.2 x FTE Psychiatrist

Consideration should be given to a more concerted roll-out of these teams in 2011-2016.

2. In partnership with Disability Services Queensland, a Specialist Assessment Unit for children and adolescents will be established in conjunction with Mater CYMHS inpatient unit. This unit will facilitate comprehensive assessment and initiation of psychopharmacology, and will foster co-ordination capacity with Disability Services Queensland. The 4-bed unit will require:

- 0.5 x FTE Psychiatrist
- 1.0 x FTE Registrar (paediatric or psychiatric Registrar)
- Running costs equal to approximately 1/3 Mater inpatient unit's current budget for 12 beds

Intersectoral Collaboration Enhancements

16 x FTE (PO3/NO3) Partnerships Facilitators
6 Joint Assessment Clinics – 6.0 x FTE Psychologist (PO3), 1.8 x FTE Administrative Officer (AO2), 1.2 x FTE Psychiatrist
Special Assessment Unit – 0.5 x FTE Psychiatrist, 1.0 x FTE Registrar, running costs equal to approximately 1/3 Mater inpatient unit's current budget

8. Information Management

While information management is recognized as a vital enabler for the provision of quality CYMHS services and for continuous quality improvement, information systems development for CYMHS is incorporated with information systems development for mental health services more broadly.

9. Research

High-quality, evidence-based mental health care relies on the clinical front-line being informed by contemporary research. While the tertiary hubs for CYMHS services have well-established links with major universities, there is a need to build on emerging opportunities for partnerships between the tertiary education and research sector, and CYMHS services particularly in outer metropolitan and regional centres.

10. Capital Works

10.1 Office Accommodation for Community Mental Health Staff

Overwhelmingly, one of the major capital works requirements identified by District mental health services is the need for office accommodation for community staff, including community CYMHS staff. Some Districts wish to co-located community mental health services with community health services. Others prefer their CYMHS services to operate from home-like environments (eg. houses in the community) or shop-front services. It is also proposed to adopt innovative approaches such as basing CYMHS teams or staff in schools or Education Queensland behaviour centres, or in GP clinics.

In view of the range of preferences, the lack of forward planning for community health facilities, and the lag-time between approval to build new facilities and completion of these facilities, a feasible option is to identify a "bank" of funding which can be accessed by District mental health services for the purposes of leasing premises or undertaking modifications to existing buildings in order to accommodate community CYMHS teams.

10.2 Accommodation for rural and remote staff

In rural and remote centres, rental accommodation is often scarce or non-existent. Staff who do not intend to stay long-term in a rural centre are reluctant to buy a home there, and currently a financial disincentive exists in that rental costs are subsidized whereas mortgage payments are not. Lack of accommodation is one factor identified as a barrier to the recruitment and retention of staff for rural and remote mental health services.

A fund should be allocated for District health services needing to buy or build staff accommodation, which can then be used by CYMHS staff among others as the need arises.

10.3 Redevelopment of acute inpatient units

It is envisioned that in the short term, the Child and Family Therapy Unit at Royal Children's Hospital, the inpatient unit at Mater Hospital, and the adolescent inpatient unit at Royal Brisbane and Women's Hospital, should be rebuilt as purpose-built, ground-floor units, each with capacity to convert some beds to a High Dependency Unit as needed, access to outdoor space, and capacity to run a day program.

10.4 Modifications to paediatric wards

In some cases, transferring children from rural and regional centres to the tertiary hubs in Brisbane may be avoided if treatment can be undertaken in a local paediatric inpatient setting. Minor modifications to paediatric wards may be necessary in order to facilitate such treatment, for example to allow rooming-in by families. A fund should be allocated for minor capital works to existing buildings to facilitate local treatment.

10.5 Day programs

Day programs in some locations will require modification and expansion of existing buildings, while others will require new buildings, or could potentially be run from leased premises in close proximity to other mental health services.

10.6 Future inpatient facilities

It is envisioned that an 8-bed inpatient unit, with capacity for 2 swing beds to be used as a High Dependency Unit or to provide secure care if needed, will be built in Townsville in the period 2011-2016. Allowance should also be made for the commencement of planning for beds at Sunshine Coast.

10.7 Redevelopment of Barrett Adolescent Centre

Barrett Adolescent Centre currently consists of a school building and a ward building, with office space for health and education staff in each. The redevelopment will require the building of a 14-bed ward areas and a 6-bed ward area (the latter with capacity to be used as a High Dependency Unit over an extended period), a school/day-program area, and a transitional/independent living house on-site. Other components of the expanded program (family stay units, and therapeutic residential) should be established in collaboration with the Department of Housing, as well as non-government service providers, but funding should be allocated for leasing costs as required.

10.8 Specialist unit for adolescents in juvenile justice system

The potential need for a 12-bed unit to care for adolescents with severe and complex mental health issues, and high risk behaviours, who are involved in the juvenile

justice system, has been flagged in the Queensland Forensic Mental Health Service Plan 2006-2011.

Capital Works Requirements

Office Accommodation for Community Mental Health Staff
Accommodation for rural and remote staff
Redevelopment of inpatient units – CAFTU, Mater, RBWH
Modifications to paediatric wards
Day programs
Future inpatient facilities
Redevelopment of Barrett Adolescent Centre
12-bed unit for adolescents with mental health issues and high risk behaviours, involved in the juvenile justice system

11. Corporate Governance

The recent restructure of Queensland Health has resulted in reduced staffing in Mental Health Branch, and a narrowing of focus to policy and legislative issues. There remains some lack of clarity regarding the responsibilities, and accountability, of the Director of Mental Health in relation to the General Managers, Area Health Services, District Managers, and Clinical CEOs, which needs to be resolved.

The implementation of clinical improvement and expansion is expected to be taken up by Area Health Services. However, while Area Health Services have been augmented, there has been no increase in mental health-specific positions commensurate with the reduction in Mental Health Branch staff.

Much of the leadership in mental health service delivery is expected to come from the Area Mental Health Networks, specifically the Clinical Chairs. However, Network members are clinicians and managers who already shoulder heavy workloads seeing clients and running services. The allocation of two sessions per week of the Clinical Chair's time, devoted to Network business, is insufficient to ensure the effective implementation of mental health service delivery across the age-range.

It is considered necessary to establish a standing Child and Youth subgroup of the Statewide Mental Health Network, and mechanisms for facilitating connectivity across the three Area Mental Health Clinical Networks.

It is important to provide some capacity for project work arising from the interests of the Child and Youth Subgroup of the Statewide Mental Health Network, and from the Area mental health networks. In addition to the support provided by the statewide Principal Project Officer, Child and Youth Mental Health, a Senior Project Officer position (AO6) should be established to provide co-ordination and leadership for specific components of CYMHS service development over time. Initially it is envisioned that this position could support the co-ordination and development of services for Children of Parents With Mental Illness.

The position of statewide Principal Project Officer, Child and Youth Mental Health, is temporarily funding to 2008. This position should be permanently funded. There is also a need to clarify and promote the role.

Corporate Governance Enhancements

AO6 Senior Project Officer

ATTACHMENT 1: Proposed Staged Implementation of Child and Youth Mental Health Enhancements

	2007-08	2008-09	2009-2010	2010-11	2011-2012
Workforce					
Traineeships	6.0 x PO1	6.0 x PO1	6.0 x PO1	6.0 x PO1	6.0 x PO1
Nurse educators	2.5 x NO3	2.0 x NO3	2.0 x NO3	2.0 x NO3	2.0 x NO3
CYMHS educators	3.0 x PO4				
Training Officers	3.0 x PO3/NO2	3.0 x PO3/NO2	3.0 x PO3/NO2	4.0 x PO3/NO2	
Allied health upgrades	All				
Team leader reviews	All				
New professional seniors PO5	1.0 x PO5	1.0 x PO5	1.0 x PO5		
New professional seniors PO4	1.0 x PO4	1.0 x PO4	1.0 x PO4	1.0 x PO4	1.0 x PO4
Administrative support	13.0 x AO2				
Backfill enhancements	13.0 x PO3/NO2				
Service Development Officers	10.0 x AO6				
Consumer Consultants	7.0	6.0	6.0		
Advanced Health Worker	1.0 x OO7				
New Workforce Project	$487 197				

Intensive Treatment Enhancements					
Redevelopment of inpatient units	1 redevelopment	1 redevelopment	1 redevelopment		
Modifications to paediatric wards	$1.3 m to be used as requested				
Staffing enhancements CAFTU, Mater	Accompany redevelopments				
Day Programs	1 program	2 programs	1 program	1 program	1 program
Expansion Mater Day Program	Mater				
Full staffing, Gold Coast Adolescent Unit	2.0 x NO1 2.0 x PO3				
Redevelopment Barrett Adolescent Centre	$17 m capital works 44.0 x FTEs				
20% loading on bed day costs	20% loading				
Increase Patient Transit Scheme					
Continuing Care Enhancements					
e-CYMHS	$431 569 + $458 383	$427 964 + $427 964	$632 124 + $632 124	$787 623 + $682 124	$863 450 + $770 656
Community staff to ratio 40:100 000					
Speech pathology input as teams roll out	1.0 x PO3 1.0 x TO2/OO4				
Young Adult Outreach Services	4.0 x PO3/NO2/ TO2/OO4	4.0 x PO3/NO2/ TO2/OO4	4.0 x PO3/NO2/ TO2/OO4	4.0 x PO3/NO2/ TO2/OO4	

Infant and Early Childhood Mental Health Enhancements					
	$5 200 000 capital works 2.6 x Psychiatrist 3.0 x Registrar 4.0 x PO4/NO3 Team Leader/NUM 10.0 x PO3/NO2 10.0 x NO2 2.5 x PO3 speech pathologist 3.0 x PO4 Prof Devt Officer 1.5 x PO3 Research Officer 2.0 x TO2 Indig MH Worker 3.0 x AO3	2.5 x Psychiatrist 2.0 x Registrar 2.0 x PO4/NO3 Team Leader/NUM 17.0 x PO3/NO2 2.0 x PO3 speech pathologist 2.0 x PO4 Prof Devt Officer 1.0 x PO3 Research Officer 4.0 x TO2 Indig MH Worker 2.0 x AO3	10.0 x PO3/NO2		
Emergency Psychiatry Enhancements					
Emergency Psychiatry Teams	20.0 x FTE	20.0 x FTE	20.0 x FTE	20.0 x FTE	16.5 x FTE
Mobile Acute Care Teams	18.0 x FTE	18.0 x FTE	18.0 x FTE	18.0 x FTE	12.0 x FTE
24-hour phone line	Commence				
Increase Accommodation Options	Commence				

Intersectoral Collaboration Enhancements					
Partnerships Facilitators	16.0 x FTEs				
Joint Assessment Clinics	2 clinics	2 clinics	2 clinics		
Special Assessment Unit	0.5 x Psychiatrist 1.0 x Registrar Running costs approximately 1/3 Mater inpatient unit budget				
Eating Disorders Enhancements					
Care Co-ordinators	8.0 x PO4	2.0 x PO4	2.0 x PO4	2.0 x PO4	
Intensive Outpatient Treatment	1 program	1 program	1 program	1 program	
Regional Enhancements	2.0 x PO3/NO2				

Promotion, Prevention, Early Intervention Enhancements					
Services for Children of Parents with Mental Illness (COPMI)	8.5 x PO3/NO2				
Consultation/Liaison Services	2.0 x PO3/NO2 0.5 x Registrar	4.0 x PO3/NO2	4.0 x PO3/NO2	2.0 x PO3/NO2	
Resourcing for mental health policy as per MH Promotion, Illness Prevention and Early Intervention Plan					
Forensic Mental Health Enhancements					
Clinical Leader	1.0 x MO2 Psychiatrist				
Southern/Central CYFOS	1.0 x PO3/NO2 1.0 x Court Liaison	1.0 x PO3/NO2 1.0 x Court Liaison	1.0 x PO3/NO2 1.0 x Court Liason		
Southern/Central MHATODS	1.0 x TO4 0.5 x TO2 3.0 x PO3/NO2 0.5 x Psychiatrist	1.0 x PO3/NO2		1.0 x TO3	
Northern CYFOS		1.0 x PO3/NO2 1.0 x Court Liaison	1.0 x PO3/NO2 1.0 x Court Liaison		
Northern MHATODS	1.0 x TO4 1.0 x PO3/NO2 0.5 x Psychiatrist	1.0 x PO3/NO2		1.0 x TO3	
Multisystemic Therapy Teams		1 Team	1 Team	1 Team	
12-bed unit for adolescents in juvenile justice system	Commence Planning				

Dual Diagnosis Enhancements					
	2.0 x PO3/NO2 Mater	1 new team (15.0 FTEs) 2.0 x PO3/NO2 Cairns	1 new team (15.0 FTEs)	1 new team (15.0 FTEs)	1 new team (15.0 FTEs)
Indigenous Mental Health Enhancements					
	1.0 x AO2 2.0 x PO3/NO2 3.0 x TO2/OO4				
Capital Works					
Office accommodation for community CYMHS staff	Fund to be quarantined				
Accommodation for rural and remote staff	Fund to be quarantined				
Modifications to paediatric wards	Fund to be quarantined				
	Acute inpatient redevelopment 1	Acute inpatient redevelopment 2	Acute inpatient redevelopment 3		
Day Programs	1 program	1 program	1 program	1 program	1 program
Future inpatient facilities	Planning to commence				
Redevelopment of Barrett Adolescent Centre	To commence				
12-bed unit for forensic MH	Planning to commence				

Corporate Governance Enhancements					
Senior Project Officer	1.0 x AO6				
Permanent funding of Statewide Principal Project Officer Child and Youth Mental Health	1.0 x AO7				

ATTACHMENT 2:
Statewide Child and Youth Mental Health Plan –
*Infant and Early Childhood Mental Health Services

*Name chosen to reflect the age range treated. Early years or Early Childhood as terms tend to be associated with the age range of early years of schooling ie. 3-5 years. It is important not to lose the emphasis on the babies and those under three that we are targeting by these mental health programs.

Background

- Research indicates that the quality of relationships in the early years of life can have far-reaching effects on human development across the lifespan and that good mental health outcomes have a basis around secure parent-child attachments (*Hay, 2003*).
- The early years of development from conception to age six, particularly the first three years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life" (*Mustard, 1999*).
- Studies have identified that "the first few months and years of life are a sensitive period when children develop attachments and learn about emotions and social interactions in their family. This lays the foundations for future social, emotional and cognitive development. Children who do not have secure relationships early in life are at greater risk of significant mental health problems, educational difficulties or conduct disorders" (*Child Psychotherapy Trust and the Association for Infant Mental Health, U.K.*).
- It is recommended that services that help parents and caregivers need to focus on the relationship of the parent or caregiver and infant; be offered at an early stage when relationships are still being formed; provide support to parents and caregivers, based on building up confidence and skills in caring for children; and address the wider environmental circumstances of the family, including their socio-economic needs (*Child Psychotherapy Trust and the Association for Infant Mental Health, U.K.*).
- It is now well recognised that the pathways to the development of mental health problems and mental disorders are complex and multi-factorial in nature. It is therefore important to consider a multiplicity of determinants including psychosocial, demographic and environmental factors that are unique to individuals and their families, as well as the social and economic inequities within our communities (*Commonwealth Department of Health and Aged Care, 2000*).
- To maximise the mental health and well being of families with young children, a comprehensive approach that is integrated across all sectors of care and all levels of society, is required. A population health approach provides a conceptual framework to address the factors that impact on individuals, families and communities such as social support networks, child development and health services, personal health practices, coping skills, education and education settings, physical environments, biology and genetics, working conditions, income and social status *(National Mental Health Plan 2003-2008)*.
- The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* has "The major mechanisms known to be instrumental in

promoting and enhancing mental health and in preventing emergent mental health disorders include: sound maternal and perinatal health; and secure attachments with caregivers who have skills and access to resources capable of stimulating infant cognitive, intellectual and emotional development . . . . . Therefore, programs aimed at providing pre- and post- natal care, enhancing parenting skills / parent-infant attachment, providing a stimulating environment and improving parental mental and physical health have long term mental health benefits".

- Priority mental health targets for Perinatal, Infants and Preschoolers are to promote cognitive and language development in the infant, reduce the incidence and prevalence of maternal depression and anxiety disorders, enhance parenting skills, child development and family functioning, and promote strong positive attachment between parent & child *(The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000)*.
- Good nutrition, nurturing and responsive caregiving in the developmental period, linked with good early childhood development programs, are beneficial for children's learning, behaviour and physical and mental health throughout life . . .Supporting families and providing early intervention programs such as preschool, childcare, child-health services, home visiting and parent education will have social and economic benefits. Research into early childhood has identified a number of environmental factors which affect the developing child and can impact on their life chances: a stimulating environment for the child, the level of harmony or conflict within the family, housing conditions, presence of positive social networks and participation in community activities *(Putting Families First, 2001)*.
- "The National agenda for Early childhood promotes prevention and early imtervention as an important strategy for improving the life chances of all children and tackling the cause of complex social problems. It encourages collaboration across sectors and governments to make the most" of resources *(Stronger Families and Communities Strategy, 2006)*.
- Future Families received funding from Second National Mental Health Plan, Promotion, Prevention and Early Intervention – February 2002 to develop, implement and evaluate the effectiveness of a pilot program in Infant Mental Health for implementation in sites across Queensland. The pilot program would be a service model based on collaboration across sectors of care and integration of existing evidence-based intervention models.
- The Future Families Framework (see Appendix) has been developed in response to identified service needs and national and state directives. In line with the *Queensland Health Prevention, Promotion and Early Intervention Framework for Mental Health (2001)*, the model aims to address the priority mental health targets of enhancing parenting skills, child development and family functioning, and promoting strong positive attachment between parent and child; with the intended outcomes of improving maternal and infant health, increasing early identification and management of individuals and families at risk of mental health problems in the antenatal and post-natal period, and improving positive nurturing learning environments. In line with research and commonwealth and state policy it uses a community-capacity building framework that can be integrated with evidence-based treatment modalities to meet the multidetermined needs of at-risk families with severe and complex mental health needs.

Closing the Gaps

- To provide mental health services for the assessment and management of infants and young children prebirth to three years at risk of impaired attachment relationships and other mental health problems.
- To develop sustainable infant mental health service delivery across metropolitan, regional, rural and remote settings.
- To ensure a critical mass of clinicians is trained and available to deliver infant mental health services across the state.
- To enhance the retention of staff by providing ongoing support and supervision.
- To allow for a capacity to grow infant mental health services in the future, particularly in areas of rapid population growth.

Innovations

- X1 **Training Centre for Infant and Early Childhood Mental Health** with x1 FTE **University affiliated academic appointment** in infant and early childhood mental health (with budget including operating costs) attached to University of Queensland Department of Psychiatry with statewide responsibility for teaching and clinical support in Infant and Early Childhood Psychiatry as well as the establishment of a program for attaining Graduate Diploma/Masters in Infant Mental Health in conjunction with New South Wales Institute of Psychiatry.
- X5 **Professional Development Officers with budget to include operating costs for airfares, accommodation, catering etc.,** to work with the academic position to provide training, support and supervision to staff around the state.
- X8 bed **Statewide tertiary inpatient and day stay assessment and treatment facility** for infants, young children up to 5 years and their families with significant mental health issues, collocated with Riverton Statewide Program, and capable of working in collaboration with adult mental health and child health services to deliver a comprehensive service to families where there are parental mental health problems **and/or** severe and complex parent-child interaction difficulties. Unit capable of admitting families for assessment and treatment with services delivered collaboratively by infant and early childhood mental health specialists, adult mental health and child health. (Currently x4 mother-baby beds located in adult mental health services around the state – these & x4 new beds to be collocated)
- X2 **Metropolitan Centres** for Infant and Early Childhood Mental Health (RCH and Mater) as stand alone teams with roles of:
    - Infant and early childhood mental health service delivery in the local district
    - Building the capacity of service providers in the community to establish linkages and work collaboratively to deliver infant and early childhood mental health services by disseminating information and establishing networks

- Promoting collaboration and cowork across services and sectors as a model for infant and early childhood mental health service delivery across the state(see attached Future Families Framework)
- Consultation/liaison and support to other CYMHS staff and MHCSST staff dealing with children and adolescents with impaired attachment relationships and a history of infant and early childhood mental health problems
- Providing training, supervision and support in infant and early childhood mental health to CYMHS staff, MHCSST staff and community service providers in metropolitan, regional, rural and remote centres (Mater to Southern Area Health Service, RCH to Central and initially Northern Area Health Service)
- Developing a consistent statewide approach to standards, quality and service delivery based on a community capacity building framework integrated with evidence-based treatment modalities to meet the multidetermined needs of at-risk families with severe and complex mental health needs
- Coordinating and encouraging research in infant and early childhood mental health mental health

- X2 **Regional Centres** for Infant and Early Childhood Mental Health (Townsville and Gold Coast) as stand alone teams with roles of:
  - Infant and early childhood mental health service delivery in the local district
  - Building the capacity of service providers in the community to establish linkages and work collaboratively to deliver infant and early childhood mental health services by disseminating information and establishing networks
  - Promoting collaboration and co-work across services and sectors as a model for infant and early childhood mental health service delivery across the state see attached Future Families Framework)
  - Consultation/liaison and support to other CYMHS staff and MHCSST staff dealing with children and adolescents with impaired attachment relationships and a history of infant and early childhood mental health problems
  - Providing training, supervision and support in infant and early childhood mental health to CYMHS staff, MHCSST staff and community service providers in regional, rural and remote centres (Northern Area Health Service)
  - Working with x2 metropolitan Centres to develop a consistent statewide approach to standards, quality and service delivery based on a community capacity building framework integrated with evidence-based treatment modalities to meet the multidetermined needs of at-risk families with severe and complex mental health needs

  - Coordinating and encouraging research in infant and early childhood mental health mental health

- Infant Mental Health clinicians and Indigenous Health Workers as **enhancements to existing Regional CYMHS** teams with roles of:
  - Infant and early childhood mental health service delivery in the local district
  - Outreach and collaborative service delivery to rural and remote districts
  - Building the capacity of service providers in the community to build linkages and work collaboratively to deliver infant and early childhood mental health services by disseminating information and establishing networks
  - Consultation/liaison and support to other CYMHS staff and MHCSST staff dealing with children and adolescents with impaired attachment relationships and a history of infant mental health problems
  - Professional development in infant and early childhood mental health to CYMHS staff, MHCSST staff and community service providers

Implementation Components (See Table in Appendix)

Sustainable Partnerships

- Adult Mental Health Services
- Child and Youth Health Services
- Child Developmental Services
- Primary Care Services including General practitioners and the non-government sector
- Child Protection Services
- Population Health
- Linkages with other Government Departments

Workforce Implications

- Recruitment
- Retention of staff
- Training, supervision and professional development

Capital Works Implications

- Construction of tertiary inpatient and day stay assessment and treatment centre for infants, young children and their families, collocated with Riverton Statewide Service, and capable of working in collaboration with adult mental health and child health services to deliver a comprehensive service to families where there are parental mental health problems and/or severe and complex parent-child interaction difficulties.

Budget

- Current estimate from Capital Works for 8 bed unit: $5.2 million
- Staffing Costs: (see table below)
  - University Affiliated Academic Position includes operating costs
  - Professional Development Officer Positions include $20,000 operating costs per position
  - All staffing costs have superannuation and payroll tax included in estimates.
  - VMO cost includes 12.75% superannuation + $2000 per annum for study leave
  - All staffing costs are **recurrent** annual costs

Staffing Costs for Positions Itemized in Implementation Components Table			
Position	**Per Annum Cost**	**Number of Positions**	**Total Position Costs**
University Affiliated Academic Position	$300,000	1	$300,000
VMO (9 hours per week)	$88,717	2	$177,434
Staff Psychiatrist	$250,000	4.5	$1,125,000
Psychiatry Registrar (Advanced)	$125,344	5	$626,720
Team Leader (PO4)	$84,366	5	$421,830
Nurse Unit Manager (NO3)	$77,225	1	$ 77,225
Clinical (PO3) or Clinical (NO2)	$72,813 or $68,943	37	$2,694,081 or $2,550,891
Nursing (NO2)	$68,943	10	$689,430
Speech and Language Pathologist (PO3)	$72,813	4.5	$327,659
Professional Development Officer (PO4)	$104,366	5	$521,830
Research Officer (PO3)	$72,813	2.5	$182,033
Indigenous Health Worker (TO2)	$54,750	6	$328,500
Administrative Officer (AO3)	$54,756	5	$273,780
Total Cost for Implementation Components - Staffing			$7,745,522 or $7,602,332

- Total estimated costs: Capital Works $5,200,000
  Recurrent Staffing Costs $7,745,522 or 7,602,332

  Total: $12,945,522 or $12,802,332

Time Frame

- Stage 1(To begin service enhancement):
  - X2 metropoliton Centres for Infant and Childhood Mental Health – RCH and Mater
  - Tertiary inpatient and day stay assessment and treatment centre for infants, young children and their families
- Stage 2 (12 months after commencement of service enhancement):
  - X2 Regional Centre for Infant and Early Childhood Mental Health – Townsville and Gold Coast
  - Training Centre for Infant and Early Childhood Mental Health with the university affiliated academic position in Infant and Early Childhood Mental Health attached to University of Queensland Department of Psychiatry
  - Infant and Early Childhood Mental Health Clinicians and Indigenous Health Workers as enhancements to regional CYMHS teams
- Stage 3 (2-3 years after commencing service enhancement):
  - Infant and Early Childhood Mental Health Clinicians as further enhancements to regional CYMHS teams

Working Group

- Elisabeth Hoehn
- Neil Alcorn
- Judith Piccone
- Merridy Wiley
- Libby Morton

Appendices

- Implementation Components Table
- Future Families Framework

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State Health Plan Service Enhancements - Infant and Early Childhood Mental Health

FTE requirements

	Psychiatrist	Psychiatry Registrar (Advanced Training)	PO4/ NO3 (Team Leader/ Nurse Unit Manager)	PO3/NO2 (Clinical – infant/adult mental health	NO2 (Child Health/ Adult Mental Health	PO3 (Speech and Language Pathologist	PO4 (Profess-ional Develop-ment Officer)	PO3 (Research Officer)	TO2 (Indig)	AO3
Phase one (to begin service enhancement)										
RCH	1	1	1TL	3 Infant		1	1	0.5	1	1
Mater	1	1	1TL	3 Infant		1	1	0.5	1	1
Residential/ Day Stay Unit	0.3 adult 0.3 child	1 combined perinatal/infant	1/1	2/2	2/8	0.5	1	0.5		1
Phase Two (12 months after commencement)										
Townsville	1	1	1	3		1	1	0.5	1	1
Gold Coast	1	1	1	3		1	1	0.5	1	1
Sunshine Coast				2						
Redcliffe-Caboolture				2						
Logan	0.5			2						
Cairns				1					1	
Rockhampton				1					1	
West Moreton				1						
Toowoomba				1						
Mackay				1						
Phase Three (2 -3 years after commencement)										
Logan				1						
Sunshine Coast				1						
Cairns				1						
West Moreton				1						
Toowoomba				1						
Rockhampton				1						
Mackay				1						
Bundaberg				1						
Fraser Coast				1						
Bayside				1						

Total FTE	5.1	5	6	37	10	4.5	5	2.5	6	5

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ATTACHMENT 3:
Recovery Support workers in Child & Youth Mental Health Services

1. Description of the Problem

Child and Youth Mental Health Services (CYMHS) are encountering difficulty in maintaining adequate workforce availability and skill mix to support a recovery focus. Contemporary mental health services' focus is now aligned to the recovery model of care.

CYMHS are critical to a comprehensive network of care across the spectrum. However, demand on services for acute assessment and intervention is increasing. Within the current workforce availability and mix, this demand is reducing capacity to implement the recovery approach by way of more intensive support services. There is a need to explore alternative ways to develop the workforce to provide a stronger recovery support capacity.

2. Size of the Problem

Without an adequate workforce, service delivery is limited. CYMHS predominantly provide clinical services at a secondary/tertiary level to children and young people suffering severe and complex mental disorders. CYMHS also allocate resources to supporting primary care, health promotion and interagency co-ordination.

CYMHS utilise a range of health professionals who are highly skilled and require considerable investment in supervision and ongoing upskilling. Services focuses on the delivery of clinical and therapeutic assessment and treatment services to individuals, families and groups.

Increasingly professional staff are under pressure, with demand and acuity constantly increasing. For therapy to be powerful, clinical staff are also providing support, psycho-education, practical service co-ordination and liaison.

3. Description of the Proposed Intervention

Funding will be used to explore the employment and utilisation of youth and family support workers within CYMHS clinical teams. It is proposed that by employing a cohort of semi-professional staff who could provide support services under direction of health professionals, there would be a twofold effect.

I. Professional staff would be freed up to provide more intensive clinical therapy interventions and also provide assessment and treatment planning to an increased caseload.

II. Enhanced support services will be available to young people and their families while engaged in treatment, thereby reducing service gaps and enhancing recovery.

Possible duties and responsibilities of the support workers can include: telephone contact including assertive follow-up; structured skills training; role modelling; assistance with engagement and followup by enabling higher level of contact; setting up liaison meetings and minuting clinical planning; provision of structured psycho-education information; accompanying clinical staff on home visits where necessary; life skills support; group therapy support and assistance with health promotion activities.

Project Plan

- Establish a suitable reference group for project support and guidance.
- Investigate workforce models and similar systems already in use.
- Consult Central Area CYMHS and scope of practice.
- Define duties and draft Job Description.
- Investigate IR/HR issues.
- Establish career structure and on the job supervision and reporting.
- Define competencies and determine those qualifications and course programs that can supply a suitable workforce.
- Trial a small cohort and evaluate to determine feasibility.

4. Details of Supporting Evidence

- Workforce Data
- Recovery Policy
- CYMHS Future Directions Policy

5. Measurement of Impact

I. Investigation of the applicability of semi-professional support staff within CYMHS teams.
II. Practical resolution of a range of IR/HR issues and appropriate drafts and recommendations for Job Description, career structure, etc.
III. Results of trial, including recommendations for full implementation and proposed staffing ratios and location.

6. Support

1 x AO6 Workforce (21 months)
Non labour budget
Computer/Communications
Travel

Plus a budget for the trial of the workforce for 12 months

Total budget: $487 197

Queensland Health
BRIEFING NOTE FOR INFORMATION

Advisor …..……..……	OK
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Minister …..……	
Dated	/ /

TO **Gloria Wallace, General Manager, Southern Area Health Service**

FROM: *Ms Pam Lane, District Manager*
West Moreton South Burnett
Health Service District

SUBJECT **Safety Concerns & Risk Issues of Delivering Services from Barrett Adolescent Centre, The Park – Centre for Mental Health**

PURPOSE

- To inform the General Manager of the current risks of providing adolescent extended mental health care services in the current Barrett Adolescent Centre (BAC).
- To outline concerns about the ability of the BAC buildings to safely accommodate adolescents requiring extended inpatient treatment.
- To seek guidance on the interim approaches that can be taken by The Park – Centre for Mental Health to reduce the risks of the environment until redevelopment under the upcoming Statewide Mental Health Capital Works Program occurs.

RECOMMENDATION

- It is recommended that the General Manager note the ongoing risks to patient safety associated with providing adolescent extended treatment services in the current environment of the BAC, and provide guidance about approaches to improving the environment until rebuilding of the Centre occurs.
- It is recommended that the General Manager note The Park's preference for Option 2 (internal redesign) given the future rebuilding of the BAC and that there is no funding identified or allocated for major risk reduction measures or infrastructure upgrades.
- It is recommended that the General Manager seek funding from within Corporate Office to support the financial impact of redesigning part of the BAC to ensure a safe environment for the delivery of extended inpatient services to adolescents.

FUNDING SOURCE

- While funding has been flagged for inclusion in the Mental Health Plan for the redevelopment of an adolescent centre to replace BAC, there has been no funding identified or allocated for major risk reduction measures or infrastructure upgrades.

CURRENT ISSUES

The Barrett Adolescent Centre provides intensive and extended psychiatric care for adolescents whose disorders remain highly disabling or distressing despite involvement of other specialised child and youth mental health services. Many aspects of the environment increase the risk of adverse outcomes associated with delivery of care to this group.

Author's Name: Dr Terry Stedman Position: Director of Clinical Services Unit: The Park – Centre for Mental Health District: West Moreton South Burnett HSD Date: 1 October 2007	Cleared by: (DM) Name: Pam Lane Position: District Manager District: West Moreton South Burnett HSD Date: 1 October 2007

Exhibit 76 WMS.9000.0003.00244

Of particular note are the following issues that highlight this level of risk:

- In the past 18 months, 204 patient-related incidents were recorded in the PRIME database.
- Six of these incidents were of an extreme risk, and 54 were of a very high risk (or SAC 2 in the new recording system). Incidents included:
  - 16 incidents of attempted suicide and/or self harm
  - 18 incidents of significant self-harm resulting in the need for medical attention
  - 32 incidents of self-harm not requiring medical care
  - 28 attempts to abscond, sometimes including self-harm or suicidal intent.
- Four Root Cause Analyses (RCAs) were conducted in 2006 for extreme risk incidents. These incidents were of the following nature:
  -
  -
  -
  -

  Each RCA made a recommendation about the redevelopment of BAC to provide a safe system of care for consumers and staff.
- Some of the above incidents have involved the Queensland Police Service, and on occasion the Queensland Fire & Rescue Service. The local police have expressed concerns in the local liaison meeting that the current Barrett buildings are unsuitable and pose a risk to the patients as well as create difficult situations to which the police need to respond.
- The clinical profile of consumers has changed considerably since the establishment of other child and youth inpatient centres, resulting in complex and challenging presentations for extended care. Children with eating disorders, self-harming, and suicidality make up a large proportion of admissions. These changes have resulted in higher demands on staff, and increases in use of emergency medical care, general health services, outpatient and inpatient general hospital care.
- The outlined issues could be largely prevented by improvements to the physical environment and infrastructure.

ACTION TAKEN TO DATE

- Use of continuous observations by nursing staff to attend to consumers assessed as a high clinical risk. 7500 hours of continuous observation were used in 2006. The cost of this level of care is beyond the budgeted establishment.
- A number of internal and external reviews have been undertaken (see 'Background' for more information) and the recommendations implemented where possible.
- Attention to ensuring adherence to hospital & district procedures, and upholding guidelines and principles of patient safety in practice.
- Various minor changes to the environment within budget.
- A Paper identifying three environmental redesign options has been written and capital works costings sought for ways to improve the safety and practicality of the environment. The three options included:

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1. A minimum upgrade including the capacity to temporarily close off the female dormitory room – concern is expressed about the impact on providing the least restrictive environment and possible fire safety issues due to changed access/egress issues.
2. An internal redesign of space to accommodate a two bed high dependency unit and enhanced capacity for kitchen and dining capacity to promote better consumer supervision and rehabilitation.
3. A 60sqm extension to provide a purpose built High Dependency Unit, kitchen and dining.

Given the planned rebuild of the BAC within the next five years, it is The Park's determination that the above second option of redesigning an area within the current BAC building be recommended for support by the General Manager.

PROPOSED ACTIONS

- It is proposed that the issue of environmental impact on patient safety in the short term is noted by the General Manager, prior to the redevelopment of the centre.
- Advice is sought as to what extent refurbishment based on the above options is possible and what funding sources may be available to meet these needs.
- The main stakeholders are the adolescent consumers and their families. The staff of the centre will be advantaged by working in a safer and less stressful environment. The community and partnership organisations (eg Queensland Police Service) will be advantaged through fewer incidents with their involvement.
- The risks inherent in the BAC environment for providing clinical services to this population of consumers are grounds for justifying this issue as a high priority.

BACKGROUND

- The BAC accommodation was constructed in 1976, as part of an adult inpatient service at Wolston Park Hospital. When established in the early 1980s, the BAC was the only specialised mental health service for youth in Queensland. It remains the only extended care inpatient adolescent program in Australia.
- BAC provides comprehensive treatment and rehabilitation programs for adolescents with severe eating disorders, social anxiety, self-harming and suicidal behaviours. Evaluations of the outcomes provide encouraging support for the effectiveness of this program. These complex issues require a range of intensive therapeutic interventions provided in an environment that is able to support the needs of consumers.
- The *Ten Year Mental Health Strategy for Queensland* envisaged replacement of the BAC with specialised inpatient units in District hospitals. The centre was intended to close in 1999 once the Child and Youth Acute Inpatient Service in the adjacent Districts were commissioned. In 1997, families of consumers and staff successfully lobbied for the retention of the BAC as a medium stay inpatient service for adolescents in Queensland. Consequently, the centre has had no major refurbishment since opening, and does not meet the needs of the current population of consumers.
- The commissioning of child and youth inpatient units during the late 1990s resulted in a change to the pattern of referrals to BAC. Adolescents are admitted with increasingly complex mental or emotional problems, and with significant degrees of functional impairment. In response to the changing profile, the average length of stay has increased from four months in 1994 to 10 months in 2006. Changes to the model of care have occurred to meet increased demands and risks.

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EXHIBIT 75 WMS.0012.0003.00246

- An external review in 2003, which followed a series of serious incidents in the centre, recommended changes to clinical, operational and risk management processes. While the majority of these recommendations have been implemented, there has been no associated reduction in patient-related incidents. The review also stated that "the building looked dated and…would benefit from a process to establish whether it could be improved by significant modifications…or a new type of facility required".
- In July 2004, the Mental Health Unit commissioned Project Services, Department of Public Works to undertake an options study to consider the ongoing suitability of the existing building to safely accommodate 15 adolescents requiring medium stay treatment and rehabilitation. While this report recommended three options, from refurbishment to completely rebuilding the centre, it found rebuilding to be the preferred option, but this has not progressed as a capital works priority.
- In February 2006, the Australian Council of Healthcare Standards in an accreditation survey identified the poor current physical environment, risk to the consumers, and inadequate staffing levels, and recommended a review of the suitability of the building.
- In December 2006, a Community Visitor report was received from the Commissioner for Children and Young People and Child Guardian. This report stated that "It appears that this facility is unable to make full provision for the safety and security of all the residents with the existing facilities. The building is not purpose built so security can be difficult for staff to maintain over longer periods of time." The report goes on to comment about the need for the building to undergo "extensive changes to bring it up to a standard in line with other facilities", and criticises the inability to separate young people with high dependency needs. The report is supportive of the policies and procedures and clinical processes being undertaken by the BAC.
- In May 2007 The Queensland Nurses' Union wrote to the Executive Director of Mental Health Services, West Moreton South Burnett Health Service District, outlining their concerns for members who had been injured as a result of responding to crisis situations at the BAC. This letter highlighted member's concerns for the physical layout of the building, and the ongoing risks related to this.
- At a Queensland Health forum in May 2006, the State-wide Child & Youth Mental Health Services Network supported the continuation of an extended treatment inpatient adolescent unit. Subsequently, rebuilding of the BAC has been incorporated in the yet to be released Mental Health Plan and in the State budget.
- An options paper was written in March 2007 by the current Nurse Unit Manager of BAC to consider the options for interim improvements to the environment. This paper has canvassed the ideas of both staff and consumers.

MEDIA IMPLICATIONS AND KEY MESSAGES

- There is a high risk of negative media and a decline in public perception of youth mental health services and Queensland Health if the current severity of risk and incidents continues, and particularly if an extreme risk situation results in severe morbidity or mortality.

ATTACHMENTS: All documents mentioned in this briefing are available upon request.

COMMENTS

Author's Name: Dr Terry Stedman Position: Director of Clinical Services Unit: The Park – Centre for Mental Health District: West Moreton South Burnett HSD Date: 1 October 2007	Cleared by: (DM) Name: Pam Lane Position: District Manager District: West Moreton South Burnett HSD Date: 1 October 2007

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Queensland Health

Advisor	OK
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Noted/ Further information required	
Minister	
Dated / /	

BRIEFING NOTE FOR INFORMATION

TO **Ms Uschi Schreiber, Director General Queensland Health**

FROM: **Ms Pam Lane, District Manager West Moreton South Burnett Health Service District**

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Author's Name Position: Centre/District Tel No: Date:	Cleared by: (DM/SD/SDIR) Name Position Centre/District: Tel No: Date:	Cleared by: (GM/ED) Name: Position: AHS Tel No: Date:	DG

EXHIBIT 75