progress of the individual patient, but was specifically about further funding requests in the case of one HHS.

(b) When did West Moreton Hospital and Health Service cease monitoring, and/or responding to queries in relation to, the BAC?

23.4 On a clinical level, once Dr Brennan had completed her post closure follow-up, no further monitoring was considered necessary from the perspective of WMHHS. That is because follow-up typically considers whether the patient is safely within an alternative pathway and whether any additional supports are needed. Once those matters are assured, it is clinically inappropriate to continue contact with former patients as their care is properly within the management of their subsequent providers and it is important for patients to engage with their new service providers.

23.5 WMHHS has never officially ceased responding to queries in relation to BAC. With the transitioning of all patients, the position is that:

(a) Any queries in relation to an individual patient's current clinical needs are directed to the service now responsible for the patient's care.

(b) Queries in relation to availability of services going forward are directed to CHQHHS as the entity responsible for State-wide governance of adolescent mental health services.

(c) Queries in relation to matters such as media interest in the reasons for closure of BAC are handled by WMHHS.

23.6 Following the closure of BAC, the SWAETRI considered undertaking a post closure review. This was not to be an assessment in relation to individual patient care, but rather an evaluation of the process more broadly. Consideration was given to a review being conducted by either CHQHHS or the Queensland Mental Health Commissioner. It was resolved that CHQHHS would undertake a review and a project officer was appointed.

23.7 However, in the course of considering a design for the review, it was felt that:

(a) A full review involving contacting former patients or families may be considered

insensitive and/or unwelcome, and carried a certain level of clinical risk if it caused a particular patient/family to revisit a period they found stressful in their life.

(b) A partial review not including families would be of questionable benefit.

23.8 Ultimately, the decision was made not to pursue a review at the current time.

24 What involvement (if any) did Dr Geppert have in consulting with, providing information and support to and/or addressing the concerns of BAC staff (including education staff)?

24.1 I had no direct role responsibility for providing support to staff as I had no line management of staff of BAC.

24.2 Staff were managed through their line managers, with Sharon Kelly having oversight as Executive Director Mental Health and Specialised Services.

24.3 I had no role with respect to providing information and support to or addressing the concerns of education staff. This was the line responsibility of the Department of Education.I would have been involved in such matters on an ad hoc basis, for example if a staff member approached me with a query I would direct them to the appropriate person. For example, I directed employment and human resource questions to the human resource team.

24.4 I had no role with respect to providing information and support to or addressing the concerns of education staff. This was the line responsibility of the Department of Education.I would have been involved in such matters on an ad hoc basis, for example if a staff member approached me with a query I would direct them to the appropriate person. For example, I directed employment and human resource questions to the human resource team.

25 Outline and elaborate upon any other information and knowledge (and the source of that knowledge) Dr Geppert has relevant to the Commission's Terms of Reference.

Nil.

26 Identify and exhibit all documents in Dr Geppert's custody or control that are referred to in her witness statement.

27 I confirm the documents referred to in my witness statement are exhibited.

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

Taken and declared before me by)
Dr Leanne Geppert at Brisbane in the)
State of Queensland this)
day of)
Before me:)

[redacted] .....

Signature of authorised witness

A Justice of the Peace/
~~Commissioner for Declarations~~

[redacted]

Signature of declarant

EXHIBIT 55

STATUTORY DECLARATION OF LEANNE GEPPERT

INDEX OF EXHIBITS

No	Document Description	Document Number	Page
LG-1	Curriculum Vitae	WMS.5000.0014.00001	1-2
LG-2	Position Description, Director of Strategy, WMHHS	WMS.5000.0006.00010	3-7
LG-3	Bundle of documents constituting employment contract	WMS.5000.0014.00003	8-20
LG-4	Briefing Note for Approval to Director-General dated 4 May 2012	WMS.1003.0003.00218	21-22
LG-5	Email from Sharon Kelly to Bill Kingswell, Jagmohan Gilhotra and Leanne Geppert, copied to Lesley Dwyer and Chris Thorburn dated 26 October 2012	WMS.0011.0001.19338	23-24
LG-6	Email from Jagmohan Gilhotra to Michael Cleary, copied to Bill Kingswell, Leanne Geppert and Sharon Kelly dated 8 November 2012	WMS.0011.0001.17015	25
LG-7	West Moreton Hospital and Health Service Project Plan – Barrett Adolescent Strategy	WMS.0012.0001.14639	26-55
LG-8	West Moreton Hospital and Health Service Minutes - Barrett Adolescent Strategy dated 23 July 2013	WMS.0012.0001.08307	56-58
LG-9	Children's Health Queensland Hospital and Health Service Terms of Reference – State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee dated 23 September 2013	WMS.1003.0003.00662	59-62
LG-10	Children's Health Queensland Hospital and Health Service Terms of Reference – Chief Executive and Department of Health Oversight	WMS.0016.0001.14279	63-66

[redacted] .....

Leanne Geppert

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

Witness

EXHIBIT 55

	Committee dated 17 October 2013		
LG-11	Barrett Adolescent Strategy Expert Clinical Reference Group – Summary of Meeting dated 7 December 2012	WMS.0012.0001.15298	67-70
LG-12	Email from Leanne Geppert to Sharon Kelly, copied to Bill Kingswell, Jagmohan Gilhotra, Lauren Stocks and Lesley Dwyer dated 9 November 2012 Email from Lesley Dwyer to Sean Hatherill, Bill Kingswell, Jagmohan Gilhotra, Leanne Geppert, Ian Williams, Judi Krause, Brett McDermott, Michelle Fryer, David Hartman, Neeraj Gill, Sharon Kelly, Terry Stedman, Trevor Sadler and Erica Lee dated 14 November 2012	WMS.5000.0010.00090 WMS.0011.0001.17034	71-73
LG-13	Briefing Note for Noting to Queensland Mental Health Commissioner dated 18 July 2013	WMS.1007.0039.00009	74-76
LG-14	West Moreton Hospital and Health Service - Barrett Adolescent Parent Session dated 11 December 2013	WMS.3001.0001.00549	77-83
LG-15	Children's Health Queensland Hospital and Health Service – Proposed Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care, undated	WMS.0016.0001.01804	84-89
LG-16		WMS.6001.0004.00332	90-92
LG-17		WMS.1007.0039.00002	93-95
LG-18	Parent Submission to Service Options Implementation Working Group, Statewide Adolescent	WMS.3001.0001.00564 WMS.3001.0001.00561	96-131

....

Leanne Geppert **Witness**

EXHIBIT 55

	Extended Treatment and Rehabilitation Implementation Strategy, undated Utilising the Barrett Centre for Research and Specialist Advisory Centre ... an added benefit of sustaining/expanding the Barrett model, undated Statement by Queensland Health on the timeframe for closure of the Barrett Adolescent Centre & the provision of services until the availability of a new model of care, undated Health Minister Lawrence Springborg's Statements on Mental Health	WMS.0016.0001.01392 WMS.0016.0001.01406	
LT19	Children's Health Queensland Hospital and Health Service Terms of Reference – Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee dated 11 March 2014	WMS.3004.0001.00205	132-134
LG-20	Email from Laura Johnson to Leanne Geppert dated 18 December 2013 West Moreton Hospital and Health Service Barrett Adolescent Centre Consumer Meeting File/Meeting Note dated 18 December 2013	WMS.0016.0001.16485 WMS.0016.0001.16494	135-137
LG-21	Email from Leanne Geppert to Laura Johnson, Stephen Stathis, Elisabeth Hoehn, Peter Steer, Ingrid Adamson, Linda Hardy and Anne Brennan dated 18 December 2013 West Moreton Hospital and Health Service Barrett Adolescent Centre Consumer Meeting File/Meeting Note dated 18 December 2013	WMS.5000.0002.00014 WMS.5000.0002.00015	138-139

....

Leanne Geppert Witness

EXHIBIT 55

LG-22	Aftercare BAC Holiday Day Program 16 Dec 2013 – 24 Jan 2014 – Implementation Plan, undated Aftercare Example BAC Holiday Program Weekly Planner 9am – 3pm (Week 1) dated 20 November 2013	WMS.0016.0001.15913 WMS.0016.0001.15932	140-143
LG-23	Aftercare WM HHS Adolescent Residential and Day Program February 2014 – Implementation Plan, undated	WMS.1003.0003.00326	144-145
LG-24	Aftercare Young Person's Extended Treatment and Rehabilitation Initiative (YPETRI) Model of Service, undated	WMS.5000.0010.00023	146-167
LG-25	Briefing Note for Noting to Director-General dated 6 February 2014 (co-authored by Leanne Geppert on 4 February 2014)	WMS.1007.0044.00001	168-172
LG-26	Document entitled 'Brief Consumer Transition Summary' prepared by Anne Brennan dated 29 January 2014 Document entitled 'Barrett Adolescent Consumers Review 03/03/2014' prepared by Anne Brennan dated 3 March 2014	WMS.0011.0001.00098 WMS.0011.0001.03027	173-178

[redacted] ... [redacted]

Leanne Geppert Witness

Resume

Dr Leanne Geppert
Xx (personal address removed)

Tertiary Education

1. Doctor of Philosophy in Psychology, Griffith University, Q
Jan 2003 – Conferred 2008
Thesis Title: *"The Impact of Amphetamine and Cannabis Use on the Symptoms and Clinical Course of Early Psychosis".*

2. Master of Clinical Psychology, Griffith University, Q
Feb 1994 – Dec 1995
Thesis Title: *"Body Dissatisfaction and Disordered Eating within Families".*

3. Bachelor of Behavioural Science with Honours in Psychology, Griffith University, Q
Feb 1993 – Dec 1993
Thesis Title: *"The Relationship between Psychological Adjustment, Perceived Stress and Coping Complexity in Epilepsy".*

4. Bachelor of Behavioural Science, Griffith University, Q
Feb 1990 – Dec 1992
Research Projects: (1) *"Acceptance of Homosexuality"* (2) *"Attitudes of Asian Migrants towards the Australian Population".*

Career History

1.	**May 2013 – Current**	***Director of Strategy*[1] *(DSO,)*** *Mental Health and Specialised Services* *West Moreton Hospital and Health Service*
2.	**Jun 2011 – May 2013**	***Director, Planning and Partnerships Unit (DSO1)*** *NOTE:* ***Permanently appointed to Assistant Director Jun 2011 then higher duties as Acting Director (Jul 2011 - Sep 2012)*** *Mental Health Alcohol and Other Drugs Branch* *Department of Health* *BRISBANE Q 4000*
3.	**Aug 2010 – Jun 2011**	***Manager – Early Psychosis Implementation Team (HP5)*** *Mental Health, Alcohol and Other Drugs Directorate* *BRISBANE Q 4000*
4.	**Jan 2010 – Aug 2010**	***Director - Clinical Service Development (DSO1 equivalent)*** *Healthe Care (Private Health Provider)* *QUEENSLAND*
5.	**Dec 2007 – Jan 2010**	***Statewide Manager – Projects (AO8)*** *Mental Health, Alcohol and Other Drugs Directorate* *BRISBANE Q 4000*

[1] Title changed to Director of Strategy and Performance as at May 2015.

6. Jul 1996 – Dec 2001 — ***Team Leader, Mater CYMHS Day Program (PO4; Mar 1998-Dec 2001)***
Clinical Psychologist, Inpatient & Community (PO3; Jul 1996-Mar 1998)
South Brisbane Child & Youth Mental Health
Mater Children's Hospital
SOUTH BRISBANE Q 4101

Tertiary Education Sector Appointments

1. **2014 – Current** — ***School of Applied Psychology Advisory Board Member***
School of Psychology, Health Faculty
Griffith University
MT GRAVATT Q 4111

2. **2010 - 2013** — ***Senior Adjunct Lectureship (3 year term)***
School of Medicine, Health Faculty
Griffith University
GOLD COAST Q 4222

3. **Various years since 1999** — ***Postgraduate Psychology Internship Supervisor***
School of Psychology, Health Faculty
Griffith University
MT GRAVATT Q 4111

4. **1997 – 2000** — ***Adjunct Lectureship (3 year term)***
School of Applied Psychology
Griffith University
MT GRAVATT Q 4111

Professional Memberships/Accreditation

- Registration with the Psychology Board of Australia
  - ✓ Registered psychologist with endorsement in clinical psychology
  - ✓ Accredited Supervisor under the Supervisory Training and Accreditation Program
- Member of the Australian Psychological Society
- Member of the Australian College of Clinical Psychologists

Publications

1. Dawe, S., Geppert, L., Occhipinti, S., & Kingswell, W. (2011). A comparison of the symptoms and short-term clinical course in inpatients with substance-induced psychosis and primary psychosis. *Journal of Substance Abuse Treatment, 40*, 95-101.
2. Dadds, M., Geppert, L., Kefer, E., & Vaka, K. (1999/2000). When family members tell on each other: Dilemmas and solutions in adolescent family therapy. *Clinical Psychologist.*
3. Geppert, L., & Shum, D. (1995). Relationship between psychological adjustment, perceived stress, and coping complexity in epilepsy (Abstract). *Epilepsia, 36*, S185.

Role Description for Director of Strategy

Business unit:	Mental Health and Specialised Services Executive Unit	**Division:**	Mental Health and Specialised Services
Position ID:	<Insert Position ID>	**Location:**	West Moreton Hospital and Health Service
Classification:	DSO1	**Contact:**	Sharon Kelly, Executive Director
Salary:	<Insert annual salary or hourly rate if part-time or casual>	**Telephone:**	<Insert phone number of contact person>
Employment status:	Permanent Full Time	**Closing date:**	Recruitment Team Use Only Applications will remain current for 12 months.
Vacancy reference:	**Recruitment Team Use Only**		

About this role

The Director of Strategy will explore, recommend, develop, implement and evaluate dynamic strategies and processes to revitalise and strengthen performance, culture and contemporary service delivery within Mental Health and Specialised Services.

The position will strategically lead and support the ongoing development of Mental Health and Specialised Services as a safe, high quality Division that is innovative, accountable, efficient and effective at both a local and statewide level.

The key accountabilities of the role are:

- Provide high-level advice to and representation of the Executive Director, Mental Health and Specialised Services and the Chief Executive of West Moreton Hospital and Health Service with respect to strategic direction and the navigation of high-level change, key challenges and opportunities, policy, performance and planning for Mental Health and Specialised Services. This will be cognisant of national, state and local agendas.
- Actively engage in statewide agendas, partnerships and negotiations at a senior leadership level in order to align the performance and development of Mental Health and Specialised Services of West Moreton Hospital and Health Service.
- Lead, support and contribute to projects, plans, business management and change management processes that facilitate the innovation, accountability, efficiency and effectiveness of Mental Health and Specialised Services.
- Lead changes in culture and practice to achieve and sustain the delivery of organisational outcomes and transformational goals.
- Establish, strengthen and maintain internal and external partnerships and relationships, to facilitate high level collaboration and engagement. In particular, this is to include consumer and carer engagement, and partnerships with other service providers including Non Government Organisation providers and other Departmental agencies.
- Develop briefing notes, submissions, reports, correspondence and presentations including analysis of options, impacts and recommendations as required on behalf of senior/executive management.

- Actively contribute to developing and maintaining a culture which values health and safety and where staff are vigilant to risks of harm to their co-workers, clients or visitors.
- Actively participate in the Health Service Performance Planning and Appraisal and Individual Development Planning processes.
- This position has operational management responsibility for Mental Health Information Systems staff, Redevelopment and Project Team staff and Consumer & Carer Services Team.

Attributes required for effective performance in this role

Mandatory Qualifications / Professional Registration:

- 5 years minimum experience in the public health system, which incorporates a range of clinical, leadership and strategic responsibilities, is mandatory.
- While not mandatory, undergraduate and postgraduate tertiary qualifications in mental health would be well regarded.
- This position requires the incumbent to operate a government vehicle and an appropriate licence endorsement to operate this type of vehicle is required (Queensland 'C' class licence). Proof of this endorsement must be provided before commencement of duty.

Key capabilities required for this role:

- Demonstrated high-level project management skills and experience, with a proven record of achieving successful and effective outcomes that are aligned with organisational objectives within a large, complex service delivery organisation.
- Demonstrated high-level knowledge of the Queensland mental health system, of innovative and contemporary care models, and of the key policy, performance and planning challenges for mental health service delivery in Australia.
- Proven ability to lead, motivate, manage and nurture multidisciplinary cross-functional teams that are responsive to consumer needs and sustainable in a large, complex organisational environment.
- Demonstrated superior negotiation, consultation, facilitation and written and oral communication skills, with the proven ability to develop effective working and strategic relationships and partnerships with a wide variety of senior internal and external stakeholders in an overall environment of change and evolution.

How to apply for this role

To apply for this role please provide the following documents:

- Your current resume including the name and contact details of at least two referees;
- A short statement (maximum 2 pages) on how your experience, abilities, knowledge and personal qualities would enable you to achieve the key accountabilities and meet the key capabilities; and
- An application form (only required if you are not applying online).

The Health Service prefers candidates to apply for roles online through www.health.qld.gov.au/workforus or www.smartjobs.qld.gov.au. If you apply online you can track your application during the selection process, maintain your personal details and contact details and withdraw your application if necessary.

If you are unable to apply online, please contact our Recruitment Services and Establishment Team on (07) 3810 1443 or email wm_recruitment@health.qld.gov.au and we will assist you. We are not able to accept hand delivered applications.

Employment related information

Pre-employment screening

Pre-employment screening including criminal history and discipline history checks may be undertaken on candidates recommended for employment. Roles providing health, counselling and support services mainly to children will require a Blue Card unless an exemption applies.

The recommended candidate is required to disclose if they have been subject to serious disciplinary action during any public sector employment. Candidates are also required to declare any factors which could prevent them from effectively fulfilling the requirements of the role.

All health professionals are responsible for maintaining their level of capability in the provision of health care and must comply with their reporting obligations in this regard.

Please refer to the document *Information for Applicants* for further information about pre-employment screening and other requirements.

Health professional roles involving delivery of health services to children and youth

All health professionals (including nurses and medical officers) who, in the course of their duties, formulate a reasonable suspicion that a child or youth has been abused or neglected in their home/community environment, have a legislative and a duty of care obligation to immediately report such concerns to Child Safety Services, Department of Communities.

Salary Packaging

For information about the Public Hospital Fringe Benefits Tax (FBT) Exemption Cap please refer to the *Salary Packaging Information Booklet* for Department of Health employees available from our salary packaging provider RemServ at http://www.remserv.com.au. Questions about salary packaging can be directed to the RemServ Customer Care Centre on 1300 30 40 10.

Disclosure of Previous Employment as a Lobbyist

Candidates appointed to the Health Service are required to give a statement of any previous employment as a lobbyist within one (1) month of taking up the appointment. Details are available at http://www.psc.qld.gov.au/library/document/policy/lobbyist-disclosure-policy.pdf.

Probation

Employees who are permanently appointed to the Health Service may be required to undertake a period of probation. For further information about probation requirements, please refer to Probation HR Policy B2 http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-197.pdf.

Please refer to the document *Information for Applicants* for further employment related information.

About the Queensland Health

The behaviour of our staff is guided by Queensland Health's commitment to high levels of ethics and integrity and the following four core values:

- Caring for people
- Leadership
- Partnership
- Innovation
- Accountability, efficiency and effectiveness.

About West Moreton Hospital and Health Service

West Moreton Hospital and Health Service has a long and proud history of caring for the communities of Ipswich, Boonah, Esk, Laidley and more recently Gatton. The hospital and health service is one of the largest employers in the region, employing more than 2500 staff.

West Moreton Hospital and Health Service delivers health services in a mix of metropolitan and small rural community settings and services a population of about 245,000 people. The Health Service catchment is the third fastest growth area in Australia and the population is forecast to increase to an about 475,000 people by 2026 (an increase of 90 per cent). The projected increase in population is the largest of any Hospital and Health Service in Queensland. The Health Service has excellent prospects for growth which makes it an ideal employer for those seeking to develop their career.

The Hospital and Health Service delivers health services across the continuum of care: preventative and primary health care services, ambulatory services, acute care, sub-acute care, oral health and mental health and specialised services (including Offender Health and Alcohol Tobacco and Other Drugs). WMHHS also has a major teaching role, providing both undergraduate and postgraduate clinical experience for members of the multi disciplinary healthcare team and has accountability for state wide research and learning facilities for mental health.

Our Health facilities include:

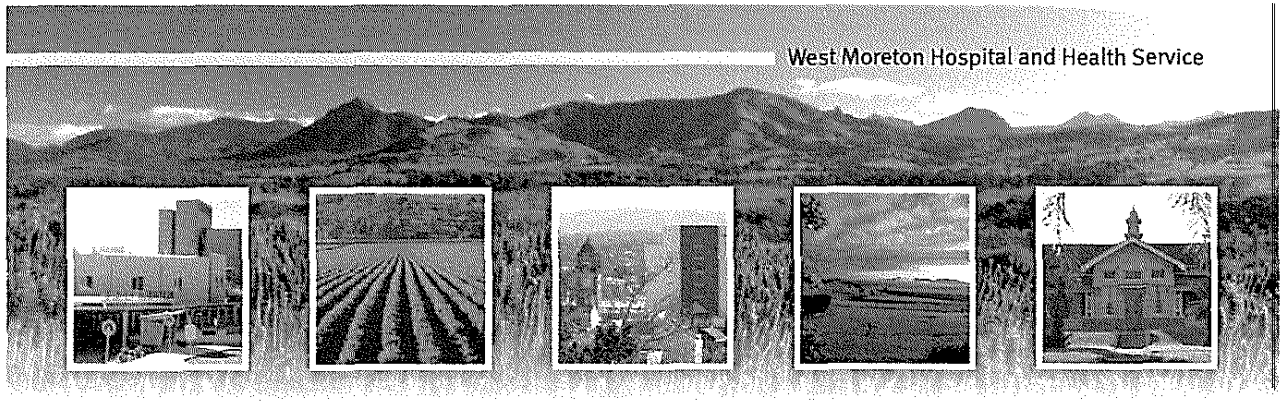
- Ipswich Hospital
- Boonah Health Service
- Esk Health Service
- Gatton Health Service
- Laidley Health Service
- Community Health Services
- The Park Centre for Mental Health

About Mental Health and Specialised Services Division

The Mental Health and Specialised Services Division is responsible for delivering high quality, comprehensive mental health services, alcohol and other drug services and offender health services across West Moreton. The Division is also responsible for a range of specialised statewide or multi Hospital and Health Services including High Secure Forensic Mental Health Inpatient Services, the Extended Forensic Treatment and Rehabilitation Unit, Secure Mental Health Rehabilitation, Queensland Centre for Mental Health Learning (QCMHL) and Queensland Centre for Mental health Research (QCMHR), the statewide Benchmarking Unit, and is statewide point of contact for Offender Health Services.

Organisation chart

Please see separate email (PDF file) for insertion.



Queensland Government

Queensland Health

Enquiries to: Sheriden Lee
Department: Recruitment Services
Telephone:
File Ref: QLD/H11HL0554 (SL)

30 June 2011

Dr L Geppert

Dear Dr Geppert

I welcome your continued contribution to Queensland Health and am pleased to inform you that approval has been given to offer you employment in the following position:

Position Details

Position Number:	30485325
Position Title:	Assistant Director
Unit/Department/Division:	Mental Health Plan Implementation Unit Mental Health, Alcohol and Other Drugs Directorate Division of the Chief Health Officer
Location:	Herston
Classification:	DSO1
Award	District Health Services Employees' Award – State 2003

Employment Details

Employment Status:	Permanent Full Time
Hours Per Fortnight:	76
Superannuable Salary:	$4697.00 Per Fortnight

Period of Employment

Commencement Date:	27 June 2011
End Date:	Not Applicable

I have enclosed for your information the DSO Terms and Conditions document which provides detailed information relating to your employment as a District Senior Officer. You will need to familiarise yourself with, and comply with the contents of this document.

Also enclosed are two copies of a draft remuneration agreement for your consideration. As a District Senior Officer, you may elect to take advantage of salary sacrifice provisions available to you.

The information provided on the superannuation form within the Agreement is as per your existing superannuation contribution arrangements or is as per the superannuation contribution arrangements for new employees to Queensland Government. Should you wish to make changes to the details provided (eg. increase/nominate a voluntary salary sacrifice contribution(s)) please amend the two copies of the form, initial and date the changes. Both copies of the Agreement need to be signed. One copy should be retained for your personal records.

Should you wish to accept this appointment, please sign and return the attached acceptance form with one copy of the signed Remuneration Agreement within **seven (7) days** of receipt of this letter.

A probation period of three months will apply to your appointment. This probation period may be extended if specified outcomes of your role are not achieved. Confirmation of your appointment will occur after successful performance during your probation period. Your supervisor will discuss your performance plan with you shortly after you commence duty in your appointed role.

Should you have any queries regarding your appointment or Remuneration Agreement, please contact Dr Aaron Groves on

Congratulations on your appointment. I look forward to your contribution to the delivery of our health services and I hope you find your work enjoyable and rewarding.

Yours sincerely

Jodie May
On behalf of
Dr Jeannette Young
Chief Health Officer
Division of the Chief Health Officer

1/7/2011

Queensland Government

Employee Movement Form - Permanent

Privacy disclaimer:
The collection of personal information on this form is authorised under the Public Service Act 2008. Your personal information will not be disclosed to other parties without your consent unless required by law. Use of personal information on this form is restricted to those involved in the authorisation and processing of this form.

This form is to be completed to document changes to an existing employee's position, status or terms of employment. Please complete all sections indicating N/A where relevant. Employees inherit the characteristics of the positional information (including cost centre). Employees must be moved into a position which is costed appropriately.

Employee Details

Person ID

Personnel assignment number

Please indicate (✓) here if you work in more than one position in QLD Health. ☐

Title	Family name	First name/s
Dr	GEPPERT	LEANNE

Proposed Position

Position Number: 3 0 4 8 5 3 2 5

Position title: Assistant Director

Start date	Classification	Probationary Period
27-06-2011	DS01	months

Organisational unit number	Organisational unit name
70067313	Mental Health Plan Implementation Unit

Facility address

Job advertisement reference (if applicable): H11HL0554

Concurrent/Aggregate: Indicate (✓) here if the employee will continue to hold their existing position in conjunction with the proposed position ☐

New Employment and Payroll Details

Appointment type

Internal temporary employee ☐ Internal permanent employee ☑ Other public sector employee ☐ Priority placement employee ☐

Employment basis

Full-time ☑ Casual ☐ Other ☐ Please Specify

Part-time ☐ No. part-time hours/fortnight (hh:mm):

First Day Contact Name: Anthony Milverton

First day contact phone number

Award/EBA name

Staff Movement Details

Reason for vacancy

Work Contract

Working arrangements		Shift arrangements		Recreation leave accrual		Reason for additional weeks leave	
19 day month (ADO accrual)	☐	Single shift only	☑	Four weeks / annum	☑	Working public holidays	☐
Standard hours (non ADO accrual	☑	Two shifts	☐	Five weeks / annum	☐	Continuous shift work	☐
Variable working hours	☐	Continuous shift work	☐	Six weeks / annum	☐	Working with radium (radiographers only)	☐
Nine day fortnight	☐	12 hour shift arrangement applies	☐				

Special conditions (e.g. RANIP Nurses, etc.). Please refer to the Payroll and Rostering Intranet Site (PARIS) for more information.

Work Schedule

Please indicate (✓) here if this employee works either: A cyclic roster (where the roster pattern repeats at regular intervals e.g. fortnightly / monthly) ☑ OR A non-cyclic roster (a roster pattern that varies from one cycle to the next) ☐

This area is provided for ease of filing

Queensland Government

Employee Movement Form - Permanent

Employee Reference

Person ID

Personnel assignment number

Please complete the table below using 24 hour time format (e.g. 07:00 - 15:30) to advise the employee's roster for their initial two week period of employment.

Week one

Day	Start time (hh:mm)	End time (hh:mm)	Meal break* Start time (hh:mm)	Meal break* End time (hh:mm)	Total daily hours
Monday	08:00	16:06	12:30	13:00	7.6
Tuesday	08:00	16:06	12:30	13:00	7.6
Wednesday	08:00	16:06	12:30	13:00	7.6
Thursday	08:00	16:06	12:30	13:00	7.6
Friday	08:00	16:06	12:30	13:00	7.6
Saturday					
Sunday					
				Total weekly hours	38

Week two

Day	Start time (hh:mm)	End time (hh:mm)	Meal break* Start time (hh:mm)	Meal break* End time (hh:mm)	Total daily hours
Monday	08:00	16:06	12:30	13:00	7.6
Tuesday	08:00	16:06	12:30	13:00	7.6
Wednesday	08:00	16:06	12:30	13:00	7.6
Thursday	08:00	16:06	12:30	13:00	7.6
Friday	08:00	16:06	12:30	13:00	7.6
Saturday					
Sunday					
				Total weekly hours	38

*Where a paid meal break applies, please insert N/A for meal break start and end times.

Pre-Employment Checks

Criminal History Check completed* (Please attach a copy of email confirmation) ☐

If Criminal History Check not required, please insert reason below: existing employee

*In accordance with Queensland Health Criminal Checking policy, no offer of employment can be made until completion of a relevant criminal history check (refer Queensland Health policy IR/A 3.12-1 for exclusions)

Blue Card (If applicable) ☐ Status: ____ Expiry date: ____

Other (If applicable) ☐ Please specify: ____ Status: ____

Qualification Payments

Does the employee possess any approved qualifications that will entitle them to additional payment(e.g. relevant AQF qualifications) under Queensland Health policy?

No ☐ Yes ☐ If yes, please provide details here: ____

Supervisor Certification

I certify that I have:

- (where the employee has been appointed to a position from another work unit) successfully negotiated the release date with the line manager of the employee's substantive position
- informed this employee of any changes to their FBT Concession Eligibility status as a consequence of this variation to their employment contract
- discussed with this employee the consequences of this change to their position, employment status, terms of employment and/or roster, and
- informed the employee where this change applies to a temporary employee moving between temporary assignments, of any impact (i.e. the ending or likelihood of extension of their previous contract) as a consequence of accepting appointment to this proposed position.

Supervisor's signature: [redacted] Date: 29/6/11 Area code: (07) Contact number: [redacted]

Supervisor's full name (please print): DR AARON GROVES

Supervisor's position title: EXECUTIVE DIRECTOR, MENTAL HEALTH, ALCOHOL & OTHER DRUGS DIRECTORATE

Employee Certification

I accept the appointment to this position and confirm my acceptance of the change in terms of employment contained in this form.
Further, I certify that I have been:

- informed by my line manager of the consequences of any change to the FBT Concession Eligibility status that may result from this variation to my employment contract, and
- made aware of the consequences of this change to my position, employment status, terms of employment and/or roster. I also acknowledge that where the proposed position is of a temporary nature, the contract may be ended by my line manager with two weeks' notice.

Employee's signature: [redacted] Date: 29/6/11

This area is provided for ease of filing

Queensland Government

Employee Movement Form - Permanent

Employee Details

Person ID

Personnel assignment number

Delegate Approval

I, the authorised Delegate for Appointments, approve:

- any increase above the position's AFT as a consequence of this appointment, and
- the above appointment subject to the receipt of acceptable criminal history report (where necessary) in accordance with Section 67 of the Public Service Act 2008 / Section 24 of the Health Services Act 1991 (delete whichever is not applicable).

Delegate's signature

Date

Area code (07)

Contact number

Delegate's full name (please print)

Delegate's position title

Processing Area Use Only

Processor's signature

Date

Reviewer's signature

Date

Processed fortnight ending

Queensland Government

Queensland **Health**

Enquiries to: Sylvie Brdjanovic
Telephone:

File Ref:

Dr Leanne Geppert
Director
C/- Mental Health Alcohol & Other Drugs Branch
HSCID Division
Queensland Health
GPO Box 48
BRISBANE QLD 4001

Dear Dr Geppert

As you know, we have been communicating with all staff about our proposed new structure.

On Friday 7th September the proposed new detailed structures and the associated workforce impacts was released to all Branch employees. The structure for the Mental Health Alcohol & Other Drugs (MHAOD) Branch has been designed to support the department to undertake functions required in its new role as system manager.

Detailed consultation has been undertaken with employees and their unions and consultation has covered the:

- Nature of the proposed changes;
- Number and category of employees impacted; and
- Expected effects for employees.

As a part of this consultation, we additionally looked at ways to avoid or minimise the effects of the proposed changes and the period over which the changes are likely to occur.

The purpose of this letter is to provide formal notification to you that you have been directly matched against a position within the MHAOD Branch, Health Services and Clinical Innovation Division. You have been matched against

Position ID: 30485325, Director, Intergovernmental Relations & System Redesign Unit, DSO1

This means you do not need to do anything further. You do not need to participate in the further stages of the closed merit process.

Office
Queensland Health
147 – 163 Charlotte Street
Brisbane Qld 4000

Postal
GPO Box 48
Brisbane Qld 4001

Phone

Fax

I would like to thank you for your active participation and patience in the process to date. Should you require any further information in relation to this matter, please contact Sylvie Brdjanovic, MHAOD Branch, Queensland Health on telephone

Yours sincerely

Dr Bill Kingswell
A/Executive Director
Mental Health Alcohol & Other Drugs Branch
Health Services and Clinical Innovation Division

2 Nov '12

SAP ✓
E-mail ✓
WB ✓ perm roster.

ENTERED
DATE 9/5/13

Queensland Government

Employee Movement - Temporary
(Higher Duties/Acting at Level)

Privacy disclaimer:
The collection of personal information on this form is authorised under the Public Service Act 2008. Your personal information will not be disclosed to other parties without your consent unless required by law. Use of personal information on this form is restricted to those involved in the authorisation and processing of this form.

This form is to be used by Queensland Health employees and line managers to document a temporary change to an employee's existing position or temporary appointment to a position either in an 'at level' or higher duties capacity.

Employee Details

Person ID

Personnel assignment number (PAN)

Please indicate (✓) here if you work in more than one position in QLD Health. ☐

Family name: Geppert

First name/s: Leanne

Visa Notification (if applicable)

If the employee to whom this movement applies holds a Temporary Business (Long Stay) Subclass 457 visa, the Department of Immigration and Citizenship (DIAC) must be notified within 10 working days of the transfer to a new location or position.
Email address: QLD.Sponsor.Monitoring@immi.gov.au
Note: The sponsorship obligations for visa holders are transferred to the new HR Unit (refer HR Policy B46 for details).

Proposed Change Type

Higher duties ☐ Acting at level ☑

Indicate below if this form relates to either a new appointment, an extension to an existing appointment or a modification of a previously documented appointment

New ☑ Extension ☐ Modification ☐

Proposed Position Details

Frontline position ☐ OR Non_Frontline position ☑ Request to Fill a Vacancy Form attached ☐

Position ID: 3 0 4 9 6 6 7 0

Position title: Director Mental Health Services

Classification (eg. AO4): DSO1

Start date: 13-05-2013

End date: 15-12-2013

Percentage of higher duties allowance payable applies only to employees under the provisions of the Public Service Act

Percentage of allowance: %

Organisational unit number: 70071581

Organisational unit name: West Moreton Mental Health Service

Facility address: The Park - Centre for Mental Health

Job advertisement reference (if applicable): N/A

Current occupant (if applicable): Vacant

Reason for higher duties / acting at level: Fulfill temporary requirement

Concurrent / Aggregate: Please indicate (✓) here if the employee will continue to hold their existing position in conjunction with the proposed position ☐

Employment basis

Full-time ☑ Part-time ☐ No. of part-time hours / fortnight:

Award/EBA Name: PSA 2008 Directive 06/09 Senior Officers - Employment conditions (SO)

Staff Movement Details

Reason for vacancy: Vacant

Work Contract

Working arrangements		Shift arrangements		Recreation leave accrual		Reason for additional weeks leave	
19 day month (ADO accrual)	☐	Single shift only	☑	4 weeks / annum	☑	Working public holidays	☐
Standard hours (non ADO accrual	☑	Two shifts	☐	5 weeks / annum	☐	Continous shift work	☐
Variable working hours	☐	Continuous shift work	☐	6 weeks / annum	☐	Working with radium (radiographers only)	☐
9 day fortnight	☐	12 hour shift arrangement applies	☐				

Special conditions (e.g. RANIP Nurses, etc.). Please refer to the Payroll and Rostering Intranet Site (PARIS) for more information.

Queensland Government

Employee Movement - Temporary - (Higher Duties/Acting at Level)

Employee Reference

Person ID

Personnel assignment number (PAN)

Work Schedule

Please indicate (✓) here if this employee works either: A cyclic roster (where the roster pattern repeats at regular intervals e.g. fortnightly / monthly) ☐ OR A non-cyclic roster (a roster pattern that varies from one cycle to the next) ☐

Please complete the table below using 24 hour time format (eg. 07:00 - 15:30) to advise the employee's roster for their initial two week period of employment.

Week one

Day	Start time (hh:mm)	End time (hh:mm)	Meal break* Start time (hh:mm)	Meal break* End time (hh:mm)	Total daily hours
Monday	09:00	17:06	12:00	12:30	7.6
Tuesday	09:00	17:06	12:00	12:30	7.6
Wednesday	09:00	17:06	12:00	12:30	7.6
Thursday	09:00	17:06	12:00	12:30	7.6
Friday	09:00	17:06	12:00	12:30	7.6
Saturday					
Sunday					
				Total weekly hours	38

Week two

Day	Start time (hh:mm)	End time (hh:mm)	Meal break* Start time (hh:mm)	Meal break* End time (hh:mm)	Total daily hours
Monday	09:00	17:06	12:00	12:30	7.6
Tuesday	09:00	17:06	12:00	12:30	7.6
Wednesday	09:00	17:06	12:00	12:30	7.6
Thursday	09:00	17:06	12:00	12:30	7.6
Friday	09:00	17:06	12:00	12:30	7.6
Saturday					
Sunday					
				Total weekly hours	38

*Where a paid meal break applies, please insert N/A for meal break start and end times.

Qualification Payments

Please list here any approved qualifications that this employee possesses that will entitle them to additional payment (e.g. relevant AQF qualifications or nursing credentials) under Queensland Health policy.

Supervisor Certification (mandatory completion required)

I certify that I have:

- (where the employee is seeking release or extension of a previously approved movement from another work unit) successfully negotiated the terms of the agreement with the line manager of the employee's substantive position
- informed this employee of any changes to their FBT Concession Eligibility status as a consequence of this variation to their employment
- discussed with this employee the consequences of this change to their position, employment status, terms of employment and/or roster and
- informed the employee where this change applies to a temporary employee moving between temporary assignments, of any impact (i.e. the ending or likelihood of extension of their previous contract) as a consequence of accepting appointment to this proposed position.

Supervisor's signature

Date 1/5/2013

Area code

Contact number

Supervisor's full name (please print) Sharon Kelly

Supervisor's position title ED Mental Health & SS

Employee Certification (mandatory completion required - refer note* below)

I agree to the above changes to my employment hours/position. I hereby claim for the extra remuneration for hours worked in a higher duties capacity (where applicable). I also certify that I have been informed by my line manager/supervisor of the consequences of this change to my:

- FBT Concession Eligibility status that may result from this variation to my employment contract and
- position, employment status, terms of employment and/or roster. I also acknowledge that as this appointment is of a temporary nature, the contract may be ended by my line manager with the appropriate notice in accordance with award provisions.

Employee's signature

Date 1/5/13

Line manager's signature in lieu*

*In exceptional circumstances where the employee is unable to sign this form (as above) the Supervisor may submit this form for processing where it has otherwise been completed in full and details of the reason that the employee cannot sign the form is listed below. The signature of the employee must be obtained on this form as soon as they become available to sign the form so that it can be retained as a formal contract of employment.

Queensland Government

Employee Movement - Temporary - (Higher Duties/Acting at Level)

Employee Reference

Person ID

Personnel assignment number (PAN)

Delegate Approval (mandatory completion required)

If the employee's entitlement to recurring allowance changes, please complete and forward the relevant form/s.

HES / SES Higher Duties only:
Will the employee be allocated a government owned motor vehicle for private use or home garaging during this period of relief? Yes ☐ No ☐

Delegate's signature

Date 2/5/13

Area code

Delegate's Contact number

Delegate's full name (please print)

Lesley Dwyer

Delegate's position title

Chief Executive

Processing Area Use Only

Processor's signature

Date

Reviewer's signature

Date

Processed fortnight ending

ENTERED
DATE 3/1

Employee Movement - Temporary
(Higher Duties/Acting at Level)

Privacy Disclaimer: Personal information collected by Queensland Health is handled in accordance with the Information Privacy Act 2009. The information provided by you will be securely stored and will be made available to appropriate authorised officers of Queensland Health or agents employed by Queensland Health. Personal information recorded on this form will not be disclosed to other parties without your consent unless required by law.

An approved 'Validation of Claims Older Than Three Months Form' must be provided in addition to this form if this claim is older than three months from the effective date.

This form is to be used by Queensland Health employees and line managers to document a temporary change to an employee's existing position or temporary appointment to a position either in an 'at level' or higher duties capacity.

This area is provided for ease of filling

Employee Details

Person ID:

Personnel assignment number (PAN):

Please indicate (✓) here if you work in more than one position in QLD Health. ☐

Family name: Geppert

First name/s: Leanne

Visa Notification (if applicable)

If the employee to whom this movement applies holds a Temporary Business (Long Stay) Subclass 457 visa, the Department of Immigration and Citizenship (DIAC) must be notified within 10 working days of the transfer to a new location or position.
Email address: QLD.SponsorMonitoring@immi.gov.au
Note: The sponsorship obligations for visa holders are transferred to the new HR Unit (refer HR Policy B46 for details).

Proposed Change Type

Higher duties ☑ Acting at level ☐

Indicate below if this form relates to either a new appointment, an extension to an existing appointment or a modification of a previously documented appointment

New ☑ Extension ☐ Modification ☐

Proposed Position Details

Request to Fill a Vacancy Form attached ☑

Position ID: 3 2 0 1 8 9 5 1

Position title: Executive Director MH Specialised Services

Classification (eg. AO4): HES2-3

Start date: 13-11-2013

End date: 01-12-2013

Percentage of higher duties allowance payable applies only to employees under the provisions of the Public Service Act

Percentage of allowance: 100 %

Organisational unit number: 7 2 0 0 1 1 8 7

Organisational unit name: WM Health Executive Management

Facility address: The Park - Centre for Mental Health, Wacol

Job advertisement reference (if applicable):

Current occupant (if applicable): Sharon Kelly

Reason for higher duties / acting at level:

Employment Basis

Full-time ☑ Part-time ☐ No. of part-time hours / fortnight:

Concurrent / Aggregate: Please indicate (✓) here if the employee will continue to hold their existing position in conjunction with the proposed position. ☐

Award/EBA Name: District Health Services Employees' Award - State 2012

Staff Movement Details

Reason for vacancy: Incumbent on secondment

Work Contract

Working arrangements		Shift arrangements		Recreation leave accrual		Reason for additional weeks leave	
19 day month (ADO accrual)	☐	Single shift only	☑	4 weeks / annum	☑	Working public holidays	☐
Standard hours (non ADO accrual)	☑	Two shifts	☐	5 weeks / annum	☐	Continous shift work	☐
Variable working hours	☐	Continuous shift work	☐	6 weeks / annum	☐	Working with radium (radiographers only)	☐
9 day fortnight	☐	12 hour shift arrangement applies	☐				

Special conditions/Allowances (e.g. RANIP Nurses, uniform, laundry allowance etc.). Please refer to the Payroll and Rostering Intranet Site (PARIS) for more information.

Employee Movement - Temporary
(Higher Duties/Acting at Level)

Employee Reference

Person ID

Personnel assignment number (PAN)

Work schedule

Please indicate (✓) here if this employee works either: A cyclic roster (where the roster pattern repeats at regular intervals e.g. fortnightly / monthly) ☑ OR A non-cyclic roster (a roster pattern that varies from one cycle to the next) ☐

Please complete the table below using 24 hour time format (eg. 07:00 - 15:30) to advise the employee's roster for their initial two week period of employment.

Week one

Day	Start time (hh:mm)	End time (hh:mm)	Meal break* Start time (hh:mm)	Meal break* End time (hh:mm)	Total daily hours (i.e. 7.6)
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
				Total weekly hours	

Week two

Day	Start time (hh:mm)	End time (hh:mm)	Meal break* Start time (hh:mm)	Meal break* End time (hh:mm)	Total daily hours (i.e. 7.6)
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
				Total weekly hours	

*Where a paid meal break applies please insert N/A for meal break start and end times.

This area provided for ease of filling

Qualification Payments

Please list here any approved qualifications that this employee possesses that will entitle them to additional payment (e.g. relevant AQF qualifications or nursing credentials) under Queensland Health policy.

QLD Health HR Solution User Access request status

Does the employee have/require Workbrain/SAP access?	☐ Yes ☐ No
Does the current access to Workbrain/SAP require a change?	☐ Yes ☐ No
Has a QLD Health HR Solution User Access Request Form been completed for the change?	☐ Yes ☐ Not applicable

Supervisor Certification (mandatory completion required)

I certify that I have:
- (where the employee is seeking release or extension of a previously approved movement from another work unit) successfully negotiated the terms of the agreement with the line manager of the employee's substantive position
- informed this employee of any changes to their FBT Concession Eligibility status as a consequence of this variation to their employment
- discussed with this employee the consequences of this change to their position, employment status, terms of employment and/or roster and
- informed the employee where this change applies to a temporary employee moving between temporary assignments, of any impact (i.e. the ending or likelihood of extension of their previous contract) as a consequence of accepting appointment to this proposed position.

Supervisor

Date: 7/1/14

Area code: (07)

Contact number

Supervisor's full name (please print): LESLEY DWYER - CHIEF EXECUTIVE

Supervisor's position title

Employee Movement - Temporary
(Higher Duties/Acting at Level)

Employee Reference

Person ID

Personnel assignment number (PAN)

Employee Certification (mandatory completion required - refer note below)

I agree to the above changes to my employment hours/position. I hereby claim for the extra remuneration for hours worked in a higher duties capacity (where applicable). I also certify that I have been informed by my line manager/supervisor of the consequences of this change to my:

- FBT Concession Eligibility status that may result from this variation to my employment contract and
- position, employment status, terms of employment and/or roster. I also acknowledge that as this appointment is of a temporary nature, the contract may be ended by my line manager with the appropriate notice in accordance with award provisions.

Employee's signature | Date: 12/11/13 | Supervisor's signature in lieu*

*In exceptional circumstances where the employee is unable to sign this form (as above) the Supervisor may submit this form for processing where it has otherwise been completed in full and details of the reason that the employee cannot sign the form is listed below. The signature of the employee must be obtained on this form as soon as they become available to sign the form so that it can be retained as a formal contract of employment.

Delegate Approval (mandatory completion required)

If the employee's entitlement to recurring allowance changes, please complete and forward the relevant form/s.

HES / SES Higher Duties only:
Will the employee be allocated a government owned motor vehicle for private use or home garaging during this period of relief? Yes ☐ No ☐

Delegate's signature | Date: 7/1/14 | Area code: (07) | Delegate's Contact number

Delegate's full name (please print): LESLEY ANYER - CHIEF EXECUTIVE | Delegate's position title

Processing Area Use Only

Processor's signature | Date | Reviewer's signature | Date | Processed fortnight ending

"LG-4"

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

Briefing Note for Approval

Director-General

Requested by: Executive Director, MHAODD | Date requested: 3 May 2012 | Action required by:

SUBJECT: Cessation of the Redlands Adolescent Extended Treatment Unit Capital Program

Proposal

That the Director-General:

Approve the cessation of the Redlands Adolescent Extended Treatment Unit capital program; and
Provide this brief to the Minister for noting.

Urgency

1. Critical. A Cabinet Budget Review Committee (CBRC) Submission has been prepared on the *Project Agreements for capital projects approved for Queensland health under the Health and Hospitals Fund 2010 Regional Priority Round* (HHF), and is likely to be submitted on 4 May 2012 – the strength of this CBRC Submission is reliant on the information in this Brief being approved and noted.

Headline Issues

2. The top three issues are:
   - The Redlands Adolescent Extended Treatment Unit capital program has encountered multiple delays to-date and has an estimated budget over-run of $1,461,224. Additionally, recent sector advice proposes a re-scoping of the clinical service model and governance structure for the Unit.
   - There is an anticipated capital funding shortfall of $3.1 million for the regional mental health HHF projects, relating to Information Communications Technology (ICT), escalation and land acquisition. It is proposed to fund this shortfall through cost savings resulting from the cessation of the 15-bed Redlands Adolescent Extended Treatment Unit which has been funded under Stage 1 of the *Queensland Plan for Mental Health 2007-17* (QPMH).
   - The HHF projects are critical in the reform of Queensland mental health services. The HHF projects focus on building community mental health service infrastructure in regional areas to facilitate a more integrated approach to service delivery in these areas – a key priority in the government's health reform agenda. This investment will address some of the inequities that exist for remote and rural consumers including lack of coordinated, integrated services that are close to their home.

Key Values

3. The key values that apply are the following:

☒ Better service for patients
☒ Improved community health
☒ Valuing Queensland Health employees and empowering its frontline staff
☐ Empowering local communities with a greater say over their hospital and local health services

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

Recommendation
That the Director-General

Approve the cessation of the Redlands Adolescent Extended Treatment Unit capital program; and
Provide this brief to the Minister for noting.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office for Approval ☐

Director-General's comments

Author:	Cleared by:	Content verified by:	Endorsed by:
Dr Leanne Geppert	Dr William Kingswell	Dr Jeanette Young	Dr Tony O'Connell
A/Director	Executive Director	Chief Health Officer	Director-General
MHPIU, MHAODD	MHAODD	Division of the Chief Health Officer	Queensland Health

/05/2012

"LG-5"

From: Sharon Kelly
Sent: 26 Oct 2012 14:46:22 +1000
To: Kingswell, Bill;Gilhotra, Jagmohan;Geppert, Leanne
Cc: Dwyer, Lesley;Thorburn, Chris
Subject: WMHHS and mental health plan

Bill, Leanne and Jagmohan,

thank you very much for my meeting yesterday afternoon with you to discuss the future mental health plan and the role West Moreton plays in this. I appreciated getting the up to date information and I trust we can move forward on a range of issues together.

if I can recap on some as I believe there were a few actions out of yesterday and it will help me get my thoughts in alignment and also allow me to provide the CE with an update at the same time:-

- The plan for The Park remains as a forensic unit and our current cohort of ETTR /DD patients will eventually be relocated to more suitable accommodation.
- I can confirm we have ceased admissions into the ETTR unit to achieve this, however a date for all to be transferred off site by June 2013 remains tenuous. I understand from our discussions that you are planning a conversation with the other units to attempt to expedite this process given the agreement of the State Mental health plan in this area. Please advise if you require any actions from us in this initial process.
- the funds that have currently been removed from WMHHS and reallocated to other HHS in anticipation of CCU movements will be formally support by yourselves with the system manager to reallocate those to us given we continue to have the consumers.
- there is a plan in place for REDACTED and it is anticipated that [redacted] will move to more suitable accommodation in [redacted] subject to [redacted] mental heath status. I appreciated being included in the next planned meeting to progress this.
- the development of the Goodna CCU has now been signed off by the Minister. I understand there is a significant amount of consultation etc moving forward so I look forward to progressing that together. If you have the signed brief back from the Minister's office we would appreciate a copy for our records as well.
- in regards to QCMHL I will ensure that the focus of QCMHL is aligned as we discussed to ensure they remain contemporary for the service requirements moving forward.
- opening of EFTRU - a number of consumers in other accommodation are awaiting the opening of EFTRU as you identified and we need to consider the opening time to relieve some congestion within the correctional facilities as well and ensure people are getting the most suitable treatment and care. I have indicated that the earliest EFTRU could open given the out of scope works etc would be March 2013 and this would rely on us being able to achieve this within our FTE etc. on that note I appreciate that besides us advising the System manager you will also advocate to the system manager regarding the omission of an increased MOHRI count into MH WMHHS for the EFTRU opening.
- Barrett Adolescent Centre- as we have all confirmed this is a somewhat sensitive issue as we define the future. I would like to confirm our discussions in regards to this however. I understand that a brief has gone to the Minister re BAC, a copy for our records would be appreciated. the content of the brief did not clearly articulate that closure was the only option, however from our discussion and opinions I have gleaned from others the model for BAC is not aligned into the future planning for The Park or for Queensland Mental Health Plan. as such the option is to close BAC as early as December 2012 given that all or most of the consumers all go home for the Christmas break. this would include the education program. an alternate would be to close the beds but keep the day program for a period of time. for any of this to occur I understand we need to commence discussions with other services that could provide the support for the young people once BAC does not exist.
  - the brief that was written to the Minister will be provided to WMHHS for noting

- I will need to brief Lesley, my CE on this early next week so our HHS board chair is made aware of this action and also the timing of our actions.
- a meeting planned for next Friday between myself, Terry and Dr Sadler will now be expanded to include Leanne in the absence of Bill and I would like to include Chris Thorburn who is working with me on redesigning mental health WM. - at this time we will advise that closure is not optional however needs to be planned
- a strategic stakeholder meeting is to be arranged by Bill the week after next in regards to meeting with the Mater services and others to map out what actions and requirements there are to ensure no young person is disadvantaged in this change. and is December achievable.
- prior to the Friday meeting a brief does need to be written that alerts appropriately as we are reasonable confident that the advice of closure will elicit community action for those families involved in BAC. thus a clear communication plan and strategy is required.

- I appreciated your advice that previous decisions with my predecessors has given commitment that once the services are removed at least 1/3 of the allocated funding would remain within WMHHS Mental Health budget. I do recognise that the funding horizon and arrangement are somewhat changed since that agreement was reached, however would be hopeful that this remains the intent.

once again I hope I have reflected our conversation and would appreciate any clarification of comment if this is not accurate.

Thank you very much for the meeting, looking forward to continuing our partnership into the future.

Regards
Sharon

Sharon Kelly
Executive Director
Mental Health and Specialised Services

West Moreton Hospital and Health Service
T:
E:
Chelmsford Avenue, Ipswich, QLD 4305
PO Box 878, Ipswich, QLD 4305
www.health.qld.gov.au

From: Jagmohan Gilhotra
Sent: 8 Nov 2012 14:11:20 +1000
To: Michael Cleary
Cc: Bill Kingswell;Leanne Geppert;Sharon Kelly
Subject: Fwd: Barrett Adolescent Centre

Dear Michael,

For your information.

Regards
Mohan

Assoc Professor J Mohan Gilhotra
MBBS, MM, FRANZCP, FRCPsych, FRACMA
Director of Mental Health and
Chief Psychiatrist
Queensland Health
Ph:
Fax:

>>> Janet Martin 8/11/2012 12:53 pm >>>
Dear Mohan

Associate Professor Brett McDermott has just informed the Child Protection Commission of Inquiry that they have been informed that the Barrett Centre will be closed in December.

He stated that it was a decision made by adult psychiatrists who don't understand it, and it was judged by adult metrics such as occupied bed days and length of stay.

I expect this will appear in the Courier Mail tomorrow.

Janet

Janet Martin
Manager, Clinical Governance
Office of the Chief Psychiatrist
Mental Health Alcohol and Other Drugs Branch
Health Service and Clinical Innovation Division
2nd Flr, 15 Butterfield St
Herston QLD 4006

West Moreton Hospital and Health Service

PROJECT PLAN

Author:	**Chris Thorburn, Director Service Redesign**	**Executive Sponsor:**	**Sharon Kelly, ED MH&SS**	**Executive Delegate:**	**Lesley Dwyer, CE WMHHS**
Start Date:	16 November 2012	**Approval:**	☐ West Moreton Hospital and Health Board		
End Date:	TBD				

Description of Project: Barrett Adolescent Strategy

BACKGROUND of PROJECT	• Barrett Adolescent Centre (BAC) is located within The Park – Centre for Mental Health (The Park) and provides a state wide service of extended treatment and rehabilitation[1] for up to 15 adolescents with severe and complex mental health disorders.
	• As part of the *Queensland Plan for Mental Health 2007-2017* (QPMH), a capital allocation had been approved to rebuild BAC in a new location as:
	  o The capital fabric of BAC is no longer able to meet the requirements of a contemporary model of care for adolescent extended treatment and rehabilitation and
	  o The Park will become exclusively a High Secure and Secure Rehabilitation Mental Health Service for adults (by end of 2013).
	• Initial consultation with stakeholders (about a replacement service for BAC) commenced as part of the planning for Stage 1 of the QPMH (approximately 2005-06).
	• Planning associated with the QPMH incorporated in a new capital project to be delivered at Redlands, which would replace the BAC. The Adolescent Extended Treatment and Rehabilitation Unit was to be built adjacent to the Redlands Hospital. It was to be commissioned in 2014. Due to environmental and other issues, the project could not proceed and has now ceased.
	• The capital allocation previously attached to the rebuild of BAC has been redirected to other Queensland Health capital priorities; this capital funding is currently no longer available for a rebuild of BAC at an alternative site.

[1] While currently classified as an extended treatment and rehabilitation model of service, the replacement model of service for BAC will likely be classified as either a subacute rehabilitation or community residential program. The classification will need to align with national and state classification frameworks, and relevant funding models.

	• It has become imperative that:
	  o alternative contemporary, statewide model(s) of care be developed to replace the services currently provided by BAC; and
	  o an implementation plan be developed to achieve the alternative statewide model(s) of care.
	• This project plan will articulate the required steps to achieve the above points.

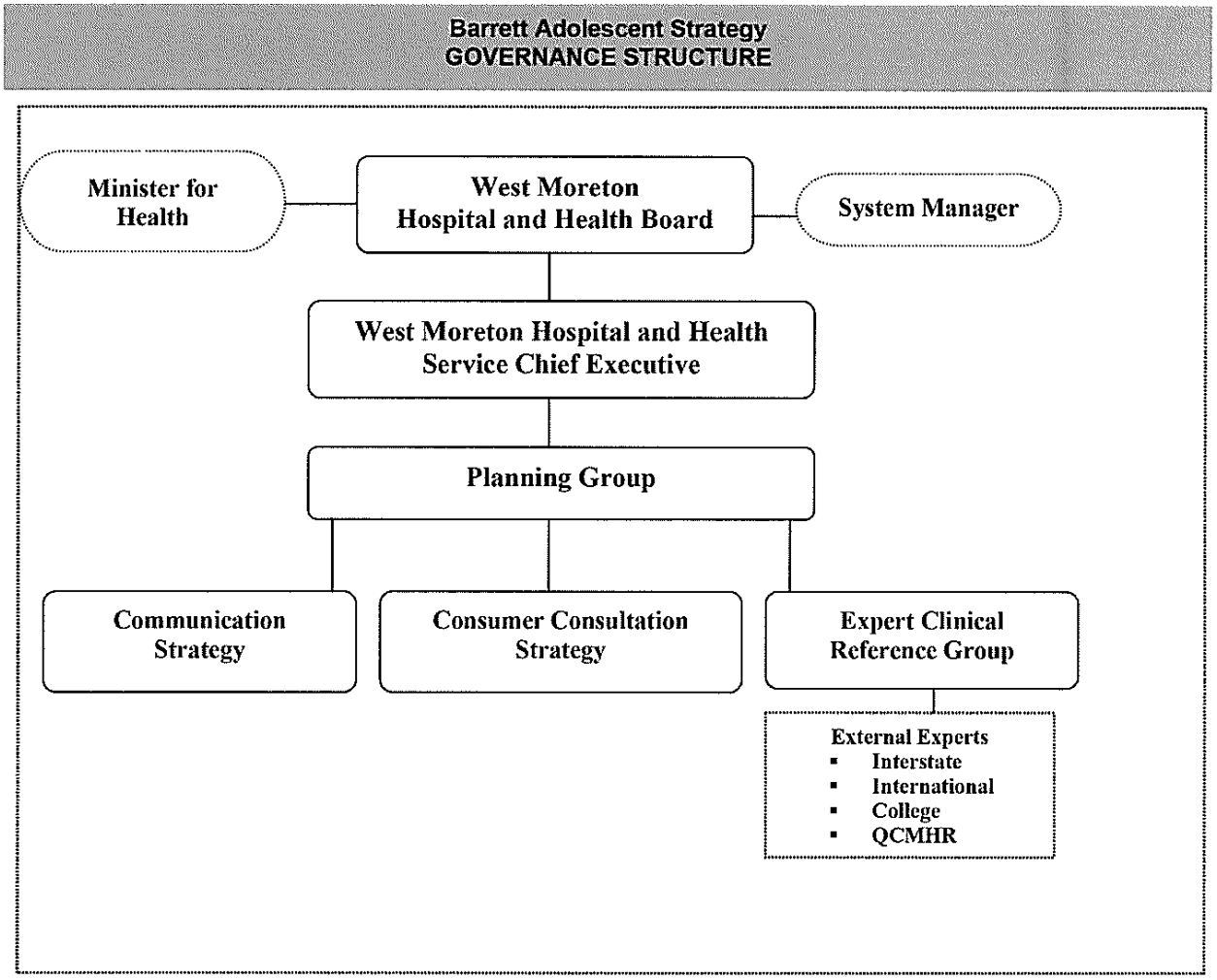
OBJECTIVES	• Through the formation of a planning group, with input from a multidisciplinary expert clinical reference group:
	  o alternative contemporary, statewide model(s) of care will be developed to replace the services currently provided by BAC and will also include the appropriate provision of educational services;
	  o an implementation plan will be developed to achieve the alternative model(s) of care; and
	  o a defined strategy will be articulated outlining the plan to achieve an alternative model of care for the current patients of the BAC.
	• Through the development and implementation of an effective communication and engagement strategy, all identified stakeholders will:
	  o be kept informed in a timely manner; and
	  o have appropriate opportunities to provide input to the process.
	• Through agreed governance and approval processes by the West Moreton Hospital and Health Board, the alternative statewide model(s) of care and implementation plan will be endorsed. This will be achieved through partnership with the System Manager.

OUTCOMES	• The final endorsed model(s) of care will clearly articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland.
	• The final endorsed model(s) of care will be evidenced based, sustainable and align with statewide mental health policy, service planning frameworks and funding models.
	• The final endorsed model(s) of care will replace the existing services provided by BAC.
	• The implementation plan will clearly identify:
	  o Stakeholders
	  o Communication and Engagement strategies
	  o Time frames and steps of implementation
	  o Human, capital and financial resources
	  o Risks, issues and mitigation strategies
	  o Evaluation strategy and criteria attached to the implementation

PROJECT SCOPE	• This project has a statewide focus, as the final endorsed model(s) of care must meet the needs of adolescents in Queensland requiring extended treatment and rehabilitation.
OUT OF SCOPE	• As there is no longer a current capital allocation to rebuild BAC on another site, the model(s) of care to be developed must exclude this as an option.
ASSUMPTIONS	• A significant assumption is that the services currently provided by BAC will not remain on the campus of The Park post June 2013. Once the implementation plan has achieved the endorsed model(s) of care for the current patients, the building that houses the service of BAC will be de-commissioned. • It is assumed that the endorsed model(s) of care will be incorporated into forward planning for the implementation of components of the remainder of the *Queensland Plan for Mental Health 2007-2017*. • It is assumed that there will be robust evaluation criteria applied to determine the quality and effectiveness of the endorsed model(s) of care. • It is assumed that the endorsed model of care will be implemented in a two staged process, ie it will initially be applied to meet the needs of the current consumers in BAC and then implemented more widely across the state as per the parameters of the endorsed model of care. • It is assumed that the existing recurrent funding for BAC and the additional future funding earmarked for the former Redlands Unit will be utilised to fund the endorsed model(s) of care for this adolescent consumer group.
CONSTRAINTS	• It is possible that the project may be constrained by a number of factors including: o Resistance to change by internal and external stakeholders o Insufficient recurrent resources available to support a preferred model of care o Insufficient infrastructure across parts of the State to support a changed model (eg skilled workforce, partnerships with other agencies and accommodation requirements) o A delay in achieving an endorsed model of care.
DEPENDENCIES	• The final model of service delivery for adolescent mental health extended treatment and rehabilitation services across Queensland will be informed by this project. • This project is dependent upon the risks, issues and constraints being appropriately addressed. • There are interdependencies between this project and the available, contemporary service planning frameworks at national and state levels. This includes the QPMH.

Accountability of Project:

PROJECT GOVERNANCE:



REPORTING	• The Planning Group will be a time limited group and it will report to the West Moreton Hospital and Health Service Chief Executive, who in turn will report to the West Moreton Hospital and Health Board. • The Planning Group will consist of representation from West Moreton HHS, Mental Health Alcohol and Other Drugs Branch, another QLD HHS service, Department of Education, a child psychiatrist and a Communication expert. • It is anticipated the Planning Group will meet initially to finalise the project plan and then meet on a regular basis to monitor progress regarding the development of a model(s) of care, the implementation of the communication and engagement plan and the develop the implementation plan. • The Expert Clinical Reference Group will be a time limited group and will consist of a representative group of multidisciplinary child and youth clinicians. In the development of a contemporary model(s) of care, the Expert Clinical Reference Group will seek the assistance of external experts at key points in the consideration of a model(s) of care for extended treatment and rehabilitation for adolescents. • The attached Communication Plan (Appendix 1) outlines the objectives, methods, frequency, target audiences and an action plan. • A specific Consumer Consultation Strategy will be developed consistent with the Communication Plan.

Project Resources:

The Planning Group: With the exception of the communication expert, there is no additional labour cost associated with the Project. The costs incurred through engagement of the communication expert will be met by the Division of Health Service and Clinical Innovation.

The Expert Clinical Reference Group: There is no expected financial cost to be incurred by West Moreton Hospital and Health Service.

Implementation of the Communication Plan: Resources associated with the implementation of the communication plan will be met by the Division of Mental Health & Specialised Services, West Moreton Hospital and Health Service.

Risk Analysis:

Risk Event and Impact	Likelihood	Severity	Risk rating	Treatment
Time frames in the gant chart are not met, leading to loss of confidence from stakeholders	Likely	Minor	Medium	Executive Sponsor EDMH&SS to closely oversight activities in gant chart to minimise this risk
Expert Clinical Reference Group do not agree on a preferred Model of Care, causing delays to the development of an implementation plan	Possible	Moderate	Medium	Input from external experts and reviewing evidence based models of care will minimise this risk
Preferred Model of Care can not be endorsed, causing implementation delays	Possible	Major	High	Close collaboration between West Moreton HHS, other HHS and the System Manager will minimise this risk as existing resources, capacity etc will be confirmed
Communication of Project objectives, scope and progress is not effective, leading to stakeholder dissatisfaction	Possible	Moderate	Medium	Implementation of the communication plan will minimise this risk.
Endorsed Implementation plan is delayed, delaying stage 1 implementation for current BAC consumers	Likely	Moderate	High	Effective project management and broad stakeholder engagement with minimise this risk

GANTT CHART:

Activities		Fortnight Ending												
		16/11	30/11	14/12	28/12	11/1	25/1	8/2	22/2	8/3	22/3	5/4	19/4	3/5
Project Sponsorship established		x												
Planning Group established	*Endorsed by CE*	x												
Expert Clinical Reference Group identified	*Endorsed by CE*		x											
External Experts identified			x											
Communication Plan developed	*Endorsed by CE*		x											
Project Plan endorsed	*Endorsed by CE & WMHH Board*		x											
Planning Group meets			x	x	x	x	x							
Expert Clinical Reference Group meets				x	x			x	x					
External Experts provide advice to Expert Clinical Reference Group					x	x								
Model of Care options developed						x								
Cost Benefits of options undertaken						x								
Consultation with stakeholders regarding preferred model							x	x	x					
Endorsement of preferred model	*Endorsed by CE, WMHH Board & System Manager*								x					
Development of project and change management plan to implement model, in a two staged process	*CE supported by System Manager*									x				
Communication regarding implementation plan	*CE supported by System Manager*									x				
Endorsement of implementation plan	*Endorsed by CE*										x			
Commence Stage 1 implementation											x	x	x	x

Appendix 1: COMMUNICATION PLAN

Communication objectives

- Ensure stakeholders understand the vision and objectives of the BAC project.
- Promote alternative contemporary model of care for Queensland adolescents.
- Gain and sustain support of key stakeholders and influencers who play a critical role in this project's success.
- Create ownership of, and support for, the BAC project within WMHHS staff.
- Increase the community's understanding of the BAC project.
- Use existing effective communication channels and forums to deliver key communication wherever possible.
- Devise new communication channels and forums to deliver key communication where possible.
- Encourage effective communication and feedback from stakeholders.
- Manage expectations and reduce negative or speculative information.

Communication principles

- Communication with all stakeholders is based on honesty and transparency
- Information is easily accessed by all stakeholders
- Communication is responsive and flexible to stakeholder feedback
- Speaks with 'one voice' to stakeholders

Communication environment

Public health care in Queensland (including WMHHS) has undergone significant change over the past 18+ months. As a result, staff morale and the public image of public health care in Queensland has been on a downward trend. This appears to be improving however there are still a number of challenges facing the HHS and Queensland Health as the system manager including:

- Managing community expectations and perceptions.
- Population growth and increased demand necessitates substantial increase in all aspects of health service capacity, including increased bed numbers and increased elective surgery services
- Workforce shortages across health professions.
- Recruiting and retaining clinical staff given overall shortages, competition from other states and countries and the private sector.
- Creating a work environment which rewards quality in service, innovation, and fosters teaching and research to attract and retain staff.

- Developing new models of providing care and reconfiguring services with less reliance on the hospital and acute setting and more emphasis on patients being managed in the community setting.
- Managing outcomes and resources when individual patient care may be provided in different locations and sectors.
- Ensuring and demonstrating that our health service is safe and of high quality.
- Improving access to the health system for Aboriginal and Torres Strait Islander people and people disadvantaged by language, disability and geographic isolation.
- Recruiting skilled, professional staff.
- Changed funding model for HHS'.

Stakeholder groups

Internal stakeholders:

- WMHHS Board, Executive and Senior Management Team
- Clinicians, other staff and management working within WMHHS
- Health Minister and key advisors
- Queensland Health Director-General, Deputy Directors-General and Executive Directors (including Mental Health Alcohol and Other Drugs Branch)
- Senior Heads of Department
- Education Queensland
- Education Minister
- Director-General Education Queensland

External stakeholders:

- The Premier and other Queensland Government Ministers
- Media
- Existing and potential patients of BAC
- General public
- Broader health professionals including GPs
- Australian Medical Association
- Members of Parliament
- Local Governments

- Opposition parties
- Relevant unions
- Professional colleges
- Other Hospital and Health Services
- Non-government organisations

Stakeholder analysis

LEVEL OF INFLUENCE

MAINTAIN CONFIDENCE HIGH INFLUENCE LOW IMPACT	**COLLABORATE** HIGH INFLUENCE HIGH IMPACT
Consumers and families Staff working in BAC West Moreton Hospital and Health Board	Expert Clinical reference Group External experts Mental Health Alcohol and Other Drugs Branch Dept of Education NGOs Other HHS'
MONITOR AND RESPOND LOW INFLUENCE LOW IMPACT	**KEEP INFORMED** HIGH IMPACT LOW INFLUENCE
Potential agencies impacted by a revised model of care Media	All Child and Youth Mental Health Services All Chief Executives, HHSs Minister for Health System Manager DG and Minister for Education Opposition parties Unions Professional colleges Broader health professionals General public

LEVEL OF IMPACT

Communication risks and issues

Risk Event and Impact	Likelihood	Severity	Risk rating	Treatment
Stakeholders are not kept adequately informed, leading to misinformation in public realm	Possible	Moderate	Medium	Adhere to communication plan, including evaluation targets
Stakeholders and issues are not scoped adequately and communication does not satisfy their concerns, leading to opposition to project	Possible	Major	High	Ensure stakeholder and issues thoroughly explored.
Political influence changes the scope of the project	Possible	Major	High	Keep Health Minister and Premier informed during all stages to help ensure support

Key messages

- West Moreton Hospital and Health Service is committed to ensuring adolescents have access to the mental health care they need.
    - West Moreton Hospital and Health Service is collaborating with an expert clinical reference group to ensure the model of care developed meets the needs of adolescents requiring extended mental health treatment. The Hospital and Health Service is working closely with mental health experts to ensure the new model of care for Queensland's adolescents is appropriate and based on best available evidence.
    - We will also work together with the community and mental health consumers to ensure their needs they are kept up-to-date.
- Developing alternative models of care does not mean the end of longer term mental health treatment and rehabilitation for young people in Queensland.
    - The Park has expanded in its capacity as a high secure forensic adult mental health facility. This is not a suitable place for adolescents
    - Our goal is to ensure that the adolescents currently at Barrett Adolescent Centre are cared for in an environment that is best suited for them.
    - It is in the best interests of young people that they are not cared for in the same environment as adult mental health consumers who require high secure treatment.
    - Queensland's youth will continue to receive the excellent mental health care that they have always received.
    - We want adolescents to be able to receive the care they need as close to their home as possible.

Communication tactics

Channel/tactic	Rationale
Online and digital communication	
Intranet (including spotlight) and Internet (new web pages and FAQs)	Low cost and a central repository for all project/program related information.
Internet new page(s) to HHS website including FAQs. Can emulate the Intranet page(s)	Low cost, engages both internal & external stakeholders
Social media (Twitter / Facebook)	Low cost, engages both internal & external stakeholders
Internal communications	
CE all staff emails / staff newsletter updates	Timely distribution from the CE re: key information (changes and updates)
E-alerts	Consider e-alerts to inform System Manager. May only be appropriate once new model of care has been determined.
Memos / letters and email to networks	Top down communications from CE on key information (changes and updates) about the project/program as they're about to roll out. These memos/ letters should be prepared for other HHS', NGOs etc.
Briefing note to Health Minister and System Manager	Bottom up communications on key information (changes and updates) about the project/program for noting or approval
Face-to-face	
Internal stakeholder briefings, trainings, meetings and focus groups	One-on-one engagement with key stakeholders such as BAC staff, Health Minister, other HHS' etc on project/program milestone activities prior to commencement.
External stakeholders briefings, meetings	Undertake a consultative approach with key stakeholders (e.g EQ, NGOs) to ensure messages align with stakeholder expectations.
Marketing collateral	
Fact sheet	Develop and distribute supporting collateral that explains, reinforces or triggers key project/program

Channel/tactic	Rationale
Mail out (letters)	messages.
Media	
Media statements	
Media conferences	
Community service announcements	
Social media (Twitter / Facebook)	

Action plan internal and external stakeholders

Activity	Target audience	Issues / risks	Messages / content	Responsibility	Budget	When	Priority	Status
Responses to correspondence	BAC existing patients, staff, general public, politicians who have submitted correspondence on issue	Correspondence writer may go to media	Develop standard response regarding background of project, reasoning etc. However, ensure response is updated to reflect various phases of project.	WMHHS CE/ Executive Team	Nil	ASAP	High	done
Media holding statements	Media, general public, WMHHS staff	Media attention will provoke negative public perception of project if not responded to quickly	Key messages with focus on care being provided to young people	Rowdy PR	Nil	ASAP	Medium	done
Fact sheet	WMHHS staff, consumers, general public, media	Outdated / inaccurate information	As above. Should also include info on consumer concerns	Rowdy PR, Project Lead, WM HHS online & marketing officer	Nil	1/12/12	Medium	
Briefing note to Health Minister & System Manager	Minister & Ministerial staff, Director-General(Dept Community Services et al)	May not support recommendations	Outline scope of project, reasoning and discussions to be covered in meeting with BAC staff	WMHHS CE MHAODB	Nil	W/C 26/11/12	High	
Internal stakeholder	BAC staff, WMHHS mental health staff	BAC staff currently do not support	Explain background for project, focus on key messages that youth	WMHHS CE	Nil	W/C 26/11/12	High	

Activity	Target audience	Issues / risks	Messages / content	Responsibility	Budget	When	Priority	Status
briefing		project	will not miss out					
Internal stakeholder briefing	Health Minister & Ministerial staff	Want solution now	Update on project and outcome of staff briefing	WMHHS CE	Nil	4/12/12	Medium	
Planning - Online communication	WMHHS staff, general public	If information is not timely and accurate will create negative perception and media attention	Start planning for content. Outline scope of project, reasoning and proposed way forward. Must be regularly updated with project phase information	Rowdy PR, Project Lead, WMHHS online & marketing officer	Nil	1/12/12	Low	
Media conferences / community service announcements	Media, general public	Negative media stories	Stick to key messages	WMHHS CE, Rowdy PR	Nil	As required	Medium	
Go live-Online communication	WMHHS staff, general public	If information is not timely and accurate will create negative perception and media attention	Go live information	Rowdy PR, Project Lead, WMHHS online & marketing officer	Nil	Mid-January	Low	
Social media (consider using the System Manager's social media channels if WMHHS has none available)	All	Negative feedback; no staff to monitor social media channels	Stick to key messages, outline scope of project, reasoning and proposed way forward. Must be regularly updated with project phase information Social media (consider using the System Manager's social media channels if WMHHS has none availalble)	WMHHS CE, Project Lead, WMHHS online & marketing officer	Nil	TBD	Low	

Evaluation

Evaluation of this plan will involve feedback being sourced at each phase of the project to ascertain the effectiveness of communications. The main channels for gaining feedback are as follows:

- Feedback from staff on concerns and issues
- Feedback from management groups
- Staff forums
- Media analysis and tracking
- Meetings

This feedback will be used as the main driver for up-dating and continually improving the communication plan.

Issues management

Issues management will form a critical part of the BAC communication plan and should be based on the following platforms:

Prevention of public media issues wherever possible

This can be achieved by:

- Avoiding the deliberate 'baiting' of likely opponents and instead focusing all information and communication on the positives of the BAC project and WMHHS.
- Providing tangible examples or explanations rather than playing the 'blame game'.
- Keeping focused on consistent delivery of key messages
- Factually answering all questions from media and opponents.
- Ensuring BAC staff and consumers are informed of the mechanisms available to address their concerns / issues, to avoid them going directly to the media with their concerns.

Effective and timely management of issues as and when they arise

This can be achieved by:

- Agreeing a process for issues management in the media with the Health Minister's and Premier's offices to ensure there are no obstacles to a fast and timely response.
- Preparing Q&As where possible for any significant issues that arise to ensure the HHS CE, Minister or Premier is prepared to answer all anticipated questions, and has a broad range of facts and figures at hand.
- Seek agreement with the HHS CE on a case-by-case basis which media inquiries the CE is prepared to respond to by interview, or via written statement.
- Preparing updated key messages for the HHS CE as issues flare to assist with responding to media inquiries.
- Ensuring all media inquiries that are issues-related are responded to quickly.
- Designating a suitable alternative spokesperson if the HHS CE is unavailable.

EXHIBIT 55

Native File (Non-image file)...Printing skipped

	• It has become imperative that: o alternative contemporary, statewide model(s) of care be developed to replace the services currently provided by BAC; and o an implementation plan be developed to achieve the alternative statewide model(s) of care. • This project plan will articulate the required steps to achieve the above points.
OBJECTIVES	• Through the formation of a planning group, with input from a multidisciplinary expert clinical reference group: o alternative contemporary, statewide model(s) of care will be developed to replace the services currently provided by BAC and will also include the appropriate provision of educational services; o an implementation plan will be developed to achieve the alternative model(s) of care; and o a defined strategy will be articulated outlining the plan to achieve an alternative model of care for the current patients of the BAC. • Through the development and implementation of an effective communication and engagement strategy, all identified stakeholders will: o be kept informed in a timely manner; and o have appropriate opportunities to provide input to the process. • Through agreed governance and approval processes by the West Moreton Hospital and Health Board, the alternative statewide model(s) of care and implementation plan will be endorsed. This will be achieved through partnership with the System Manager.
OUTCOMES	• The final endorsed model(s) of care will clearly articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland. • The final endorsed model(s) of care will be evidenced based, sustainable and align with statewide mental health policy, service planning frameworks and funding models. • The final endorsed model(s) of care will replace the existing services provided by BAC. • The implementation plan will clearly identify: o Stakeholders o Communication and Engagement strategies o Time frames and steps of implementation o Human, capital and financial resources o Risks, issues and mitigation strategies o Evaluation strategy and criteria attached to the implementation

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CONSTRAINTS	• It is possible that the project may be constrained by a number of factors including: o Resistance to change by internal and external stakeholders o Insufficient recurrent resources available to support a preferred model of care o Insufficient infrastructure across parts of the State to support a changed model (eg skilled workforce, partnerships with other agencies and accommodation requirements) o A delay in achieving an endorsed model of care.
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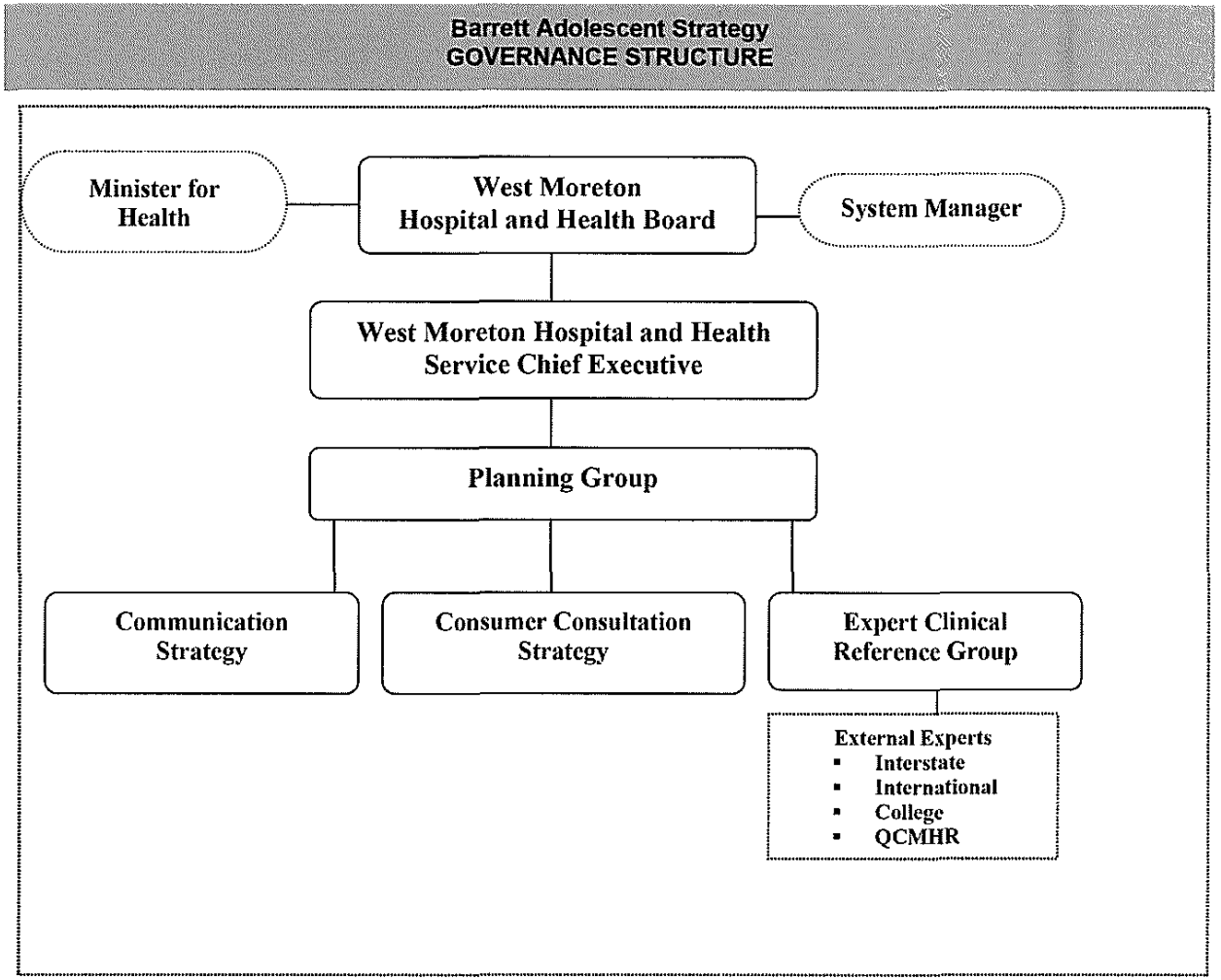
Accountability of Project:

PROJECT GOVERNANCE:



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Expert Clinical Reference Group meets				x	x			x	x					
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Commence Stage 1 implementation											x	x	x	x

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- Opposition parties
- Relevant unions
- Professional colleges
- Other Hospital and Health Services
- Non-government organisations

Stakeholder analysis

MAINTAIN CONFIDENCE HIGH INFLUENCE LOW IMPACT		**COLLABORATE** HIGH INFLUENCE HIGH IMPACT
Consumers and families Staff working in BAC West Moreton Hospital and Health Board		Expert Clinical reference Group External experts Mental Health Alcohol and Other Drugs Branch Dept of Education NGOs Other HHS'
MONITOR AND RESPOND LOW INFLUENCE LOW IMPACT		**KEEP INFORMED** HIGH IMPACT LOW INFLUENCE
Potential agencies impacted by a revised model of care Media		All Child and Youth Mental Health Services All Chief Executives, HHSs Minister for Health System Manager DG and Minister for Education Opposition parties Unions Professional colleges Broader health professionals General public

LEVEL OF INFLUENCE ↑

LEVEL OF IMPACT →

Communication risks and issues

Risk Event and Impact	Likelihood	Severity	Risk rating	Treatment
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Stakeholders and issues are not scoped adequately and communication does not satisfy their concerns, leading to opposition to project	Possible	Major	High	Ensure stakeholder and issues thoroughly explored.
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Key messages

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    - West Moreton Hospital and Health Service is collaborating with an expert clinical reference group to ensure the model of care developed meets the needs of adolescents requiring extended mental health treatment. The Hospital and Health Service is working closely with mental health experts to ensure the new model of care for Queensland's adolescents is appropriate and based on best available evidence.
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    - The Park has expanded in its capacity as a high secure forensic adult mental health facility. This is not a suitable place for adolescents
    - Our goal is to ensure that the adolescents currently at Barrett Adolescent Centre are cared for in an environment that is best suited for them.
    - It is in the best interests of young people that they are not cared for in the same environment as adult mental health consumers who require high secure treatment.
    - Queensland's youth will continue to receive the excellent mental health care that they have always received.
    - We want adolescents to be able to receive the care they need as close to their home as possible.

Communication tactics

Channel/tactic	Rationale
Online and digital communication	
Intranet (including spotlight) and Internet (new web pages and FAQs)	Low cost and a central repository for all project/program related information.
Internet new page(s) to HHS website including FAQs. Can emulate the Intranet page(s)	Low cost, engages both internal & external stakeholders
Social media (Twitter / Facebook)	Low cost, engages both internal & external stakeholders
Internal communications	
CE all staff emails / staff newsletter updates	Timely distribution from the CE re: key information (changes and updates)
E-alerts	Consider e-alerts to inform System Manager. May only be appropriate once new model of care has been determined.
Memos / letters and email to networks	Top down communications from CE on key information (changes and updates) about the project/program as they're about to roll out. These memos/ letters should be prepared for other HHS', NGOs etc.
Briefing note to Health Minister and System Manager	Bottom up communications on key information (changes and updates) about the project/program for noting or approval
Face-to-face	
Internal stakeholder briefings, trainings, meetings and focus groups	One-on-one engagement with key stakeholders such as BAC staff, Health Minister, other HHS' etc on project/program milestone activities prior to commencement.
External stakeholders briefings, meetings	Undertake a consultative approach with key stakeholders (e.g EQ, NGOs) to ensure messages align with stakeholder expectations.
Marketing collateral	
Fact sheet	Develop and distribute supporting collateral that explains, reinforces or triggers key project/program

Channel/tactic	Rationale
Mail out (letters)	messages.
Media	
Media statements	
Media conferences	
Community service announcements	
Social media (Twitter / Facebook)	

Action plan internal and external stakeholders

Activity	Target audience	Issues / risks	Messages / content	Responsibility	Budget	When	Priority	Status
Responses to correspondence	BAC existing patients, staff, general public, politicians who have submitted correspondence on issue	Correspondence writer may go to media	Develop standard response regarding background of project, reasoning etc. However, ensure response is updated to reflect various phases of project.	WMHHS CE/ Executive Team	Nil	ASAP	High	done
Media holding statements	Media, general public, WMHHS staff	Media attention will provoke negative public perception of project if not responded to quickly	Key messages with focus on care being provided to young people	Rowdy PR	Nil	ASAP	Medium	done
Fact sheet	WMHHS staff, consumers, general public, media	Outdated / inaccurate information	As above. Should also include info on consumer concerns	Rowdy PR, Project Lead, WM HHS online & marketing officer	Nil	1/12/12	Medium	
Briefing note to Health Minister & System Manager	Minister & Ministerial staff, Director-General(Dept Community Services et al)	May not support recommendations	Outline scope of project, reasoning and discussions to be covered in meeting with BAC staff	WMHHS CE MHAODB	Nil	W/C 26/11/12	High	
Internal stakeholder	BAC staff, WMHHS mental health staff	BAC staff currently do not support	Explain background for project, focus on key messages that youth	WMHHS CE	Nil	W/C 26/11/12	High	

Activity	Target audience	Issues / risks	Messages / content	Responsibility	Budget	When	Priority	Status
briefing		project	will not miss out					
Internal stakeholder briefing	Health Minister & Ministerial staff	Want solution now	Update on project and outcome of staff briefing	WMHHS CE	Nil	4/12/12	Medium	
Planning - Online communication	WMHHS staff, general public	If information is not timely and accurate will create negative perception and media attention	Start planning for content. Outline scope of project, reasoning and proposed way forward. Must be regularly updated with project phase information	Rowdy PR, Project Lead, WMHHS online & marketing officer	Nil	1/12/12	Low	
Media conferences / community service announcements	Media, general public	Negative media stories	Stick to key messages	WMHHS CE, Rowdy PR	Nil	As required	Medium	
Go live-Online communication	WMHHS staff, general public	If information is not timely and accurate will create negative perception and media attention	Go live information	Rowdy PR, Project Lead, WMHHS online & marketing officer	Nil	Mid-January	Low	
Social media (consider using the System Manager's social media channels if WMHHS has none available)	All	Negative feedback; no staff to monitor social media channels	Stick to key messages, outline scope of project, reasoning and proposed way forward. Must be regularly updated with project phase information Social media (consider using the System Manager's social media channels if WMHHS has none availalble)	WMHHS CE, Project Lead, WMHHS online & marketing officer	Nil	TBD	Low	

Evaluation

Evaluation of this plan will involve feedback being sourced at each phase of the project to ascertain the effectiveness of communications. The main channels for gaining feedback are as follows:

- Feedback from staff on concerns and issues
- Feedback from management groups
- Staff forums
- Media analysis and tracking
- Meetings

This feedback will be used as the main driver for up-dating and continually improving the communication plan.

Issues management

Issues management will form a critical part of the BAC communication plan and should be based on the following platforms:

Prevention of public media issues wherever possible

This can be achieved by:

- Avoiding the deliberate 'baiting' of likely opponents and instead focusing all information and communication on the positives of the BAC project and WMHHS.
- Providing tangible examples or explanations rather than playing the 'blame game'.
- Keeping focused on consistent delivery of key messages
- Factually answering all questions from media and opponents.
- Ensuring BAC staff and consumers are informed of the mechanisms available to address their concerns / issues, to avoid them going directly to the media with their concerns.

Effective and timely management of issues as and when they arise

This can be achieved by:

- Agreeing a process for issues management in the media with the Health Minister's and Premier's offices to ensure there are no obstacles to a fast and timely response.
- Preparing Q&As where possible for any significant issues that arise to ensure the HHS CE, Minister or Premier is prepared to answer all anticipated questions, and has a broad range of facts and figures at hand.
- Seek agreement with the HHS CE on a case-by-case basis which media inquiries the CE is prepared to respond to by interview, or via written statement.
- Preparing updated key messages for the HHS CE as issues flare to assist with responding to media inquiries.
- Ensuring all media inquiries that are issues-related are responded to quickly.
- Designating a suitable alternative spokesperson if the HHS CE is unavailable.

West Moreton Hospital and Health Service
Minutes

"LG-8"

Minutes: Barrett Adolescent Strategy					
Date:	23 July 2013	**Commencement Time:**	8:00 am – 9:00 am	**Location:**	QHB Level 5

Committee Members					
Position	Name	Key	Present	T/Conf	Comment
WM HHS; Chair	Lesley Dwyer	LD	X		
WM HHS	Sharon Kelly	SK	X		
WM HHS	Leanne Geppert	LG	X		
WM HHS; Communications	Naomi Ford	NF	X		
CHQ HHS	Peter Steer	PS	X		
CHQ HHS	Stephen Stathis	SS		X	
CHQ HHS	Judi Krause	JK		X	
DoH; Communications	Craig Brown	CB	X		
DoH; MHAODB	Bill Kingswell	BK	X		

1.0	Meeting Opening	Responsible Officer
1.1	Nil apologies	
1.2	Nil previous minutes	

2.0	Matters for Decision/Discussion			
Item	Title / Item	Action	Key Officer	Due Date
2.1	**Update on Barrett Adolescent Strategy (LD & SK)** • Key stakeholders engaged in communication process and supportive, including Department of Education Training & Employment (DETE). • No public announcements to-date regarding future of Barrett Adolescent Centre (BAC). • Planning to close BAC 31/12/13. • WM HHS will ensure ongoing service provision for BAC consumer group as needed until an alternative service is identified to meet individual need. • Majority of current BAC consumer group aged 16y or older with lengths of admission up to 2 yrs. Approx 9 consumers preparing to graduate from high school in December 2013. • DETE will develop their future model of service provision independent of (but in consultation with) QH.			
	Update on Department of Health (DoH) Service Planning – Youth Prevention and Recovery Care Model (BK) • DG approval to dedicate $2M recurrent from the ceased Redlands build towards a YPARC service as a pilot site (new to Qld). YPARC model = 16-25yo age group, inpatient beds delivered by NGO with daily in-reach by mental health clinicians, short term admissions, 6 - 8 beds, delivered on hospital campus. • Potential site for the first supra-district YPARC is Metro Sth HHS. Meeting called next week by DoH with ED, Mental Health Metro Sth HHS to discuss.	a. Conduct meeting with Metro Sth HHS, inviting CHQ HHS, WM HHS.	a. BK	

	• BK has confidence in procurement timeline to open YPARC service by January 2014. Longer term plan will consider a second YPARC site in North Qld - Sector preference for second site to be Townsville. DoH identified Cairns as another potential site. • Potential to establish Youth Residential Rehab Service in addition to YPARC. Funding source not identified. Domestic build, service model is residential not therapeutic, extended length of stay for target group. BK unable to provide timeline for service establishment – likely to be second priority to YPARC establishment. Potential for this pilot site also in Metro Sth HHS. **Recommendations**: • Invite CHQ HHS and WM HHS to meeting with Metro Sth HHS and DoH. Include Chief Executives. • In addition to YPARC, Youth Residential Rehab Service identified as important component of service continuum if BAC closes. A portion of existing BAC operational funds could be utilised to fund this service type. • Statewide service provision an essential factor for consideration.			
2.3	**Next Steps (all)** • Communication and media plan high priority. • Discussion regarding ongoing referrals to BAC, and risks associated with transition from current BAC clinical model to new YPARC clinical model in Dec/Jan. **Recommendations:** • Joint communication plan is essential between key stakeholders attending today – consistent clear messages, and clear governance over Strategy. • Barrett Adolescent Strategy will now move into the Implementation Phase. • CHQ HHS will lead the implementation phase of the Barrett Adolescent Strategy moving forward. WM HHS and DoH will remain key stakeholders. Other HHSs and Departments will be included as relevant. • Implementation Steering Committee to be formed to drive next phase of Strategy. Sub groups will be invited to advise/support the Implementation Steering Committee as required. • Consider the potential to transition current BAC staff to services being established. • Continue to admit to BAC as required, but ensure that admissions align with criteria suited to the new clinical model (ie., YPARC).	a. Draft Project Plan to be submitted to this group in next 2 wks b. Propose Implementation Steering Committee membership for approval.	a. SK, LG, SS, JK b. SK, LG, SS, JK	a. 6/8/13 b. 6/8/13

3.0	**Attachments**	
Item		
3.1	Expert Clinical Reference Group: **Proposed Service Model Elements – Adolescent Extended Treatment and Rehabilitation Services**	F:\WM HHS\BAC\ Proposed Service Mo

3.2	Briefing Note (copy as sent to Queensland Mental Health Commissioner 18 July 2013): **Barrett Adolescent Strategy**	F:\WM HHS\BAC\ Briefing Note QMHC 1

4.0	**Matters for Noting**
Item	Noted
4.1	Written and verbal updates have been provided to the Minister for Health, DoH, the Queensland Mental Health Commissioner, CHQ HHS, and the DETE.
4.2	Support to proceed with the closure of BAC has been received from all parties noted in 4.1 above. Closure of the BAC is reliant on adequate services being available for the target adolescent consumer group – there should be no gap in service provision.
4.3	No public announcement has been made regarding the closure of BAC. This includes current staff members and consumers of the BAC.
4.4	Implementation and communications from this point forward will ensure key stakeholder involvement – WM HHS, CHQ HHS, Department of Health/MHAODB, and as relevant Metro Sth HHS.

5.0	**Meeting Finalisation**
Item	
5.1	Next meeting details to be confirmed, following submission of draft Project Plan to this group by Tuesday 6 August 2013.
5.2	The meeting closed at 9:00 am.

Minutes authorised by Chair as an accurate record of proceedings	
	/ /
Lesley Dwyer **Chief Executive, WM HHS**	**Date**

Children's Health Queensland Hospital and Health Service

Terms of Reference

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee

1. Purpose and Functions

The purpose of the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee (Steering Committee) is to:

- Monitor and oversee the implementation of the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Project Plan (Project Plan) to ensure that project milestones and key deliverables are met in the required timeframes, and that all accountabilities are fulfilled.
- Review and submit any proposed amendments of the Project Plan to the Chief Executive (CE) and Department of Health (DoH) Oversight Committee for approval.
- Establish, monitor and oversee the three Working Groups and their associated processes and outputs.
- Provide a decision-making, guidance and leadership role with respect to mental health service planning, models of care, staffing transition, financial management and consumer transition associated with the project.
- Provide governance of the project risk management process and associated mitigation strategies, and escalate in a timely manner to the CE and DoH Oversight Committee.
- Identify roles and responsibilities within the key stakeholder groups regarding information collection and reporting, transition of consumers, re-allocation of funding, including the identification of overlap and related roles.
- Prepare a communication plan for endorsement by the CE and DoH Oversight Committee.
- To facilitate expert discussion from key clinician and consumer stakeholder groups around planning and implementation activity associated with the Project Plan.
- Preparation and provision of update reports to the Executive Management Team, and Hospital and Health Service Board as required.
- To oversee the management of strategic risks.
- To monitor overall budget and financial management associated with the Project Plan.
- Provide an escalation point for the resolution of issues and barriers associated with implementation of the Project Plan.

2. Guiding principles

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

3. Authority

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

The Committee will endorse all deliverables for approval by the Chief Executive and Department of Health (CE DoH) Oversight Committee.

Decision Making:

- Recommendations made by the Steering Committee, to the CE DoH Oversight Committee, will be by majority.
- If there is no group consensus in relation to critical matters the Chair has the right to decide
- Decisions (and required actions) will be recorded in the minutes of the meeting.

4. Frequency of meetings

Meetings will be held fortnightly on a Monday at 0830 am for 1.5 hours in duration unless otherwise advised.

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

Attendance can be in-person, or via teleconference mediums.

The Committee is life limited for the duration of development, implementation and evaluation of the **project SW AETR options**. The Chair will advise the Committee members approximately one month prior to the dissolution of the Steering Committee once the service is mainstreamed.

5. Membership

Divisional Director	CYMHS, CHQ HHS	Co Chair
Clinical Director	CYMHS, CHQ HHS	Co Chair
Director of Strategy	MHSS, West Moreton HHS	Member
Director	Planning and Partnership Unit, MHAOD Branch	Member
Senior Representative	Queensland Alliance	Member
Senior Representative	*headspace*	Member
Senior Representative	Mental Health, Northern Clinical Cluster (or equivalent)	Member
Senior Representative	Mental Health, Central Clinical Cluster (or equivalent)	Member
Senior Representative	Mental Health, Southern Clinical Cluster (or equivalent)	Member
Consumer Representative		Member
Carer Representative		Member
Clinical Director	BAC, MHSS, West Moreton HHS	Member
Senior Representative	Metro South HHS	Member
Executive Director	Office of Strategy Management CHQ HHS	Member

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

Chair:
The Steering Committee will be co chaired by the Divisional Director of CYMHS CHQ and the Clinical Director of CYMHS CHQ, or his/her delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

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

- Venue
- Agenda
- Minutes of previous meetings
- Briefs for any agenda items that require endorsement by the Chair five (5) working days prior to the meeting.

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

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

6. Quorum

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

7. Reporting

The Statewide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee provides the following:

- Monthly Project Status Reports will be provided by the Steering Committee to the CE and DoH Oversight Committee, Queensland Mental Health Commissioner, Department of Education Training and Employment, and HHS Boards as identified by the CE and DoH Oversight Committee.
- Fortnightly written updates will be provided by each of the Working Groups to the Steering Committee seven (7) days prior to each Committee meeting for discussion as a standing agenda item.

8. Performance and Reporting

Performance will be determined by objectives of the Project Plan being met within the required time-frames.

The Secretariat is to circulate an action register to Steering Committee members within three business days of each Steering Committee meeting.

The Secretariat will coordinate the endorsement of status reports and other related advice to be provided as required to the Executive Management Team and/or the Hospital and Health Service Board. Members are expected to respond to out of session invitations to comment on reports and other advice within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

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

9. Risk Management

A proactive approach to risk management will underpin the business of this Steering Committee.

The Committee will:

- Identify risks and mitigation strategies associated with the implementation of the project plan; and
- Implement processes to enable the Committee to identify, monitor and manage critical risks as they relate to the functions of the Committee.

Risks will be identified and documented in the project plan and new risks identified will be escalated to the Steering Committee and reviewed as a standing agenda item.

A Risk Register will be established and reviewed at the Steering Committee meetings.

Children's Health Queensland Hospital and Health Service

Document history

Version	Date	Author	Nature of amendment
1.0	26/08/13	Divisional Director CYMHS CHQ HHS	Initial Draft
1.1	03/09/13	A/Senior Project Officer OSM CHQ HHS	Incorporate CHQ HHS feedback
2.0		A/Director of Strategy, MHSS	Additional comments
2.1	09/09/13	A/Director of Strategy, MHSS	Incorporate SC feedback
3.0	19/09/13	Project Manager, SW AETRS	Edit Authority Section
FINAL	23/09/13	Project Manager, SW AETRS	Endorsed by SW AETR Steering Committee

Previous versions should be recorded and available for audit.

Terms of Reference

Chief Executive and Department of Health Oversight Committee

1. Purpose

The purpose of the Chief Executive and Department of Health Oversight Committee (CE DoH OC) is to provide strategic leadership and governance for the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy.

2. Guiding principles

- *Hospital and Health Boards Act 2011*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the Oversight Committee include:

- Provision of executive leadership, strategic advice and advocacy in the implementation of Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) service options.
- To identify the priorities and objectives associated with the development and implementation of SW AETR services, and to endorse plans and actions to achieve these objectives.
- To oversight the development of a contemporary model of care for SW AETR services within the allocated budget.
- To provide a strategic forum to drive a focus on outcomes and achievement of the transition of SW AETR services to CHQ HHS.
- To facilitate expert discussion from key executive around planning, development, and implementation of SW AETR services.
- To oversee the management of strategic risks.
- To monitor overall financial management of the transition of AETR services from West Moreton HHS to CHQ HHS.
- Provision of guidance and oversight for communication and stakeholder planning.
- Provide an escalation point for the resolution of issues and barriers associated with implementation of the SW AETR services.

4. Authority

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

Decision Making:

- Decisions made by the Steering Committee will be by majority.
- Where group consensus cannot be reached in relation to critical decisions, the Chair takes the final position

5. Frequency of meetings

Meetings will be held monthly, following the Chief Executive Forums, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Committee or in respect of matters the Committee wishes to pursue within the Term of Reference.

Attendance can be in-person or via teleconference mediums.

The Committee is life limited for the duration of development, implementation and evaluation of transition to CHQ HHS. The Chair will advise the Committee members approximately one month prior to the dissolution of the Oversight Committee.

6. Membership

Dr Peter Steer (Chair)	Health Service Chief Executive, CHQ HHS
Dr Michael Cleary	Deputy Director General, Health Service and Clinical Innovation Division
Mrs Lesley Dwyer	Health Service Chief Executive, West Moreton HHS
Dr Richard Ashby	Health Service Chief Executive, Metro South HHS
Mrs Julia Squire	Health Service Chief Executive, Townsville HHS
Dr Bill Kingswell	Executive Director, Mental Health Alcohol & Other Drugs Directorate
Ms Deb Miller	A/Executive Director, Office of Strategy Management, CHQ HHS
Mr Stephen Stathis	Clinical Director, CYMHS CHQ HHS
Ms Leanne Geppert	A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS
Ms Ingrid Adamson (Secretariat)	Project Manager, SW AETRS, CHQ HHS

Chair:
The Steering Committee will be chaired by the Health Service Chief Executive, CHQ, or his delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Secretariat:
Secretariat support will be provided by the Project Manager, SW AETRS or an alternate officer nominated by the Chair.

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

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

7. Quorum

A quorum will comprise half of the voting members, including the Chair, plus one.

8. Performance and Reporting

The Secretariat is to circulate an action register to Committee members within three business days of each Committee meeting.

The Secretariat will coordinate the endorsement of status reports and other related advice to be provided, as required, to the Children's Health Queensland Hospital and Health Service Board. Members are expected to respond to out of session invitations to comment on reports and other advice within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

9. Confidentiality

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

10. Risk Management

A proactive approach to risk management will underpin the business of this Committee. The Committee will:

- Identify risks and mitigation strategies associated with the implementation of the SW AETR services; and
- Implement processes to enable the Committee to identify, monitor and manage critical risks as they relate to the functions of the Committee.

Document history

Version	Date	Author	Nature of amendment
1.0	18/09/13	Ingrid Adamson	First draft
1.1	19/09/13	Ingrid Adamson	Comments from Deb Miller, A/ED OSM
1.2	23/09/13	Ingrid Adamson	Comments from SW AETR Steering Committee
Final	17/10/13	Ingrid Adamson	Comments from CE DoH Oversight Committee

Previous versions should be recorded and available for audit.

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Summary of Meeting – Friday 07 December 2012

- Chair – Dr Leanne Geppert
- Attendees:
  - Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital
  - Amelia Callaghan, State Manager Qld NT and WA, Headspace.
  - Dr Cary Breakey, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service (Proxy for Dr Sadler)
  - Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS
  - Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland
  - Dr Leanne Geppert, Director, Planning & Partnerships Unit ,QH Mental Health Alcohol & Other Drugs Branch (MHAODB)
  - Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
  - Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service – joined the meeting at 10.00am
  - Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service
  - Professor Philip Hazel, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts,
- Dr Ray Cash has not yet responded to the invitation to join the Expert Clinical Reference Group (ERCG).
- Meeting schedule will be weekly, 1.5 hours in duration as from 09 January 2013.

1. Welcome and Introductions
   - ECRG consists of a multidisciplinary group who are experts in the field of adolescent mental health having expertise in psychiatry, nursing, allied health and education.
   - All invitees are keen to commit to participate and contribute. Independent clinical expert from interstate member; Dr Philip Hazel joined the group.

2. Background
   - Brief background provided by the Chair noting historical context and current events leading to the establishment of this group.
   - Noted cancellation of Redlands capital works project, the redirection of capital funds to other capital project and the hope that operational funds will remain for the use of child and youth mental health purposes.
   - Noted the condition of the current facility and its co-location with adult secure and forensic service.

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Barrett Adolescent Strategy

Expert Clinical Reference Group

- Noted the Queensland Plan for Mental Health 2007-2017 (QPMH) and clear policy direction to ensure that young people are treated close to their homes in the least restrictive environment with the minimum possible disruption to their families, educational, social and community networks.

3. Next steps
   - Task of the ERCG is to recommend a statewide model of care for adolescents requiring longer term mental health care.
   - Governance is provided by the Barrett Adolescent Strategy Planning Group. The Planning Group has developed a Project Plan under which the ERCG is identified.
   - West Moreton Hospital and Health Service (WMHHS) will be responsible for responding to consumers and their families and ensure that they are kept informed of plans and developments. WMHHS will work closely with the Director General and Minister for Health.

4. Discussion points
   - Of the highest priority are the current consumers of BAC (and any future consumers) and what is planned for them in the interim while decisions and plans are being made.
   - Risk of dispersal of clinical expertise and possible loss of this expertise to Queensland with possible BAC closure. Noted that this has already begun to happen due to uncertain future of BAC. Erosion of confidence of consumers with staff due to lack of consistency and boundaries provided by inexperienced casual staff.
   - ECRG members agreed that any model that is recommended will retain the education component. The challenge is ensuring how this will be incorporated.
   - ECRG noted the endorsed Terms of Reference for the group and provided the following feedback to the Planning Group for consideration:
     - The TOR does not clearly articulate the complexity and severity of the consumer group being addressed
     - Noted that the scope does not articulate alignment with current state models of service and frameworks.
     - Any model of care that is recommended will need to 'fit' closely with state models of service and national mental health planning frameworks as future funding will be determined by these.
     - Noted that the timeframes identified in the Project Plan are ambitious.
   - Concern was raised regarding an assumption that the current BAC model of care is not contemporary.

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Barrett Adolescent Strategy

Expert Clinical Reference Group

- It was noted that the current BAC model has been refined over many years to meet the needs of this cohort. Further that the model is robust and comparable to international models.
- Suggestion that rather than re-developing a new model, group should identify gaps and recommend innovative strategies to address these.
- Chair noted that there have been a number of attempts to re-develop the current BAC model *however* the difference now is BAC cannot continue on the current site and there is no funding to build another BAC.

- ERCG noted that this was an opportunity to start afresh with respect to model development.
  - It provides an opportunity to look at innovative strategies and models such as using the Non government sector and developing partnerships and opportunities with other stakeholders.
  - Provides an opportunity to address service gaps for adolescents on the waiting list for BAC and for those young people that currently don't 'fit' such as those with developing chronic psychiatric disorders and intellectual disabilities etc.
  - ECRG acknowledged that there is a lot to learn from BAC model. The BAC day programme has been drawn on heavily to model the day programme for adolescents at Townsville Child and Youth Mental Health Service hence the ECRG should consider what components of the BAC model to take forward.
- The profile of consumers accessing BAC has changed and the service is not dealing with the same group or type of consumer as in the past. This may be as a result of increased access to child and youth acute units.
- In order to better understand the target client group, ECGR agreed that members needed to inform themselves about the following:
  1. Service models for adolescents that have been developed including;
     - Barrett Adolescent Centre Model of Service (MOS)
     - Draft Adolescent Extended Treatment and Rehabilitation MOS
     - Draft Acute Adolescent Inpatient Unit MOS
     - The Walker Unit MOS, Concord Centre for Mental Health , NSW
  2. Profile of current BAC consumers.
  3. Cumulative demographic profile of consumers in BAC over a period of 1-2 years.
  4. Client profile of possible consumers that services would like to refer to BAC.
  5. Any BAC consumer or carer satisfaction surveys.
  6. Any investigations of reports by students etc on longer term outcomes of BAC consumers.

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Barrett Adolescent Strategy

Expert Clinical Reference Group

- The ECRG secretariat will disseminate these documents by 14/12/2012. Members will contribute to the package.
- Discussion to determine the consumer profile was initiated using the following domains:
    1. Age range
    2. Diagnostic profile
    3. Referral sources and pathway
    4. Complexities of presentation

Age range

- The current age criterion is 13-17 years old. This is seen as an artificial divide. The recommendation is to consider the conceptual developmental age i.e. when the individual begins to deal with adolescent issues.
- ECRG agreed that the lower age range should be retained at 13 years but upper age limit should be flexible.
- Average age range now seen at BAC is 15-16 year olds which has an impact on the type of curriculum offered at the BAC school.
- Agreement in principle that the presenting issue rather than the age range flexibility should be the determinant at the higher age range. Further, that the developmental age of the young person rather than chronological age should be considered.
- Noted a higher ratio of females to males at BAC.
- Sexuality and gender issues need to be addressed both in the recommended model and at this stage of development.

Other discussion points:

- Noted again that any model of care that is recommended will need to 'fit' closely with state models of service and national mental health planning frameworks as future funding will be linked to these.
- Possible scenarios for distribution of this service could include:
    - One specific HHS funded to provide statewide service
    - Stand alone statewide service
    - Individual flexible funding packages within the Non government sector
    - Day programme places
- A cost benefit analysis would be required for each proposed model. This is a high service user group. Noted that there is no highly visible system cost to the population of adolescents and young people that are house bound, invisible and hard to find. There is however, a 'huge cost to society'. Note also the impact of adolescent suicide on families.
- % population that the service will meet needs to be defined.

Meeting closed: 11.30am

"LG-12"

From: Leanne Geppert
Sent: 9 Nov 2012 17:31:40 +1000
To: Sharon Kelly
Cc: Bill Kingswell;Jagmohan Gilhotra;Lauren Stocks;Lesley Dwyer
Subject: Re: strategic partnership meeting for BAC changes
Importance: High

Hi Sharon
I agree, this meeting needs to occur as a priority next week.
I will ask my ESO Lauren Stocks to coordinate asap.

I assume Bill will chair?, however, I will prepare the agenda jointly with you Sharon.
Again, I will discuss this with you Bill and Sharon, but my thinking so far is that the aim of the mtg will be to clarify the events of this week, identify the next steps/tasks in the process, and identify the steering committee to progress the work of establishing the alternative models of service for the State.

For your input Bill, but I suggest the attendees would include:

- Bill, Mohan, myself
- Sharon Kelly, Terry Stedman (The Park)
- David Hartman (Townsville)
- Brett McDermott and Erica Lee (Mater)
- Stephen Stathis and Judi Krause (Metro North CYMHS)
- Neeraj Gill (or delegate from CYMHS) (Toowoomba)
- Michael Daubney (Logan)

Given the urgency of the mtg, we will set up v/conf and/or t/conf, and the aim will be to get as many of these stakeholders to attend (however, we will not delay the mtg if there are apologies).

Hope your weekend is peaceful Sharon and Lesley! Feel free to call if needed.
Leanne

Dr Leanne Geppert

Director
Planning & Partnerships Unit
Mental Health Alcohol and Other Drugs Branch
Health Services and Clinical Innovation Division
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Senior Lecturer
School of Medicine I Health I Griffith University I Gold Coast Campus

>>> Sharon Kelly 11/9/2012 2:16 pm >>>
Leanne,

as we discussed when I met with you all a couple of weeks ago, our next step for BAC was to get together the key strategic partners so we can consider the MH strategies required, options, implications etc. Given the issues that have arisen over the past 24 hours the timing of that meeting is now more urgent.

I would appreciate if you could progress establishing that meeting if possible during the next week.
Happy to talk more.

Regards
Sharon

Sharon Kelly
Executive Director
Mental Health and Specialised Services

West Moreton Hospital and Health Service
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From: Lesley Dwyer
Sent: 14 Nov 2012 13:21:16 +1000
To: Sean Hatherill;Bill Kingswell;Jagmohan Gilhotra;Leanne Geppert;Ian Williams;Judi Krause;Brett McDermott;Michelle Fryer;David Hartman;Neeraj Gill;Sharon Kelly;Terry Stedman;Trevor Sadler;
Subject: Information re Barrett Adolescent Centre Stakeholder Meeting
Importance: High

Dear Colleagues

Recent media reports have raised to the forefront the role and future of the Barrett Adolescent Centre at The Park.

I am seeking your support, advice and collaboration in relation to developing an alternative model or models of service to replace the services currently provided at the Barrett Adolescent Centre (BAC), at The Park - Centre for Mental Health.

Initial high level discussion had commenced with Mental Health Branch and senior staff at The Park, as you would be aware, the Redlands Adolescent Extended Treatment capital project has been recently cancelled.

The BAC facility at The Park is approaching 40 years of age and has been identified by the Australian Council of Healthcare Standards as unsafe and necessitating urgent replacement. Further, there is concern regarding its co-location with adult forensic and secure services at The Park.

At this point in time, no decision has been made by the West Moreton Hospital and Health Board and the purpose of the planned meeting tomorrow, Thursday, is to provide some clarity and commence discussions in regards to the next steps for determining the solution and alternate services for this consumer group.

I look forward to working with you.

Thank You

Lesley Dwyer
Chief Executive

West Moreton Hospital and Health Service
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Department RecFind No:	
Division/HHS:	MD09
File Ref No:	

Briefing Note for Noting

Queensland Mental Health Commissioner

Requested by: Lesley Dwyer, Chief Executive, West Moreton Hospital and Health Service

Date requested: 16 July 2013

Action required by: 19 July 2013

SUBJECT: Barrett Adolescent Strategy

Proposal

That the Commissioner:

Note progress in the Barrett Adolescent Strategy and the pending actions.
And
Note no public announcement has been made to-date about closure of the Barrett Adolescent Centre, but is anticipated within the next two weeks.

Urgency

1. Urgent. There is growing concern amongst stakeholders of the Barrett Adolescent Strategy, (the Strategy) regarding timely communication about the future of the Barrett Adolescent Centre (BAC).

Headline Issues

2. The top issues are:
   - Commencing December 2012, the Strategy conducted broad consultation and planning processes pertaining to the provision of adolescent mental health extended treatment and rehabilitation care in Queensland.
   - Seven recommendations made by the Expert Clinical Reference Group were considered by the West Moreton Hospital and Health Board (the Board) on 24 May 2013.
   - The Board considered the recommendations and decided to approve the closure of BAC dependent on alternative, appropriate care provisions for the adolescent target group and a targeted communication process prior to public announcement.
   - Consultation was most recently conducted with the Minister for Health on 15 July 2013, with his support to proceed following communication with the Director General, Department of Education, Training and Employment and the Queensland Mental Health Commissioner.

Key issues

3. It is proposed that BAC will close by 31 December 2013.
4. There is significant consumer/carer, community, mental health sector and media interest about a decision regarding the future of the BAC. Timely public notification is a priority and a comprehensive communication plan has been developed.
5. Some stakeholders within the mental health sector and community have noted strong support for maintaining services at BAC indefinitely and the issue has attracted significant media attention.
6. The pending actions for the Strategy include:-
   - finalisation of the targeted communication process with the Director General, Department of Education, Training and Employment and the Queensland Mental Health Commissioner;
   - public notification of the closure of BAC and ceasing all new admissions to the service;
   - supporting the transition of current BAC consumers to alternative care options that best meet their individual needs; and

Department RecFind No:	
Division/HHS:	MD09
File Ref No:	

- the transfer of current operational funding from BAC to the alternative service options being developed/identified.

7. The Department of Health is urgently progressing planning for Youth Prevention and Recovery Care (Y-PARC) services to be established in Queensland by January 2014. This service type will provide one alternative care option for the adolescent target group currently accessing BAC.

Background

8. BAC is a 15-bed inpatient service for adolescent mental health extended treatment and rehabilitation that is located at The Park – Centre for Mental Health (The Park).
9. The BAC model of care and education program was developed and implemented 30 years ago.
10. Department of Education, Training and Employment provide an on-site school for BAC consumers (including some day patients).
11. The BAC cannot continue to provide services due to The Park becoming an adult secure and forensic campus by 2014, and because the capital fabric of BAC is no longer fit-for-purpose.
12. It is not in the best interests of adolescents requiring extended treatment and rehabilitation services to be cared for in an inpatient facility that is located within the same environment as adults with forensic mental health diagnoses requiring high secure treatment.
13. There is currently no capital funding to build a replacement adolescent extended treatment and rehabilitation facility at an alternate location in Queensland.
14. Contemporary models of care support community-based services for adolescents requiring extended treatment and rehabilitation.
15. The Expert Clinical Reference Group consisted of multidisciplinary state wide representation of child and youth mental health clinicians, an interstate child and youth mental health psychiatrist, education representative, and consumer and carer representatives.

Consultation

9. Consultation about the proposed next stages of the Strategy and Board decision for closure of BAC has been limited to the Minister for Health; the Director General Department of Health; Dr Peter Steer, Children's Health Services; and Dr Michael Cleary and Dr Bill Kingswell, Health Services and Clinical Innovation, Department of Health. A briefing will also be provided to the Director General, Department of Education, Training and Employment.
16. Agreement has been reached that the Strategy will be finalised through a partnership between West Moreton Hospital and Health Service, Children's Health Services and the Department of Health.

Department RecFind No:	
Division/HHS:	MD09
File Ref No:	

Recommendation
That the Commissioner:

Note progress in the Barrett Adolescent Strategy and the pending actions.
And
Note no public announcement has been made to-date about closure of the Barrett Adolescent Centre, but is anticipated in the next two weeks.

APPROVED/NOT APPROVED **NOTED**

Dr Lesley van Schoubroeck
Commissioner

/ /

Commissioner's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Dr Leanne Geppert	Sharon Kelly	Lesley Dwyer
A/Director of Strategy	Executive Director	Chief Executive
Mental Health & Specialised Services, WM HHS	Mental Health & Specialised Services, WM HHS	West Moreton HHS
17 July 2013	17 July 2013	18 July 2013

Barrett Adolescent Parent Session

11 December 2013

Today…

1. Overview of the Transitional Service Options
2. Update from Children's Health Queensland on elements of the proposed future service options
3. Presentation – Dr Sandra Radovini (Victoria)

Goals…

- Update on progression of work around future service options
- Opportunity to ask questions and provide input
- Hear about Victorian service models and their experience in caring for young people with complex mental health needs

WM HHS Transitional Service Options - an interim plan

Recovery oriented treatment and rehabilitation for young people (aged 16 – 21 years) with severe and persistent mental health problems

Key Issues:

- Imperative at all levels to ensure no gap to service delivery for BAC consumers and other young people in Qld
- Partnership service model – WM HHS, CHQ, Aftercare, Department of Health
- The interim options will be a pilot for the future service options
- Need to focus on individual, recovery–orientated packages of care, that reintegrate and reconnect young people to their communities, family, school/vocation and local mental health services
- Clinical safety and risk mitigation are key priorities
- Interface between QH and DETE is high priority – Alignment between QH and DETE model of service delivery

EXHIBIT 55

WM HHS Transitional Service Options - 3 Phases

Phase 1

Activity Based Holiday Program

Site – The Park
16 December 2013 – 24 January 2014

Target population
Current BAC inpatients and day patients (as clinically safe and indicated)
Severe and persistent mental health problems – rehabilitation
Medium to high level of acuity

Referral Process
BAC Assessment and Referral

Overview of service / treatment
Activity and socialisation focus
Monday to Thursday school hours + parent session on Fridays

Staffing Required
Core staff:– Aftercare team (clinical and other) + BAC staff

Length of Program Delivery
Up to length of Christmas School Holidays 2013/14

Governance
WM HHS and Aftercare

Phase 2

West Moreton Transitional Service:
- **Assertive Community Outreach Service**
- **Day Program**
- **Supported Accommodation**
- **Pursuing option for sub-acute inpatient beds**

Site – To be confirmed (pursuing Greenslopes option)
February 2014 commencement

Target population
Current BAC inpatients and day patients 16y-21y
New patients meeting criteria from other HHSs – previously eligible for referral to BAC
Severe and persistent mental health problems – rehabilitation
Medium to high level of acuity

Referral Process
CYMHS Assessment and Referral
State-wide Clinical Referral Panel

Overview of service / treatment
Assertive Community Outreach Service: 5 days / extended hours
Delivered in least restrictive environment and utilising a recovery model – range of flexible outreach services for engagement, treatment & rehabilitation to assist young people to meet their developmental tasks in the context of recovery from mental health presentations
Day Program: Monday to Thursday school hours and school terms
Delivered in a therapeutic milieu – range of facilities in community
Individual, family and group therapeutic & rehabilitation programs
In-reach educational tutors + ongoing access to local school/vocation
Supported Accommodation: 7 days
Delivered in a therapeutic milieu – domestic style facility
In-reach CYMHS clinical team

Staffing Required
Core staff:– Aftercare team (clinical and other) + identified CYMHS clinician/s

Length of Program Delivery
ACOS & Day Program: Up to 12 months, Supported Accomm: Up to 6 months

Governance
Joint – CHQ, WMHHS, Aftercare

Phase 3

Transition to State-wide Adolescent Extended Treatment and Rehabilitation Services*

***Details to be defined via the Statewide AETR Strategy, under leadership of CHQ HHS**

Target population
As per State-wide Adolescent Extended Treatment and Rehabilitation Strategy

Governance
CHQ HHS

Children's Health Queensland Hospital and Health Service

Proposed Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care

Assoc. Prof. Stephen Stathis
Clinical Director, CYMHS
Children's Health Queensland, Hospital & Health Service

Great State. Great Opportunity

Queensland Government

Background

On 6 August, 2013, the Minister for Health, the Honourable Lawrence Springborg MP made an announcement that adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.

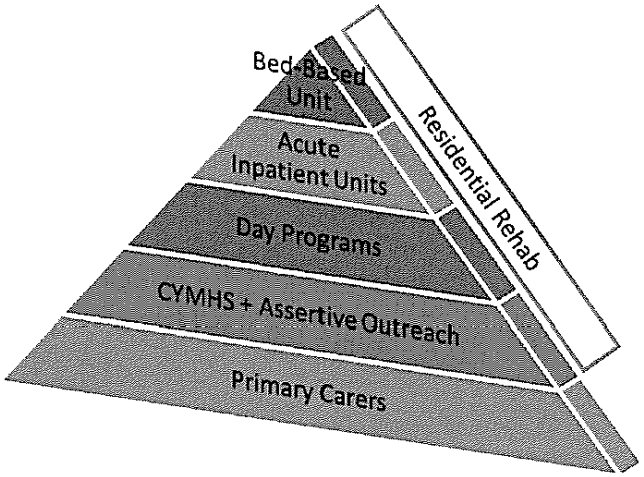
Our Consultation Process

- Expert Clinical Reference Group
- Mental health experts and care providers across QLD and Australia
- Site Visits:
  - Victoria – Intensive Mobile Youth Outreach Services; Y-PARC; Youth Residential Units
  - NSW – Walker Unit and Rivendell – Concorde Hospital
  - QLD – Mobile Intensive Team (Adult); ADAWS; TOHI
- Consumer / Carer Engagement on Working Groups and Steering Committee
- Regular communication with families, carers, and young people currently using services

ECRG Recommendations

Tier 1	Public Community Child and Youth Mental Health Services (existing)
Tier 2a	Adolescent Day Program Services (existing + new)
Tier 2b	Adolescent Community Residential Service/s (new)
Tier 3	Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service (new)

Proposed Model of Care Options*



* Please note that the number and location of services, proposed in the Model of Care above, is subject to the availability of skilled workforce and funding.

Proposed Assertive Community Treatment Service (Tier 2a)

This service provides ongoing care and treatment through intensive mobile interventions in a community or residential setting.

For adolescents who may have…

- A need for intensive supportive care out of hours
- No fixed address or are transient
- A high risk of disengagement from treatment services
- No bed-based or Day Program options in their local community

Proposed Day Program (Tier 2a)

This service provides a range of intensive therapy, extended treatment, and rehabilitation through individual and group therapy.

For adolescents who ...

- Have a history of school exclusion or refusal
- Have social difficulties requiring group-based work
- Have a supportive home environment that ensures safety and/or access to CYMHS
- Live within proximity to the Day Program
- Don't require inpatient care

Proposed Step Up / Step Down Unit (Tier 2b)

This service provides short-term residential treatment, in partnership with NGOs, with services provided by specialist-trained mental health staff.

For adolescents who ...

- Require an increase in intensity of treatment to prevent admission into an acute inpatient unit (Step Up)
- Enables early discharge from a subacute/acute inpatient unit (Step Down)

Proposed Residential Rehabilitation Unit (Tier 2b)

This service provides long-term accommodation and recovery-oriented treatment, in partnership with NGOs, with inreach services from specialist-trained mental health staff.

For adolescents who ...

- Are 16 to 21 years old and able to consent to treatment
- May be unable to return home
- Require additional support to develop independent living skills
- Don't require inpatient care

Proposed Subacute Bed-Based Unit (Tier 3)

This service provides medium-term, intensive, hospital-based treatment and rehabilitation services in a secure, safe, structured environment.

For adolescents who ...

- Have a level of acuity or risk that requires inpatient admission
- Are unlikely to improve in the short term (i.e. weeks or months)
- Require a therapeutic environment not provided by an acute inpatient unit

Timeframes

Model of Care

Nearing completion, with work being undertaken to finalise the details of all options.

Implementation

Needs to consider:

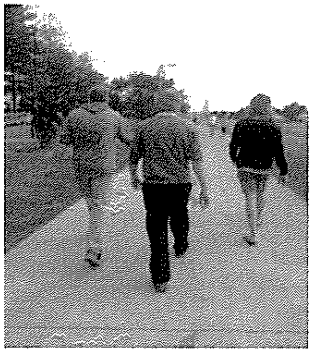
- Areas of community need
- Availability of skilled resources and funding

Some service options will be available earlier than others

For more information...

More information about the model of care, and its implementation, will be made available at:

http://www.health.qld.gov.au/rch/families/cymhs-extendedtreat.asp



In the meantime, if you have any questions about our plans, please contact:

Children's Health Queensland *The best care for our kids*

EXHIBIT 55

EXHIBIT 55

"I G-17"

EXHIBIT 55

EXHIBIT 55

"LG-18"

Parent Submission to Service Options Implementation Working Group, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

Laura Johnson - Project Officer

Mental Health and Specialised Services

West Moreton Hospital and Health Services

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

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

Introduction

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

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

reducing the numbers of young people with severe and complex needs. Even with a widespread system of well-funded, well-staffed, well-coordinated services for these young people existed state-wide, there will always be some young people who will fall through the gaps. Lack of staff, lack of funding, geographic isolation, unsupportive home environment, abuse, young person's avoidance of help, complexity of young person's mental illness (dual diagnosis) – many reasons will cause the young person to progress to a point where they will need the treatment and rehabilitation of a centre like Barrett. No system or model of care will be perfect and be able to catch every young person that needs help or treatment at the time they most need it. However these young people should be provided with the very best and most comprehensive treatment and rehabilitation available. They are the most vulnerable of all young people and the reality is not all of them will survive. There must be extended treatment and rehabilitation services with onsite schooling for young people with severe and complex mental health problems.

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

(i) Education: Onsite Schooling.

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

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

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

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

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

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

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

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

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

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

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

(ii) Services away from home:

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

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

(iii) Combined Inpatient/Day-patient capacity:

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

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

(iv) Community:

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

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

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

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

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

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

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

(i) No/insufficient service available:

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

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

(ii) Lack of recognition of developmental theory:

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

(iii) Failure to access service:

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

(iv) Lack of networking and collaboration between services:

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

(v) Lack of recognition of genuine family support

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

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

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

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

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

(i) E-health/E-Therapy:

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

(ii) Family Units:

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

(iii) Mobile Services

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

(iv) Clinical Case Management Advisory Teams:

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

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

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

Refer to attachment

(v) **How did they get here?**

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

Imaging your child having attempted suicide several times and then the only way you can get your child into the specialist care they so obviously need is by advocating to your federal MP to pressure the Health Minister to do something so your child doesn't die. Imagine being a parent who has told specialists over and over again what they see their child do, how they see their child behave, how their child won't leave the house – won't get off their bed because of the anxiety that they will vomit: and then being looked at as a though you are 'helicopter parent'; a 'Munchausen by Proxy' candidate; a neurotic, deluded possibly menopausal woman with her own mental health problems who is misunderstanding

adolescent behaviour. Parents/carers fight. They get tired: exhausted. They will dissolve into tears when they tell you about their children – not because they are coming unhinged – but because they love them and it devastates them to see their child spiral into despair; because they've sat beside a hospital bed after a suicide attempt and wondered if their child would live; because they listen to their child banging their head on the metal bed frame out of frustration because they can't understand why they can't be 'normal' and they don't understand why they feel the way they do. You would cry too. There is a huge push to end the stigma surrounding Mental Illness, but there should also be a campaign to end the judgement, blame, preconceptions, against parents/carers. Obviously there are parents that don't care, abuse and neglect and fail to support their children. But don't demonise all parents and automatically assume the worst. There is an enormous and devastating impact on the parents/carers and families of young people with severe and complex mental health problems. They need support, understanding, and they know their children.

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

4. Other comments for consideration.

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

Recommendation 10

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

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

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

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

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

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

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

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

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

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

Utilising the Barrett Centre for Research and Specialist Advisory Centre ... an added benefit of sustaining/expanding the Barrett model

The Fourth National National Mental Health Plan states that *"services should be informed by the available evidence and look to innovative models as examples of service improvement."* Therefore, with 30 years of data and information that could be utilised for retrospective studies, Barrett is in a unique position to study a range of aspects of adolescent mental health and mental illness. It is therefore consistent with National mental health objectives. With its move to governance by Children's Health Queensland, the research and education function of Barrett would fit well within Children's Health Queensland Strategic Plan, under Strategic Direction 6 i.e. *"excellence in paediatric health care through innovation, research, education and the application of evidence-based practice across daily processes and systems. We will embrace invention and innovation to continually improve the value of our service."*

Study areas could include self-harming, social anxiety (in particular its role in social isolation and exclusion) and benefits to recovery of the 'community' environment created at Barrett. Barrett could link with other institutions/research facilities to become part of larger studies or focus on research in the unique environment – where adolescents engage in a range of activities and environments (including Education) always supervised and observed by staff.

Information gathered from Barrett could be used to inform practice and treatment in many other areas. With such an emphasis on prevention and early intervention in National and State mental healthcare objectives, Barrett could make a valuable contribution by analysing the circumstances under which adolescents find themselves admitted to Barrett and use this information to develop strategies and processes for prevention, early intervention and even identification of risk factors. I acknowledge that an extended treatment facility is an expensive model to fund, however the capacity for research within such a facility to inform practice and structure of models for earlier intervention could prove invaluable – and provide savings in the long term, particularly if this could result in the reduction of young people requiring extended treatment. That research could improve the effectiveness of earlier intervention, improving outcomes and recovery for adolescents at an earlier stage. That would both reduce the cost of service provision and reduce waiting lists for services offering more intensive/inpatient care – and importantly save young people from progressing further through the mental health system than they would otherwise do.

Barrett is also in the unique position of being able to observe the effects of treatment on and the associated changes that take place in adolescents who transition from full-time inpatient to day patient. Barrett can continue to monitor the progress of day patients and adjust treatment level and type accordingly. Follow-up studies on young people after discharge could identify successes and reasons why others may need to return to other forms of care. Observations and knowledge gained from these observations is quite unique and could be applied to a range of treatment settings.

There is opportunity to build on and improve the treatment program:, family units, for those who live outside the metropolitan area, could be attached to Barrett to better facilitate the involvement in and support of parents in their child's treatment, such as is available for parents of children with other health problems (Ronald McDonald House). Barrett could develop models for interaction with young people via this E-Health/E-Therapy. This could be integrated into the full range of treatment and therapy programmes for young people who are on leave from the centre, follow-up of recently discharged patients, even to commence contact with young people on the waitlist and their clinicians, therapists and family/supports. Group therapy and professional development could be

delivered to rural and regional areas, facilitated by local staff. Offering the facility for family contact would enable to young people to have a more meaningful interaction with their families, especially when they are a long way from home. E-health modes could be used to facilitate contact/consultation with rural/regional clinicians who request or require consultation with the specialist team at Barrett, even so far as establishing case conferencing for young people on the waitlist or for consideration for referral.

Introducing promotion and early intervention strategies into schools and training school staff in the identification of students at risk of mental health problems is an avenue for reducing the stigma of mental health issues and increasing the opportunity for early intervention. In Priority Area 2 of the Fourth National Mental HealthWork one of the actions is to " work with schools..to deliver programs to improve mental health literacy and enhance resilience." One of the "indicators for monitoring change is the proportion of primary and secondary schools with mental health literacy component included in curriculum." The Barrett School could provide training opportunities for education students, such as the treatment side of Barrett does now for a range of clinical and therapeutic students. The Education staff working in the Barrett School possess many years of experience working with adolescents in an education environment. One of the great tragedies, should Barrett close, is that the collective knowledge and experience of the team will be lost. With mental health issues so prevalent in adolescence, this expert education team are in a position to be able to document practices and strategies and share this information throughout the state education system – a valuable opportunity that should not be lost. The educators at Barrett recognise this and have commenced an action research project on *Pedagogy for adolescents with psychiatric disorders* and presented at a conference in Amsterdam. In addition, the teaching group could link with other organisations to participate in studies and/or contribute to the community knowledge base of mental health issues in schools.

The Queensland Health Minister, during interviews at the time he announced the closure of Barrett Adolescent Centre, repeatedly claimed Barrett had done a good job over the years. *Why then, close it?* The wealth of knowledge and expertise at Barrett is extremely valuable and it has been a successful facility. Why not build on the important role it has played in treating a unique and specific group of adolescents, whose needs will not be adequately met by community-based models. It is intended that the Mental Health Commission will *"promote greater use of research and evaluation in service development and delivery."* It is to develop a whole-of-government strategic plan that in part *"drives innovation and best practice through knowledge sharing, research and evidence-based policy and practice."* Barrett *with a research function* could certainly aspire those QMHC objectives. Surely there is scope even for Barrett to link with University of Queensland and/or other Tertiary institutions and the Queensland Centre for Mental Health Research? Orygen Youth Health in Victoria very successfully combines a research function with a youth mental health service model and it attracts significant funding – another $18 million from the new Federal Government for its research into youth mental health issues and service delivery. There is no reason that the Barrett Research facility could not be in the same position.

There is a considerable and increasing amount of research into community based/collaborative models of care and but little research on Tier 3 service provision for severe levels of mental illness other than acute care – certainly no research on a unique facility such as Barrett that combines treatment and rehabilitation and education with community connection, from a 'recovery platform'. If Barrett is being closed because of a lack of evidence in contrast to that existing to support community based models of care, that is, in essence, a false premise, as there is a general lack of any research and any evidence, supportive or otherwise. Can the government guarantee that the recovery and social inclusion for this cohort of youth with severe mental illness will be better under

new models of care – what measures did they use? Does the government know what the rates for re-engagement in education, training, employment and socially are for these young people – how did they measure those? Is the government certain that readmissions and relapses will be reduced under the new model – if so, how did they arrive at these figures? These questions and many others could be answered if the Barrett model could incorporate with a research facility. The argument for a new model to replace Barrett must be based on more than just being 'contemporary'. There must be some justification based on outcomes. There is significant justification for the existence of Barrett model within the National Mental Health Framework and the Fourth National Mental Health Plan. Rather than close in favour of new options, the government should be valuing the unique resource and knowledge base of Barrett and building on its significant foundations and looking at ways to utilise this valuable knowledge.

We urge those undertaking the future planning for mental healthcare across Queensland to consider the opportunities that retention of the Barrett Centre affords – not simply in providing the ongoing successful treatment of young sufferers of severe mental illness (there is no doubt that that is ample reason for the centre's existence), but as a vital tool in the research that could define future models beyond Queensland and even Australia. To neglect this valuable resource and the role it could play in the future not only ignores the needs of current adolescent sufferers of mental illness, but those in the generations to come.

STATEMENTS BY QUEENSLAND HEALTH ON THE TIMEFRAME FOR CLOSURE OF THE BARRETT ADOLESCENT CENTRE & THE PROVISION OF SERVICES UNTIL THE AVAILABILITY OF A NEW MODEL OF CARE

6 AUGUST 2013

PARENTS/CARERS OF CURRENT BARRETT PATIENTS PHONED BY WMHHS MANAGEMENT

WMHHS states that the Barrett Centre will close in January 2014.

6 AUGUST 2013

RADIO INTERVIEW WITH REBECCA LEVINGSTON ON 612 ABC BRISBANE

HEALTH MINISTER LAWRENCE SPRINGBORG

So it is true that some time in early 2014 that Centre will be closing as we come up with a range of new options to deliver services closer to people in their own home or right in their own home town.

... we expect to have the options available to people in early 2014 and the transition will start in the early part of 2014 once we build up services in other areas around the State.

*(In response to the question **Will you guarantee that there will be services operating in Queensland before Barrett shuts?)*** That's the whole point of this to leave no one who is currently a patient or resident there and those that are hopefully, you know, on the list so that they can have services closer to their own home ...

... as I've indicated we've probably got about another 7 to 8 months before its completely formalised and that's being done in consultation with this expert panel.

*(In response to the question **Alright so 7 to 8 months before you finalise the plan and is that the point at which you'll be able to tell Queensland "Look this is where these centres will be located"?)*** ... Absolutely and where the options are and an additional $2,000,000 will be put in to it over and above the money which is currently allocated so we believe that will not only properly have facilities and support for these young people with complex needs but to accommodate additional young people as well who have these care needs ... we'll have a much clearer picture by the latter stages of this year and the final details around it will be the early part of next year. Where are we – in August now – so it will probably be looking in that 6 or odd months down the track.

6 AUGUST 2013

QUEENLAND GOVERNMENT MEDIA STATEMENT

WEST MORETON HOSPITAL & HEALTH SERVICE and
CHILDREN'S HEALTH QUEENSLAND HOSPITAL & HEALTH SERVICE

West Moreton Hospital and Health Service Chief Executive Lesley Dwyer and Children's Health Queensland Chief Executive Dr Peter Steer today said adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Ms Dwyer said the young people who were receiving care from Barrett Adolescent Centre at that time, would be supported to transition to other contemporary care options that best meet their individual needs. ... Dr Steer said as part of its statewide role to

provide healthcare for Queensland's children, Children's Health Queensland would provide the governance for any new model of care. "This means that we will work closely with West Moreton HHS as well as other hospital and health services and non-government agencies to ensure there are new service options in place by early 2014," Dr Steer said.

6 AUGUST 2013

QUEENLAND GOVERNMENT FAQ SHEET

WEST MORETON HOSPITAL & HEALTH SERVICE and CHILDREN'S HEALTH QUEENSLAND HOSPITAL & HEALTH SERVICE

Barrett Adolescent Centre will continue to provide care to young people until suitable service options have been determined. We anticipate adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. ... The governance of the adolescent mental health service has been handed to the Children's Health Queensland Hospital and Health Service and an implementation group will progress the next step. This group will use the expert clinical reference group recommendations, and broader consultation, to identify and develop the service options. We anticipate that some of those options will be available by early 2014.

7 AUGUST 2013

FIRST SESSION OF THE FIFTY-FOURTH PARLIAMENT

HEALTH MINISTER LAWRENCE SPRINGBORG

That expert panel is working towards a final decision on the model of care for the early part of 2014 and the transition of those young people into that particular model of care ... I can assure this House that none of those young clients currently there will be left in the lurch. They will be properly accommodated and looked after, and there will be additional capacity for others— (Time expired)

7 AUGUST 2013

RADIO INTERVIEW WITH STEPHANIE SMAIL ON 'THE WORLD TODAY', ABC RADIO

HEALTH MINISTER LAWRENCE SPRINGBORG

The final makeup of this will be known to us early next year and no decision will be made to actually put those young people with complex care needs into the alternative services until it's been properly worked out by the clinicians, properly discussed, properly consulted and all finalised. But the likely changes will be made; we'll know early next year.

7 AUGUST 2013

THE AUSTRALIAN

Health Minister Lawrence Springborg told the ABC the closure would go ahead early next year.

7 AUGUST 2013

THE BRISBANE TIMES (TONY MOORE)

Health Minister Lawrence Springborg says it will take eight months to finalise where Barrett Adolescent Centre patients will go when the mental health facility shuts down next year. Mr Springborg announced on Tuesday night that the 15-bed centre - Queensland's only adolescent mental centre - would close in early 2014. The location of the new mental health care services will be announced in early 2014.

HEALTH MINISTER LAWRENCE SPRINGBORG

We will be taking the advice of the expert panel who is indicating to us whether the need is to have more inpatient beds, or whether these young people can be supported in residential accommodation in their own community, with the experts in a more homey-type environment," *Mr Springborg told 612 ABC Brisbane on Tuesday night. ... Last week, Queensland's new mental health commissioner Lesley van Schoubroeck said there were no immediate plans to close the Barrett Centre, but she believed it would eventually be replaced by a better facility. Mr Springborg said he would present options to parents early in 2014.*

We expect to have the options available to people in early 2014 and the transition will start in the early part of 2014, as we build up services in the other parts of the state.

(Mr Springborg said an extra $2 million had been allocated to fund these new services.)

We understand these young people have very, very complex mental health care needs and that will involve that they have inpatient, or very, very supportive residential requirements around the state.

(He later described the service as "in-patient equivalent".)

There has to be in-patient equivalent support for all of them and hopefully for additional young people around Queensland.

(Mr Springborg ruled out building a replacement adolescent mental health care facility at Redland Hospital, as the previous government proposed.)

That will not be going ahead per se, as a major development, but it may very well be possible as part of this, that smaller residential type options with that acute support in various areas are available to people closer to their own homes.

7 AUGUST 2013

EMAIL TO ALISON EARLS, INITIATOR OF SAVE THE BARRETT CENTRE PETITION

EXECUTIVE DIRECTOR, MENTAL HEALTH & SPECIALISED SERVICES, WEST MORETON HOSPITAL & HEALTH SERVICE

As identified in an announcement yesterday, adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from Barrett Adolescent Centre at that time will be supported to transition to other contemporary care options that best meet their individual needs.

8 AUGUST 2013

THE QUEENSLAND TIMES

HEALTH MINISTER LAWRENCE SPRINGBORG

They are working towards a final decision with regards to a model of care around about the early part of 2014. ... The transition of those young people...may involve in-patient, complex treatment and also support from the Department of Education

for the educational needs of those young persons with complex mental health needs.

8 AUGUST 2013

4ZZZ RADIO INTERVIEW

WEST MORETON HOSPITAL & HEALTH SERVICE CHIEF EXECUTIVE, LESLEY DWYER

I need to be really clear – we will continue as West Moreton Hospital & Health Service to provide care at the Barrett Adolescent Service until there is an agreed statewide model for adolescent mental health services.
*(In response to the question **Is there, or will there be, a timeline so that staff, patients and parents can essentially know what's going to happen to them and know how they'll be adjusted into the new model?)*** Look, we've been talking about early in 2014 but what I will say is we will continue to operate Barrett until at such time there is an agreed model and those models are up and running and that the transition plans for our current adolescents have been agreed with by their treating clinicians, the adolescent themselves and their carer and families.

9 AUGUST 2013

EMAIL TO [redacted] PARENT OF BARRETT CENTRE PATIENT

WEST MORETON HOSPITAL & HEALTH SERVICE BOARD CHAIR, DR MARY CORBETT

Children's Health Queensland will provide the leadership for a new model for adolescent services. In the meantime the Barrett Adolescent Centre will continue to provide services until this model is operational.

22 AUGUST 2013

FIRST SESSION OF THE FIFTY-FOURTH PARLIAMENT

HEALTH MINISTER LAWRENCE SPRINGBORG

... with regard to the expert panel and its recommendations and working with the Mental Health Commissioner, no decision will be made to close that facility until such time as we know that appropriate alternatives are in place, including alternatives which adequately ensure that young people with educational needs, as many of them are, can be supported in conjunction with Education Queensland. ... This is a decision which will be made some time in the early part of next year. ... I can assure the House that no-one will be disadvantaged by this decision.

EDUCATION MINISTER JOHN-PAUL LANGBROEK

It is very clear that my department through the metropolitan region is establishing a working group to review and make recommendations on effective educational provisions to meet the needs of the new service model being investigated by Queensland Health. I am advised that Queensland Health advises that this model could take up to three years to develop and implement.

23 AUGUST 2013

WEST MORETON HOSPITAL & HEALTH SERVICE 'FAST FACTS' 6

... adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from the Barrett Adolescent Centre (BAC) at that time will be supported to transition to other contemporary service options that best meet their individual needs. ... so we are ready to deliver new service options by early 2014. ... There will be no gap to service provision for the young people currently receiving care from BAC.

28 AUGUST 2013

EMAIL TO ALISON EARLS, INITIATOR OF SAVE THE BARRETT CENTRE PETITION

HEALTH SERVICE CHIEF EXECUTIVE, CHILDREN'S HEALTH QUEENSLAND HOSPITAL & HEALTH SERVICE DR PETER STEER

... adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care for the Barrett Adolescent Centre at that time will be supported to transition to other contemporary care options that best meet their individual needs.

12 SEPTEMBER 2013

THE BRISBANE TIMES (TONY MOORE)

Mr Springborg last month said no patients would be moved from the Barrett Centre until options were prepared for parents in early 2014.

HEALTH MINISTER LAWRENCE SPRINGBORG

We expect to have the options available to people in early 2014 and the transition will start in the early part of 2014, as we build up services in the other parts of the state.

30 SEPTEMBER 2013

RADIO INTERVIEW WITH REBECCA LEVINGSTON ON 612 ABC BRISBANE

***(In response to the question** In terms of the closure, is it still January 2014?)*

QUEENSLAND MENTAL HEALTH COMMISSIONER, LESLEY VAN SCHOUBROECK

My understanding is that they want to get it done before the next school year starts. And my understanding is also they're working with each individual child so it won't be necessarily everybody will go to a new place. But an individual plan for every child is what they're focussing on.

STATEMENTS BY QUEENSLAND HEALTH ON THE TIMEFRAME FOR CLOSURE OF THE BARRETT ADOLESCENT CENTRE & THE PROVISION OF SERVICES UNTIL THE AVAILABILITY OF A NEW MODEL OF CARE

6 AUGUST 2013

PARENTS/CARERS OF CURRENT BARRETT PATIENTS PHONED BY WMHHS MANAGEMENT

WMHHS states that the Barrett Centre will close in January 2014.

6 AUGUST 2013

RADIO INTERVIEW WITH REBECCA LEVINGSTON ON 612 ABC BRISBANE

HEALTH MINISTER LAWRENCE SPRINGBORG

So it is true that some time in early 2014 that Centre will be closing as we come up with a range of new options to deliver services closer to people in their own home or right in their own home town.

... we expect to have the options available to people in early 2014 and the transition will start in the early part of 2014 once we build up services in other areas around the State.

*(In response to the question **Will you guarantee that there will be services operating in Queensland before Barrett shuts?)*** That's the whole point of this to leave no one who is currently a patient or resident there and those that are hopefully, you know, on the list so that they can have services closer to their own home ...

... as I've indicated we've probably got about another 7 to 8 months before its completely formalised and that's being done in consultation with this expert panel.

*(In response to the question **Alright so 7 to 8 months before you finalise the plan and is that the point at which you'll be able to tell Queensland "Look this is where these centres will be located"?)*** ... Absolutely and where the options are and an additional $2,000,000 will be put in to it over and above the money which is currently allocated so we believe that will not only properly have facilities and support for these young people with complex needs but to accommodate additional young people as well who have these care needs ... we'll have a much clearer picture by the latter stages of this year and the final details around it will be the early part of next year. Where are we – in August now – so it will probably be looking in that 6 or odd months down the track.

6 AUGUST 2013

QUEENLAND GOVERNMENT MEDIA STATEMENT

WEST MORETON HOSPITAL & HEALTH SERVICE and
CHILDREN'S HEALTH QUEENSLAND HOSPITAL & HEALTH SERVICE

West Moreton Hospital and Health Service Chief Executive Lesley Dwyer and Children's Health Queensland Chief Executive Dr Peter Steer today said adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Ms Dwyer said the young people who were receiving care from Barrett Adolescent Centre at that time, would be supported to transition to other contemporary care options that best meet their individual needs. ... Dr Steer said as part of its statewide role to

provide healthcare for Queensland's children, Children's Health Queensland would provide the governance for any new model of care. "This means that we will work closely with West Moreton HHS as well as other hospital and health services and non-government agencies to ensure there are new service options in place by early 2014," Dr Steer said.

6 AUGUST 2013

QUEENLAND GOVERNMENT FAQ SHEET

WEST MORETON HOSPITAL & HEALTH SERVICE and CHILDREN'S HEALTH QUEENSLAND HOSPITAL & HEALTH SERVICE

Barrett Adolescent Centre will continue to provide care to young people until suitable service options have been determined. We anticipate adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. ... The governance of the adolescent mental health service has been handed to the Children's Health Queensland Hospital and Health Service and an implementation group will progress the next step. This group will use the expert clinical reference group recommendations, and broader consultation, to identify and develop the service options. We anticipate that some of those options will be available by early 2014.

7 AUGUST 2013

FIRST SESSION OF THE FIFTY-FOURTH PARLIAMENT

HEALTH MINISTER LAWRENCE SPRINGBORG

That expert panel is working towards a final decision on the model of care for the early part of 2014 and the transition of those young people into that particular model of care ... I can assure this House that none of those young clients currently there will be left in the lurch. They will be properly accommodated and looked after, and there will be additional capacity for others— (Time expired)

7 AUGUST 2013

RADIO INTERVIEW WITH STEPHANIE SMAIL ON 'THE WORLD TODAY', ABC RADIO

HEALTH MINISTER LAWRENCE SPRINGBORG

The final makeup of this will be known to us early next year and no decision will be made to actually put those young people with complex care needs into the alternative services until it's been properly worked out by the clinicians, properly discussed, properly consulted and all finalised. But the likely changes will be made; we'll know early next year.

7 AUGUST 2013

THE AUSTRALIAN

Health Minister Lawrence Springborg told the ABC the closure would go ahead early next year.

7 AUGUST 2013

THE BRISBANE TIMES (TONY MOORE)

Health Minister Lawrence Springborg says it will take eight months to finalise where Barrett Adolescent Centre patients will go when the mental health facility shuts down next year. Mr Springborg announced on Tuesday night that the 15-bed centre - Queensland's only adolescent mental centre - would close in early 2014. The location of the new mental health care services will be announced in early 2014.

HEALTH MINISTER LAWRENCE SPRINGBORG

We will be taking the advice of the expert panel who is indicating to us whether the need is to have more inpatient beds, or whether these young people can be supported in residential accommodation in their own community, with the experts in a more homey-type environment," *Mr Springborg told 612 ABC Brisbane on Tuesday night. ... Last week, Queensland's new mental health commissioner Lesley van Schoubroeck said there were no immediate plans to close the Barrett Centre, but she believed it would eventually be replaced by a better facility. Mr Springborg said he would present options to parents early in 2014.*

We expect to have the options available to people in early 2014 and the transition will start in the early part of 2014, as we build up services in the other parts of the state.

(Mr Springborg said an extra $2 million had been allocated to fund these new services.)

We understand these young people have very, very complex mental health care needs and that will involve that they have inpatient, or very, very supportive residential requirements around the state.

(He later described the service as "in-patient equivalent".)

There has to be in-patient equivalent support for all of them and hopefully for additional young people around Queensland.

(Mr Springborg ruled out building a replacement adolescent mental health care facility at Redland Hospital, as the previous government proposed.)

That will not be going ahead per se, as a major development, but it may very well be possible as part of this, that smaller residential type options with that acute support in various areas are available to people closer to their own homes.

7 AUGUST 2013

EMAIL TO ALISON EARLS, INITIATOR OF SAVE THE BARRETT CENTRE PETITION

EXECUTIVE DIRECTOR, MENTAL HEALTH & SPECIALISED SERVICES, WEST MORETON HOSPITAL & HEALTH SERVICE

As identified in an announcement yesterday, adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from Barrett Adolescent Centre at that time will be supported to transition to other contemporary care options that best meet their individual needs.

8 AUGUST 2013

THE QUEENSLAND TIMES

HEALTH MINISTER LAWRENCE SPRINGBORG

They are working towards a final decision with regards to a model of care around about the early part of 2014. ... The transition of those young people...may involve in-patient, complex treatment and also support from the Department of Education

for the educational needs of those young persons with complex mental health needs.

8 AUGUST 2013

4ZZZ RADIO INTERVIEW

WEST MORETON HOSPITAL & HEALTH SERVICE CHIEF EXECUTIVE, LESLEY DWYER

I need to be really clear – we will continue as West Moreton Hospital & Health Service to provide care at the Barrett Adolescent Service until there is an agreed statewide model for adolescent mental health services.
*(In response to the question **Is there, or will there be, a timeline so that staff, patients and parents can essentially know what's going to happen to them and know how they'll be adjusted into the new model?)*** Look, we've been talking about early in 2014 but what I will say is we will continue to operate Barrett until at such time there is an agreed model and those models are up and running and that the transition plans for our current adolescents have been agreed with by their treating clinicians, the adolescent themselves and their carer and families.

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EMAIL TO , PARENT OF BARRETT CENTRE PATIENT

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QUEENSLAND MENTAL HEALTH COMMISSIONER, LESLEY VAN SCHOUBROECK

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HEALTH MINISTER LAWRENCE SPRINGBORG's STATEMENTS ON MENTAL HEALTH

The Mental Health Commission will be happening in Queensland sometime in the next few months and that will take key responsibility for the co-ordination of and also advising government with regards to expenditure of mental health funds here in Queensland. We are going almost beyond this particular stage of what is an epidemically fast-approaching pandemic, when it comes to mental health. If you're looking at any one year, the figures say this, 1 in 5 people have a mental health incident in their life. 1 in 2 have a serious mental health incident and we are not necessarily getting the outcomes for the funding we are putting into those areas. Sometimes what we are finding, I think, is something that's more self-serving and not necessarily being able to be measured in positive outcomes.

August 2012, Speech to Health Media Club

Mr Springborg said he and the West Moreton Hospital and Health Service were "committed to ensuring Queensland's adolescents have access to the mental health care and treatment they need. ... Any revised model of care will ensure that Queensland's youth will continue to receive the excellent mental health care that they have always received. *Mr Springborg said patients, families and the wider community would be updated on any decisions to do with the centre.*

25 March 2013, Queensland Times

If you look at all of our research you see that that is the cohort of people who are at very real risk and have a proportionately high level of mental health issues. So we have to make sure we get the right mix of inpatient facility or supported facility, as has been available at the Barrett for a long period of time. Then we need to look at whether we should be working more with the private sector and not-for-profit sector on how we can provide more community options—as we do with tens of millions of dollars of public money each and every year, engaging on community options. I am very keen on that because I think that is where we need to move to with regard to our treatment, rehabilitation and support options in the future. Having said that, it is also important to understand, as the honorable member does, that there is the need for some capacity that exists in a facility such as Barrett. There is no doubt about it. ... I have actually made it a priority, right across the service providers—making sure the Commonwealth is in the tent, the not-for-profit providers are in the tent and our HHSs are in the tent in terms of dealing with this. We have a disparate and fragmented system. That is a matter I have discussed with the commissioner. I have said to her that I would like to have her policy direction about how we can better knit together the state's $1 billion effort in the area of mental health policy to provide us with holistic guidance around the place.

24 July 2013, Estimates – Health & Community Services Committee – Health

Mental health is of enormous concern in our community not only in adults but also in young people. As the honourable member would be well aware, we contribute about $1 billion to support people who have mental illness in Queensland. Unfortunately, it is an area of not only rising concern but also rising need in this state. The honourable member would also be very much aware that in his own area there are people who are routinely required to seek the assistance of the Barrett centre located within the confines of The Park because it is the only facility at the moment which is capable of